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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KELI

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00903

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245207**
2.STATE VENDOR OR MEDICAID NO.
(L2) **722519900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - STILLWATER**
(L4) **1119 OWENS STREET NORTH**
(L5) **STILLWATER, MN** (L6) **55082**

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 **12/23/2014** (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 **94** (L18)

13.Total Certified Beds **94** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 94 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE Date :
Sue Reuss, Supervisor 12/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 12/23/2014 (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
**05/01/1976**
(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
**12/19/2014**
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

***Protecting, Maintaining and Improving the Health of Minnesotans***

CMS Certification Number (CCN): 245207

Electronically Delivered: December 23, 2014

Mr. Nathan Pearson, Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, Minnesota 55082

Dear Mr. Pearson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective December 5, 2014 the above facility is certified for:

94 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 94 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

***Protecting, Maintaining and Improving the Health of Minnesotans***

Electronically Delivered: December 23, 2014

Mr. Nathan Pearson, Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, Minnesota 55082

RE: Project Number S5207025

Dear Mr. Pearson:

On November 17, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 6, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 23, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 6, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 5, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 6, 2014, effective December 5, 2014 and therefore remedies outlined in our letter to you dated November 17, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report



| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245207 | A. Building<br>B. Wing | 12/23/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| GOOD SAMARITAN SOCIETY - STILLWATER | 1119 OWENS STREET NORTH<br>STILLWATER, MN 55082 |

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 **F0280**<br>Reg. # **483.20(d)(3), 483.10(k)(2)**<br>LSC | Correction Completed **12/05/2014** | ID Prefix **F0282**<br>Reg. # **483.20(k)(3)(ii)**<br>LSC | Correction Completed **12/05/2014** | ID Prefix **F0309**<br>Reg. # **483.25**<br>LSC | Correction Completed **12/05/2014** |
| ID Prefix **F0441**<br>Reg. # **483.65**<br>LSC | Correction Completed **12/05/2014** | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By State Agency | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| | SR/AK | 12/23/2014 | 16022 | 12/23/2014 |
| **Reviewed By CMS RO** | **Reviewed By** | **Date:** | