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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IZPD

Facility ID: 00697

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245593**

2.STATE VENDOR OR MEDICAID NO.
(L2) **713343000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - ST JAMES**
(L4) **1000 SOUTH SECOND STREET**
(L5) **ST JAMES, MN** (L6) **56081**

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 **12/19/2013** (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 **55** (L18)

13.Total Certified Beds **55** (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
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date : 12/03/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 12/24/2013 (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 **01/01/1992** (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 **12/26/2013** (L33)

DETERMINATION APPROVAL

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

CCN=24-5539

On December 19, 2013, a Post Certification Revisit (PCR) was completed by the Department of Health and on December 13, 2013, the Minnesota Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility has achieved substantial compliance pursuant to the abbreviated standard survey completed on September13, 2013. Refer to the CMS 2567B for both health and life safety code.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 24, 2014

Mr. Timothy Swoboda, Administrator
Good Samaritan Society - St. James
1000 South Second Street
St. James, Minnesota 56081

RE: Project Number S5593024 and H5593023

Dear Mr. Swoboda:

On November 20, 2013, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 25, 2013 (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 13, 2013. (42 CFR 488.417 (b))

Also, we notified you in our letter of November 20, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 13, 2013.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on September 13, 2013 and a standard survey completed on October 24, 2013. The most serious deficiencies in your facility at the time of the abbreviated standard survey were found 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. The most serious deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On December 19, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 13, 2013 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 an abbreviated standard survey, completed on September 13, 2013 and a standard survey, completed on October 24, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 19, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on September 13, 2013 and our standard survey completed on October 24, 2013, as of December 19, 2013. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 19, 2013.

Also, as a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of November 20, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 13, 2013, be discontinued effective December 19, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective December 13, 2013, is to be discontinued effective December 19, 2013. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 13, 2013, is to be discontinued effective December 19, 2013.

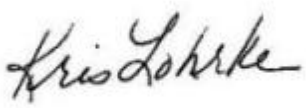
In our letter of November 20, 2013, in accordance with Federal Law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 13, 2013.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,



Kris Lohrke, Assistant Director
Office of Health Facility Complaints
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-4215
General Information: (651) 201-4201, or 1-800-369-7994
Fax: (651) 281-9796

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245593	A. Building B. Wing	12/19/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

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 **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **11/21/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **11/21/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **11/24/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **10/27/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **11/29/2013**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MW/kfd	02/26/2014	28588	12/19/2013
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
10/24/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245593	A. Building B. Wing 01 - MAIN BUILDING 01	12/13/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

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 K0021	Correction Completed 11/25/2013	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** PS/KFD	**Date:** 02/26/2014	**Signature of Surveyor:** 03049	**Date:** 12/13/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 10/25/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 26, 2014

Mr. Timothy Swoboda, Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, Minnesota 56081

Re: Enclosed Reinspection Results - Project Number S5593024, H5593015

Dear Mr. Swoboda:

On December 19, 2013 survey staff of the Minnesota Department of Health, completed a reinspection of your facility, to determine correction of orders found on the complaint investigation completed on September 13, 2013 and the survey completed on October 24, 2013, with orders received by you on November 22, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

cc: Original - Facility
Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00697	A. Building B. Wing	12/19/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **20265** Reg. # **MN Rule 4658.0085** LSC	Correction Completed **11/21/2013**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **11/21/2013**	ID Prefix **20920** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **11/24/2013**
ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **10/27/2013**	ID Prefix **21620** Reg. # **MN Rule 4658.1345** LSC	Correction Completed **11/29/2013**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MW/kfd	02/26/2014	28588	12/19/2013
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
10/24/2013				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: IZPD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00697

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245593**

2.STATE VENDOR OR MEDICAID NO.
(L2) **713343000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - ST JAMES**
(L4) **1000 SOUTH SECOND STREET**
(L5) **ST JAMES, MN** (L6) **56081**

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 **10/24/2013** (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 **55** (L18)

13.Total Certified Beds (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Wendy Buckholz, HFE NE II — 12/03/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 12/24/2013 (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
01/01/1992
(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

CCN=245539

Upon completion of the abbreviated standard survey September 13, 2013 the facility was not in substantial compliance and the most serious deficiencies found constituted actual harm that was not immediate jeopardy (Level G), where by corrections are required as evidenced by attached 2567. As a result the following remedy was imposed:

-State Monitoring, effective November 25, 2013 (42 CFR 488.422)

In Addition, sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that the Department recommends to the CMS Region V Office the following remedy for imposition:

-Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 13, 2013. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment.

Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5168

November 20, 2013

Mr Timothy Swoboda, Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, Minnesota 56081

RE: Project Number H5593015, S5593024

Dear Mr. Swoboda:

On October 1, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on September 13, 2013. 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 October 25, 2013, the Minnesota Departments of Health and Public Safety completed a standard survey to determine if your facility was in compliance with Federal participation requirementsfor skilled nursing facility and/or nursing facilities participating in the Medicare and/or Medicaid programs. The survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), where by corrections are required. As a result of the October 25, 2013 standard survey, this Department is imposing the following remedy:

- State Monitoring, effective November 25, 2013 (42 CFR 488.422)

In Addition, sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, this Department is recommending to the CMS Region V Office the following remedy for imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 13, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective December 13, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 13, 2013. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Good Samaritan Society - St James is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 13, 2013. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Statement of Deficiencies (CMS-2567) for both health and life safety code from the October 25, 2013 visit is enclosed.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathyrn Serie, Unit Supervisor
Minnesota Department of Health
1400 East Lyon Street
Marshall, Minnesota 56258-2529

Telephone: (507) 537-7158
Fax: (507) 344-2723

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,
- Include signature of provider and date.

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

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 December 13, 2013 (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 March 13, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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 March 13, 2014 (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.

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
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5593s14OHFC&LC.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING _____ B. WING _____	10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

(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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	approved 12/3/13 KMS	

RECEIVED
DEC 02 2013
Minnesota Department of Health
Marshall

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

Tim Sundvold | Administrator | 11/27/13

ıy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ıer safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ɔgram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician of a change in condition related to right arm pain and swelling following a fall for 1 of 1 resident (R43) reviewed for death. These factors resulted in harm for R43, who required medical treatment and was subsequently diagnosed with a fractured right arm. Findings include: During review of the closed record of R43, it was noted that documentation was lacking to indicate the physician had been notified of the symptoms experienced by R43 after a fall on 8/19/13. Staff failed to coordinate resident care/symptoms between therapy and nursing staff so that timely physician notification had occurred. R43 was admitted to the facility on 8/16/13 with a history of a fall at home and general weakness. Review of an admission assessment dated 8/23/13, revealed a brief interview for mental status (BIMS) score of 15, indicating R43 to be cognitively intact. Review of an incident report dated 8/19/13 at 10:30 a.m., indicated R43 had been found on the floor in his room, "lying on right side - feet towards bed - parallel to nightstand". The incident report further indicated that R43 had injured his right arm with a bruise/contusion	F 157	Res #43 expired on 8-30-13. The facility policy and procedures related to recognizing change in condition, notifications of condition change and observation, and notification of change in status were reviewed by the Director of Nursing. Written training regarding these areas was given to licensed staff on 10-23-13, with follow-up at the 11-21-13 Nursing meeting. Audits of the resident charts, including Nursing documentation, faxes and other Nurse/Physician communication regarding resident changes were initiated by the Director of Nursing on 10-19-13 and continued x 4 weeks. Audits will continue monthly x 3 months. Results will be monitored by the Director of Nursing and forwarded to the Quality Committee for review.	10-23-13

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F 157	Continued From page 2 measuring 0.8 centimeters (cm) x 0.5 cm. Review of documentation on the clinical monitoring/acute care flowsheets and in the interdisciplinary progress (IDP) notes dated 8/20/13 through 8/23/13, indicated that R43 had experienced daily pain, bruising and a swollen right wrist. Documentation dated 8/22/13 indicated R43 had a "swollen right wrist" and had commented "that hand, I can't even hold a fork". The flowsheet documentation indicated R43 had rated his pain between 6-7 (a rating scale from 1-10 for intensity (10 being the worst pain)) during this timeframe (8/20-8/23). The neuro-check flow sheet dated 8/21/13 indicated that a "muscle rub" had been applied to the right wrist. Occupational therapy (OT) notes were reviewed. An occupational therapy (OT) note dated 8/22/13, included: "...Gentle massage and range of motion to R (right) elbow wrist forearm and fongers[sic]. report soreness in distal, lateral forearm..." Review of the Physical Therapy (PT) Daily Note dated 8/22/13, included: "Pt (patient) states his R wrist is bothering him and he can't put weight through it and that is why he can't lower himself into seat. OT was notified. Wrist appeared visibly swollen..." Review of the PT Daily Note dated 8/23/13, indicated, "Pt required extra encouragement to participate today stating 'I'm sore today, I don't want to do anything.' Pt agreed to 'a little walk' but refused to participate in tx (treatment) after amb (ambulation) wanting to 'sit in the sun' instead." Documentation in the IDP notes revealed that registered nurse (RN)-B had conducted a pain assessment on 8/23/13, which indicated that R43 had identified pain "here" and pointed at a small skin tear on the right arm. According to the assessment, R43 had stated it [pain] had	F 157		

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 3 occurred frequently, had rated the pain an 8 out of 10 (10 being the worst), and that therapy made the pain worse. Additional review of the IDP notes indicated that on 8/25/13 at 10:15 a.m., R43 had left on an outing with a family member for the day. The family member had later contacted the facility at 6:50 p.m. to report that R43 had been taken to the emergency room (ER) and an X-ray of the right wrist had been conducted. Upon return to the facility, from the ER at 8:10 p.m., the family member reported that R43 had been diagnosed with an ulnar fracture. The nurses' notes documentation indicated the resident had a splint applied and had a follow-up orthopedic appointment scheduled. When interviewed on 10/24/13 at 8:53 a.m., RN-B reviewed R43's record and stated that on 8/23/13, while completing the pain assessment, she had noticed that the fingers on R43's right hand were "puffy". RN-B confirmed that R43 had indicated he had right wrist pain, had used muscle rub to alleviate the pain, and that therapy had made the pain worse. When interviewed on 10/24/13 at 12:40 p.m., the director of nursing (DON) confirmed the expectation would have been for the nurse to notify the physician of the resident's change in condition related to the pain and swelling in the right wrist/arm. During the interview, the DON stated, "The physician should be notified of any change in condition." No further documentation was evident to substantiate that the physician had been promptly notified of the resident's change in condition based on the symptoms exhibited by R43. The facility policy titled "Notification of Change in Resident Status," revised February 2005	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 4 indicated, "The center will IMMEDIATELY inform the resident, if appropriate (except in a medical emergency or when resident is incompetent), and consult with the resident's physician and, if known, notify the resident's family or legal representative in the following cases: (1.) Resident accident which results in injury with a potential for requiring physician intervention; (2.) Significant change in the resident's physical, mental or psychosocial status."	F 157		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to seek timely medical direction and/or treatment for right arm pain and swelling following a fall for 1 of 1 resident (R43) whose closed record was reviewed. These factors resulted in harm for R43, who required medical attention and was subsequently diagnosed with a fractured right arm. Findings include: Although R43 had exhibited symptoms of increased pain and swelling of the right wrist after sustaining a fall on 8/19/13, staff failed to report	F 309	Res #43 expired on 8-30-13. The facility policy and procedures related to recognizing change in condition, notifications of condition change and observation, and notification of change in status were reviewed by the Director of Nursing. Written training regarding these areas was given to licensed staff on 10-23-13, with follow-up at the 11-21-13 Nursing meeting. Audits of the resident charts, including Nursing documentation, faxes and other Nurse/Physician communication regarding resident changes were initiated by the Director of Nursing on 10-19-13 and continued x 4 weeks. Audits will continue monthly x 3 months. Results will be monitored by the Director of Nursing and forwarded to the Quality Committee for review.	10-23-13

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F 309	Continued From page 5	F 309		

this change to the physician and ensure that R43 had received a timely medical evaluation. Staff failed to coordinate resident care and monitoring of symptoms, between therapy and nursing staff. It was was not until a family member transported R43 to the emergency room on 8/25/13, that R43 received the necessary services and medical attention for the right wrist pain and swelling, that subsequently was diagnosed as a right ulnar fracture.

R43 was admitted to the facility on 8/16/13, with a history of a fall at home and general weakness. Review of an admission assessment dated 8/23/13, revealed a brief interview for mental status (BIMS) score of 15, indicating R43 to be cognitively intact. The assessment indicated R43 required extensive assistance with bed mobility, transfer, toilet use, dressing, eating and personal hygiene.

Review of an incident report dated 8/19/13 at 10:30 a.m., indicated R43 had been found on the floor in his room, "lying on right side - feet towards bed - parallel to nightstand". The incident report further indicated that R43 had injured his right arm with a bruise/contusion measuring 0.8 centimeters (cm) x 0.5 cm.

Review of documentation on the clinical monitoring/acute care flowsheets and the interdisciplinary progress (IDP) notes dated 8/20/13 through 8/23/13, indicated that R43 had experienced daily pain, bruising and a swollen right wrist. Documentation dated 8/22/13 indicated that R43 had a "swollen right wrist" and had commented "that hand, I can't even hold a fork". The flowsheet documentation indicated R43 had rated his pain between 6-7 (on a rating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 6 scale from 1-10 for intensity, with 10 being the worst pain) during this time frame 8/20-8/23/13. The neuro-check flow sheet dated 8/21/13, indicated that "muscle rub" had been applied to the right wrist. During review of an occupational therapy (OT) note dated 8/22/13, the following was written: "...Gentle massage and range of motion to R (right) elbow wrist forearm and fongers[sic]. report soreness in distal, lateral forearm." Review of the Physical Therapy (PT) Daily Note dated 8/22/13, included: "Pt (patient) states his R wrist is bothering him and he can't put weight through it and that is why he can't lower himself into seat. OT was notified. Wrist appeared visibly swollen..." Review of the PT Daily Note dated 8/23/13 indicated, "Pt required extra encouragement to participate today stating, 'I'm sore today, I don't want to do anything.' Pt agreed to 'a little walk' but refused to participate in tx (treatment) after amb (ambulation) wanting to 'sit in the sun' instead." Additional documentation in the IDP notes revealed that registered nurse (RN)-B had conducted a pain assessment on 8/23/13, which indicated that R43 had identified pain "here" and pointed at a small skin tear on the right arm. According to the assessment, R43 had stated it [pain] had occurred frequently, had rated the pain an 8 out of 10 (10 being the worst), and that R43 had stated therapy made the pain worse. The pain assessment indicated R43 had denied that the pain had affected his sleep but had confirmed the pain did limit activity. The assessment documentation included, "hand et [and] fingers slightly edematous" and the resident had stated,	F 309		

ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 7 "oxycodone (narcotic pain medication) used PRN (as needed) helps." Review of the medication administration record (MAR) revealed that R43 had requested and was administered Tylenol 650 milligrams (mg) orally on 8/24/13 at 2:50 p.m. for complaints of wrist pain. Additional review of the IDP notes indicated that on 8/25/13 at 10:15 a.m., R43 had left on an outing with a family member for the day. The family member had later contacted the facility at 6:50 p.m. to report that R43 had been taken to the emergency room (ER) and an X-ray of the right wrist had been conducted. Upon return to the facility, from the ER at 8:10 p.m., the family member reported that R43 had been diagnosed with an ulnar fracture. The nurses' notes documentation indicated the resident had a splint applied and had a follow-up orthopedic appointment scheduled. When interviewed on 10/24/13 at 8:53 a.m., RN-B reviewed R43's record and stated that on 8/23/13, while completing the pain assessment, she had noticed that the fingers on R43's right hand were "puffy". RN-B confirmed that R43 had indicated he had right wrist pain, had used muscle rub to alleviate the pain, and that therapy had made the pain worse. When interviewed on 10/24/13 at 12:53 p.m., RN-B stated she could not remember whether PT had notified her or any other nursing staff related to complaints of pain during therapy sessions. RN-B stated she had been unaware of R43's right wrist pain until she had performed the pain assessment on 8/23/13.	F 309		

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F 309	Continued From page 8 When interviewed on 10/24/13 at 12:35 p.m., RN-C (who was identified as the 'Medicare nurse'), stated she had not been informed by therapy about R43's complaints of right wrist pain. Interview with the DON on 10/24/13 at 8:14 a.m. confirmed the family member had wanted the wrist evaluated due to the increased swelling and when further interviewed at 12:40 p.m. she confirmed the expectation would have been to notify the physician of the resident's change in condition related to the pain and swelling in the right wrist/arm. The DON stated , "The physician should be notified of any change in condition." Phone interview with the occupational therapist on 10/24/13, at 1:28 p.m. revealed that she could not recall whether R43 had complained of pain during therapy. Phone interview with the physical therapy assistant (PTA)-B on 10/24/13, at 1:54 p.m. confirmed that R43 had complained of pain while in therapy; "I remember him [R43] complaining about it." PTA-B could not recall whether that information had been communicated to the nursing staff, but recalled having reported the pain symptom to OT. PTA-B also confirmed the resident's right wrist had been noted as swollen. Although R43 exhibited symptoms of increased pain and swelling of the right wrist after experiencing a fall on 8/19/13, staff failed to ensure that prompt notification of medical personnel had been initiated so that appropriate interventions could have been implemented to alleviate and treat this medical condition.	F 309		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING _____ B. WING _____	10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

(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 312 SS=D	Continued From page 9 DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide grooming services which included removal of facial hair for 1 of 3 residents (R3) who was dependent on staff to meet personal hygiene needs. Findings include: During all days of the survey, R3 was observed to have long chin hairs on her chin. R3 was admitted to the facility with diagnoses that included general weakness. During an observation on 10/22/13 at 9:45 a.m., R3 was observed to have chin hairs. During observations on 10/23/13 at 10:46 am, and 10/24/13 at 9:52 a.m. R3 was again observed to have chin hairs; (approximately a dozen chin hairs, 1/4-1/2 inch in length and easily identifiable). During interview with R3 on 10/24/13 at 9:52 a.m., R3 stated if she had chin hair, she'd like to have them removed. The quarterly minimum data set (MDS) dated 7/10/13 specified that R3 had no behavior issues of resisting cares, that she had bilateral upper extremity impairment and required extensive assistance of 1 staff for personal hygiene needs.	F 312	The resident observed to have facial hairs was groomed (shaved) by staff on 10-24-13. Residents who require assistance with shaving were identified. Care plans are in place that address the grooming needs for each resident. A written communication was placed in the staff communication book on 10-28-13 with follow-up verbal education at the 11-24-13 Nursing inservice. The Director of Nursing began weekly audits on 10-31-13 and will continue x 4 weeks, then 2x/month x 3 months to ensure compliance. Results of the audits will be monitored by the Director of Nursing and forwarded to the Quality Committee for review.	10-28-13

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F 312	Continued From page 10 Review of the bath list for section 1, revealed that R3 received a bath every Monday. The plan of care dated 10/23/13 specified that R3 required assistance of staff for personal hygiene needs. During an interview on 10/24/13 at 11:01 a.m. with nursing assistant (NA)-B, it was verified that she was responsible for the personal care of R3 on the day shift. NA-B stated she had not identified the need to remove R3's chin hair that morning, but upon visually observing the resident at the time of the interview, confirmed the chin hairs should have been removed. During the interview, registered nurse (RN)-A verified personal care should include the removal of facial hair on both men and women. A policy related to shaving of residents was requested from the director of nursing (DON) but was not provided.	F 312		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

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F 371	Continued From page 11 by: Based on observation, interview, and document review the facility failed to maintain the kitchen in a manner that promoted sanitary food preparation, storage, and service which had the potential to affect 54 of 54 residents who had their meals prepared in the kitchen. Findings include: The facility failed to maintain food preparation equipment and general kitchen environment in a sanitary manner. During the initial kitchen observation on 10/21/13 from 12:40 p.m. through 1:10 p.m. the following observations were made: (a.) The large mixing bowl, which the facility dietary manager stated was used frequently, was noted to have excess dried food debris on the agitator arm and mixer motor assembly where the agitator arm attached to the motor. The agitator arm spring located at the base of the mixer motor was noted to have a black moist substance under and periphery to the spring that could drip into the mixing bowl during the mixing process. The certified dietary manager (CDM) and cook-A verified the mixer had not been utilized since 10/20/13 and the mixer should have been sanitized after use. (b.) The small Kitchen Aide mixer located in the kitchen was noted to have dried white and gray food particles located on the agitator arm and base of motor unit where the agitator arm connected to the motor. The substance was dry and flaked off when a finger was rubbed across the mixer surface. The CDM stated the mixer is	F 371	All areas of the kitchen identified during the survey process were cleaned between October 21st and 24th. The Dietary Manager reviewed the cleaning schedule on 10-24-13. The schedule was reviewed with all dietary staff. Audits to ensure compliance with the cleaning schedule were completed by the Dietary Manager starting the week of Oct. 27th and continued x 4 weeks. Audits will continue to be done weekly x 60 days then monthly x 4 months. Results of the audits will be monitored by the Dietary Manager and forwarded to the Quality Committee for review.	10-24-13

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GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

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F 371	Continued From page 12 seldom utilized and she was unsure when it was last used. The CDM and cook-A stated the mixer was only used one to two times a month. Both staff verified the findings and stated the mixer should have been cleaned and sanitized after each use and verified it had not been sanitized, (c.) The heater and air condition air deflectors in the kitchen located over food preparation, food service, equipment storage, and equipment sanitization areas were noted to have heavy dust and grease build up on the deflectors and periphery ceiling area. Dust particles were noted hanging from the vents and ceiling throughout the kitchen. The findings were verified by the CDM. (d.) The stainless steel roll-up cover and top panel in the kitchen service window between the dining room and kitchen was noted to have excess dust build up on the surface. The dust could be visualized hanging down from the top of the window and on the walls periphery to the window. This was located directly over the area where the steam table was positioned during meal service. On 10/23/13 at 7:50 a.m. the kitchen was evaluated again. During the observation the service window between the kitchen and dining room was noted to have a heavy dust buildup on the top surface. The facility had the breakfast steam table located directly under the location where dust was hanging from the stainless steel service window. Staff were observed to uncover food pans on the steam table and serve food to include: scrambled eggs, toast, and hot cereal to the dining room. During interview with the CDM on 10/23/13 at 8:05 a.m. she verified the findings and stated the surface needed to be cleaned.	F 371		

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F 371	Continued From page 13 On 10/23/13 at 8:15 a.m. the CDM presented a kitchen cleaning schedule that failed to include a cleaning schedule for the walls, ceiling, air conditioning/heater vents or service window. The CDM stated the walls, ceilings and vents were to be cleaned twice a year but did not have a scheduled cleaning time designated. The CDM was unsure when cleaning had last been completed. The cleaning schedule identified a weekly cleaning schedule for the small and large mixer. The CDM stated the expectation would be to clean the mixers after each use and then again on a weekly basis.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	The Ziploc bags containing Flu vaccine were labeled with the medication name and expiration date on 10-24-13. The expired medication was discarded on 10-23-13. All medication storage areas were inspected by the Director of Nursing to identify any other unlabeled or expired meds. Licensed staff were given verbal education on 11-21-13. Follow-up written education will be given to licensed staff on 11-29-13. The Pharmacy consultant will continue a quarterly Quality Assurance Review that includes inspection of the medication carts	10-24-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 14 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications available for use in 2 of 3 medication rooms (section 1 and section 2), were properly labeled and not in use past the expiration date. Findings include: During observation of the section two medication room on 10/24/13 at 7:15 a.m., three Ziploc bags containing syringes filled with 0.5 millimeters (ml) of a clear substance were observed available for use in the medication refrigerator. The outside of each bag was labeled 25 g x 1" (25 gauge, one inch-indicates needle size). One bag contained three prefilled syringes, one bag contained ten prefilled syringes, and the last bag contained sixteen prefilled syringes. Licensed practical nurse (LPN)-A, present during the observation, stated "I am not sure what is in them (the syringes)." During interview with the director of nursing (DON) on 10/24/13 at 7:25 a.m., the DON verified	F 431	and medication storage areas. The Director of Nursing began weekly audits on 10-31-13 that will continue x 4 weeks, then monthly x 3 months to ensure compliance in these areas. The results of the audits will be monitored by the Director of Nursing and forwarded to the Quality Committee for review.	

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F 431	Continued From page 15 the Ziploc bags had not been appropriately labeled to indicate what the syringes contained, or when they had been prefilled. However, the DON stated they had held a flu vaccine clinic recently and verified the prefilled syringes were individual doses of the flu vaccine. The DON stated the clinic for staff had been held last week, and stated she had verified the contents of the prefilled syringes with the registered nurse (RN)-A who had filled the syringes for the flu vaccination clinic. The DON verified the syringes should have been labeled properly when stored in the refrigerator. During observation of the section 1 medication room on 10/23/13 at 11:00 a.m., two 20 cubic centimeter vials of lidocaine were observed to be available for use. The labels indicated the lidocaine had expired on 8/1/11. During an interview with the DON on 10/23/13 at 11:30 a.m., she verified the lidocaine had expired and should have been removed from available use.	F 431		

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/25/2013

IAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

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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, on October 25, 2013. At the time of this survey, Good Samaritan Society St. James was found not to be 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 Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. K21 The quick release magnetic hold-open door on the dietary store room was removed and replaced with an electric magnetic door hold-open device interconnected to the fire alarm system by Gopher Alarms on 11-25-13. The magnetic door hold-open was tested to activate and release with the fire alarm system and will be monitored monthly by the Director of Maintenance for continued compliance.	11-25-13

RECEIVED
DEC 2 2013
MINNESOTA DEPARTMENT OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

DC: 12-3-13
EXIT: 10-24-13
POC OK
12-3-13

.BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tim Sundeen	Administrator	12/2/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 By eMail to: Barbara.Lundberg@state.mn.us, and Marian.Whitney@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. This one-story with partial basement facility was determined to be of Type V(000) construction. The original building was constructed in 1963, with additions in 1965, 1993, 1996 and 2002. The facility was fully sprinklered, and had a complete corridor smoke detection system with monitoring for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 54 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:	K 021		

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K 021	Continued From page 2 a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation, the facility had a corridor door which was held open improperly and was not in conformance with NFPA 101 (2000) Chapter 19, Section 19.2.2.2.6 and Chapter 7, Section 7.2.1.8. In a fire emergency, this deficient practice could adversely affect 10 of 55 residents. FINDINGS INCLUDE: On 10/25/2013 at 11:55 AM, it was observed the The Dietary Storage Room was a space greater than 100 square feet, and was used to store combustible materials in a quantity deemed hazardous. Further observation revealed the corridor door to the Dietary Storage Room was improperly held-open with a two-piece magnetic door hold open device, which was not electrically interconnected with the building fire alarm system to release upon activation of the fire alarm system. This finding was confirmed with the chief building engineer at the time of discovery.	K 021		

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/25/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	**1000 SOUTH SECOND STREET** **ST JAMES, MN 56081**

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Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5168

November 20, 2013

Mr. Timothy Swoboda, Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, Minnesota 56081

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5593024

Dear Mr. Swoboda:

The above facility was surveyed on October 21, 2013 through October 24, 2013 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

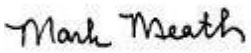
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 1400 East Lyon Street Marshall, Minnesota 56258-2529. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathryn Serie at (507) 537-715.

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.

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

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
	00697	A. BUILDING: _____ B. WING _____	10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	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 October 21, 22, 23, and 24, 2013, 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,	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00697	A. BUILDING: _____ B. WING _____	10/24/2013

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2 000	Continued From page 1 Licensing and Certification Program; 12 Civic Center Plaza, Suite 2105, Mankato, Minnesota 56001.	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.	
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an	2 265		

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2 265	Continued From page 2 attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician of a change in condition related to right arm pain and swelling following a fall for 1 of 1 resident (R43) reviewed for death. These factors resulted in harm for R43, who required medical treatment and was subsequently diagnosed with a fractured right arm. Findings include: During review of the closed record of R43, it was noted that documentation was lacking to indicate the physician had been notified of the symptoms	2 265		

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2 265	Continued From page 3 experienced by R43 after a fall on 8/19/13. Staff failed to coordinate resident care/symptoms between therapy and nursing staff so that timely physician notification had occurred. R43 was admitted to the facility on 8/16/13 with a history of a fall at home and general weakness. Review of an admission assessment dated 8/23/13, revealed a brief interview for mental status (BIMS) score of 15, indicating R43 to be cognitively intact. Review of an incident report dated 8/19/13 at 10:30 a.m., indicated R43 had been found on the floor in his room, "lying on right side - feet towards bed - parallel to nightstand". The incident report further indicated that R43 had injured his right arm with a bruise/contusion measuring 0.8 centimeters (cm) x 0.5 cm. Review of documentation on the clinical monitoring/acute care flowsheets and in the interdisciplinary progress (IDP) notes dated 8/20/13 through 8/23/13, indicated that R43 had experienced daily pain, bruising and a swollen right wrist. Documentation dated 8/22/13 indicated R43 had a "swollen right wrist" and had commented "that hand, I can't even hold a fork". The flowsheet documentation indicated R43 had rated his pain between 6-7 (a rating scale from 1-10 for intensity (10 being the worst pain)) during this timeframe (8/20-8/23). The neuro-check flow sheet dated 8/21/13 indicated that a "muscle rub" had been applied to the right wrist. Occupational therapy (OT) notes were reviewed. An occupational therapy (OT) note dated 8/22/13, included: "...Gentle massage and range of motion to R (right) elbow wrist forearm and fongers[sic]. report soreness in distal, lateral forearm..." Review of the Physical Therapy (PT) Daily Note dated 8/22/13, included: "Pt (patient) states his R wrist is bothering him and he can't put weight	2 265		

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2 265	Continued From page 4	2 265		

through it and that is why he can't lower himself into seat. OT was notified. Wrist appeared visibly swollen..." Review of the PT Daily Note dated 8/23/13, indicated, "Pt required extra encouragement to participate today stating 'I'm sore today, I don't want to do anything.' Pt agreed to 'a little walk' but refused to participate in tx (treatment) after amb (ambulation) wanting to 'sit in the sun' instead."

Documentation in the IDP notes revealed that registered nurse (RN)-B had conducted a pain assessment on 8/23/13, which indicated that R43 had identified pain "here" and pointed at a small skin tear on the right arm. According to the assessment, R43 had stated it [pain] had occurred frequently, had rated the pain an 8 out of 10 (10 being the worst), and that therapy made the pain worse.

Additional review of the IDP notes indicated that on 8/25/13 at 10:15 a.m., R43 had left on an outing with a family member for the day. The family member had later contacted the facility at 6:50 p.m. to report that R43 had been taken to the emergency room (ER) and an X-ray of the right wrist had been conducted. Upon return to the facility, from the ER at 8:10 p.m., the family member reported that R43 had been diagnosed with an ulnar fracture. The nurses' notes documentation indicated the resident had a splint applied and had a follow-up orthopedic appointment scheduled.

When interviewed on 10/24/13 at 8:53 a.m., RN-B reviewed R43's record and stated that on 8/23/13, while completing the pain assessment, she had noticed that the fingers on R43's right hand were "puffy". RN-B confirmed that R43 had indicated he had right wrist pain, had used muscle rub to alleviate the pain, and that therapy had made the pain worse.

When interviewed on 10/24/13 at 12:40 p.m., the

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2 265	Continued From page 5	2 265		

director of nursing (DON) confirmed the expectation would have been for the nurse to notify the physician of the resident's change in condition related to the pain and swelling in the right wrist/arm. During the interview, the DON stated, "The physician should be notified of any change in condition." No further documentation was evident to substantiate that the physician had been promptly notified of the resident's change in condition based on the symptoms exhibited by R43.

The facility policy titled "Notification of Change in Resident Status," revised February 2005 indicated, "The center will IMMEDIATELY inform the resident, if appropriate (except in a medical emergency or when resident is incompetent), and consult with the resident's physician and, if known, notify the resident's family or legal representative in the following cases:
(1.) Resident accident which results in injury with a potential for requiring physician intervention;
(2.) Significant change in the resident's physical, mental or psychosocial status."

SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review and revise the policies and procedures regarding notification of the physician and family members. All staff involved with notifying the physician of resident changes could be educated regarding the procedure. The quality assurance committee could randomly audit records to ensure compliance.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

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2 830	Continued From page 6	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to seek timely medical direction and/or treatment for right arm pain and swelling following a fall for 1 of 1 resident (R43) whose closed record was reviewed. These factors resulted in harm for R43, who required medical attention and was subsequently diagnosed with a fractured right arm. Findings include: Although R43 had exhibited symptoms of increased pain and swelling of the right wrist after sustaining a fall on 8/19/13, staff failed to report this change to the physician and ensure that R43 had received a timely medical evaluation. Staff failed to coordinate resident care and monitoring of symptoms, between therapy and nursing staff. It was was not until a family member transported R43 to the emergency room on 8/25/13, that R43	2 830		

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2 830	Continued From page 7 received the necessary services and medical attention for the right wrist pain and swelling, that subsequently was diagnosed as a right ulnar fracture. R43 was admitted to the facility on 8/16/13, with a history of a fall at home and general weakness. Review of an admission assessment dated 8/23/13, revealed a brief interview for mental status (BIMS) score of 15, indicating R43 to be cognitively intact. The assessment indicated R43 required extensive assistance with bed mobility, transfer, toilet use, dressing, eating and personal hygiene. Review of an incident report dated 8/19/13 at 10:30 a.m., indicated R43 had been found on the floor in his room, "lying on right side - feet towards bed - parallel to nightstand". The incident report further indicated that R43 had injured his right arm with a bruise/contusion measuring 0.8 centimeters (cm) x 0.5 cm. Review of documentation on the clinical monitoring/acute care flowsheets and the interdisciplinary progress (IDP) notes dated 8/20/13 through 8/23/13, indicated that R43 had experienced daily pain, bruising and a swollen right wrist. Documentation dated 8/22/13 indicated that R43 had a "swollen right wrist" and had commented "that hand, I can't even hold a fork". The flowsheet documentation indicated R43 had rated his pain between 6-7 (on a rating scale from 1-10 for intensity, with 10 being the worst pain) during this time frame 8/20-8/23/13. The neuro-check flow sheet dated 8/21/13, indicated that "muscle rub" had been applied to the right wrist. During review of an occupational therapy (OT)	2 830		

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2 830	Continued From page 8 note dated 8/22/13, the following was written: "...Gentle massage and range of motion to R (right) elbow wrist forearm and fongers[sic]. report soreness in distal, lateral forearm." Review of the Physical Therapy (PT) Daily Note dated 8/22/13, included: "Pt (patient) states his R wrist is bothering him and he can't put weight through it and that is why he can't lower himself into seat. OT was notified. Wrist appeared visibly swollen..." Review of the PT Daily Note dated 8/23/13 indicated, "Pt required extra encouragement to participate today stating, 'I'm sore today, I don't want to do anything.' Pt agreed to 'a little walk' but refused to participate in tx (treatment) after amb (ambulation) wanting to 'sit in the sun' instead." Additional documentation in the IDP notes revealed that registered nurse (RN)-B had conducted a pain assessment on 8/23/13, which indicated that R43 had identified pain "here" and pointed at a small skin tear on the right arm. According to the assessment, R43 had stated it [pain] had occurred frequently, had rated the pain an 8 out of 10 (10 being the worst), and that R43 had stated therapy made the pain worse. The pain assessment indicated R43 had denied that the pain had affected his sleep but had confirmed the pain did limit activity. The assessment documentation included, "hand et [and] fingers slightly edematous" and the resident had stated, "oxycodone (narcotic pain medication) used PRN (as needed) helps." Review of the medication administration record (MAR) revealed that R43 had requested and was administered Tylenol 650 milligrams (mg) orally on 8/24/13 at 2:50 p.m. for complaints of wrist pain.	2 830		

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2 830	Continued From page 9 Additional review of the IDP notes indicated that on 8/25/13 at 10:15 a.m., R43 had left on an outing with a family member for the day. The family member had later contacted the facility at 6:50 p.m. to report that R43 had been taken to the emergency room (ER) and an X-ray of the right wrist had been conducted. Upon return to the facility, from the ER at 8:10 p.m., the family member reported that R43 had been diagnosed with an ulnar fracture. The nurses' notes documentation indicated the resident had a splint applied and had a follow-up orthopedic appointment scheduled. When interviewed on 10/24/13 at 8:53 a.m., RN-B reviewed R43's record and stated that on 8/23/13, while completing the pain assessment, she had noticed that the fingers on R43's right hand were "puffy". RN-B confirmed that R43 had indicated he had right wrist pain, had used muscle rub to alleviate the pain, and that therapy had made the pain worse. When interviewed on 10/24/13 at 12:53 p.m., RN-B stated she could not remember whether PT had notified her or any other nursing staff related to complaints of pain during therapy sessions. RN-B stated she had been unaware of R43's right wrist pain until she had performed the pain assessment on 8/23/13. When interviewed on 10/24/13 at 12:35 p.m., RN-C (who was identified as the 'Medicare nurse'), stated she had not been informed by therapy about R43's complaints of right wrist pain. Interview with the DON on 10/24/13 at 8:14 a.m. confirmed the family member had wanted the wrist evaluated due to the increased swelling and when further interviewed at 12:40 p.m. she	2 830		

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2 830	Continued From page 10 confirmed the expectation would have been to notify the physician of the resident's change in condition related to the pain and swelling in the right wrist/arm. The DON stated , "The physician should be notified of any change in condition." Phone interview with the occupational therapist on 10/24/13, at 1:28 p.m. revealed that she could not recall whether R43 had complained of pain during therapy. Phone interview with the physical therapy assistant (PTA)-B on 10/24/13, at 1:54 p.m. confirmed that R43 had complained of pain while in therapy; "I remember him [R43] complaining about it." PTA-B could not recall whether that information had been communicated to the nursing staff, but recalled having reported the pain symptom to OT. PTA-B also confirmed the resident's right wrist had been noted as swollen. Although R43 exhibited symptoms of increased pain and swelling of the right wrist after experiencing a fall on 8/19/13, staff failed to ensure that prompt notification of medical personnel had been initiated so that appropriate interventions could have been implemented to alleviate and treat this medical condition. SUGGESTED PERIOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure residents consistently are provided the appropriate interventions. The director of nursing or her designee could educate all appropriate staff on these policies and procedures. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance.	2 830		

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2 830	Continued From page 11 TIME PERIOD FOR CORRECTION: Fourteen (14)Days.	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide grooming services which included removal of facial hair for 1 of 3 residents (R3) who was dependent on staff to meet personal hygiene needs. Findings include: During all days of the survey, R3 was observed to have long chin hairs on her chin. R3 was admitted to the facility with diagnoses that included general weakness. During an observation on 10/22/13 at 9:45 a.m., R3 was observed to have chin hairs. During observations on 10/23/13 at 10:46 am, and 10/24/13 at 9:52 a.m. R3 was again observed to have chin hairs; (approximately a dozen chin hairs, 1/4-1/2 inch in length and easily identifiable). During interview with R3 on 10/24/13 at 9:52 a.m., R3 stated if she had chin hair, she'd like to have them removed.	2 920		

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2 920	Continued From page 12 The quarterly minimum data set (MDS) dated 7/10/13 specified that R3 had no behavior issues of resisting cares, that she had bilateral upper extremity impairment and required extensive assistance of 1 staff for personal hygiene needs. Review of the bath list for section 1, revealed that R3 received a bath every Monday. The plan of care dated 10/23/13 specified that R3 required assistance of staff for personal hygiene needs. During an interview on 10/24/13 at 11:01 a.m. with nursing assistant (NA)-B, it was verified that she was responsible for the personal care of R3 on the day shift. NA-B stated she had not identified the need to remove R3's chin hair that morning, but upon visually observing the resident at the time of the interview, confirmed the chin hairs should have been removed. During the interview, registered nurse (RN)-A verified personal care should include the removal of facial hair on both men and women. A policy related to shaving of residents was requested from the director of nursing (DON) but was not provided. SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with grooming according to the plan of care. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care.	2 920		

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2 920	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	2 920		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain the kitchen in a manner that promoted sanitary food preparation, storage, and service which had the potential to affect 54 of 54 residents who had their meals prepared in the kitchen. Findings include: The facility failed to maintain food preparation equipment and general kitchen environment in a sanitary manner. During the initial kitchen observation on 10/21/13 from 12:40 p.m. through 1:10 p.m. the following observations were made: (a.) The large mixing bowl, which the facility dietary manager stated was used frequently, was noted to have excess dried food debris on the agitator arm and mixer motor assembly where the agitator arm attached to the motor. The agitator arm spring located at the base of the mixer motor was noted to have a black moist substance under and periphery to the spring that could drip into the	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00697	A. BUILDING: _____ B. WING _____	10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

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21015	Continued From page 14	21015		

mixing bowl during the mixing process. The certified dietary manager (CDM) and cook-A verified the mixer had not been utilized since 10/20/13 and the mixer should have been sanitized after use.

(b.) The small Kitchen Aide mixer located in the kitchen was noted to have dried white and gray food particles located on the agitator arm and base of motor unit where the agitator arm connected to the motor. The substance was dry and flaked off when a finger was rubbed across the mixer surface. The CDM stated the mixer is seldom utilized and she was unsure when it was last used. The CDM and cook-A stated the mixer was only used one to two times a month. Both staff verified the findings and stated the mixer should have been cleaned and sanitized after each use and verified it had not been sanitized,

(c.) The heater and air condition air deflectors in the kitchen located over food preparation, food service, equipment storage, and equipment sanitization areas were noted to have heavy dust and grease build up on the deflectors and periphery ceiling area. Dust particles were noted hanging from the vents and ceiling throughout the kitchen. The findings were verified by the CDM.

(d.) The stainless steel roll-up cover and top panel in the kitchen service window between the dining room and kitchen was noted to have excess dust build up on the surface. The dust could be visualized hanging down from the top of the window and on the walls periphery to the window. This was located directly over the area where the steam table was positioned during meal service.

On 10/23/13 at 7:50 a.m. the kitchen was

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21015	Continued From page 15	21015		

evaluated again. During the observation the service window between the kitchen and dining room was noted to have a heavy dust buildup on the top surface. The facility had the breakfast steam table located directly under the location where dust was hanging from the stainless steel service window. Staff were observed to uncover food pans on the steam table and serve food to include: scrambled eggs, toast, and hot cereal to the dining room. During interview with the CDM on 10/23/13 at 8:05 a.m. she verified the findings and stated the surface needed to be cleaned.

On 10/23/13 at 8:15 a.m. the CDM presented a kitchen cleaning schedule that failed to include a cleaning schedule for the walls, ceiling, air conditioning/heater vents or service window. The CDM stated the walls, ceilings and vents were to be cleaned twice a year but did not have a scheduled cleaning time designated. The CDM was unsure when cleaning had last been completed. The cleaning schedule identified a weekly cleaning schedule for the small and large mixer. The CDM stated the expectation would be to clean the mixers after each use and then again on a weekly basis.

SUGGESTED METHOD OF CORRECTION: The dietary manager or her designee could develop a system to monitor the kitchen air exchange vents and preparation areas to ensure that all surfaces are clean and in good repair, and develop policies and procedures to ensure food preparation equipment is kept clean. The Dietary Manager could educate all staff on the importance of cleaning the mixers after every use . The Dietary Manager could develop a monitoring system to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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	00697	A. BUILDING: _____ B. WING _____	10/24/2013

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21015	Continued From page 16 (21) days.	21015		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications available for use in 2 of 3 medication rooms (section 1 and section 2), were properly labeled and not in use past the expiration date. Findings include: During observation of the section two medication room on 10/24/13 at 7:15 a.m., three Ziploc bags containing syringes filled with 0.5 millimeters (ml) of a clear substance were observed available for use in the medication refrigerator. The outside of each bag was labeled 25 g x 1" (25 gauge, one inch-indicates needle size). One bag contained three prefilled syringes, one bag contained ten prefilled syringes, and the last bag contained sixteen prefilled syringes. Licensed practical nurse (LPN)-A, present during the observation, stated "I am not sure what is in them (the syringes)." During interview with the director of nursing (DON) on 10/24/13 at 7:25 a.m., the DON verified the Ziploc bags had not been appropriately labeled to indicate what the syringes contained, or when they had been prefilled. However, the DON stated they had held a flu vaccine clinic recently and verified the prefilled syringes were	21620		

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21620	Continued From page 17 individual doses of the flu vaccine. The DON stated the clinic for staff had been held last week, and stated she had verified the contents of the prefilled syringes with the registered nurse (RN)-A who had filled the syringes for the flu vaccination clinic. The DON verified the syringes should have been labeled properly when stored in the refrigerator. During observation of the section 1 medication room on 10/23/13 at 11:00 a.m., two 20 cubic centimeter vials of lidocaine were observed to be available for use. The labels indicated the lidocaine had expired on 8/1/11. During an interview with the DON on 10/23/13 at 11:30 a.m., she verified the lidocaine had expired and should have been removed from available use. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee and the pharmacist could conduct monthly inspections of the medication storage areas to ensure proper labeling of medications. The director of nursing could monitor to ensure expired medications are not available for use. The director of nursing or her designee could then monitor the licensed staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Thirty (30) days	21620		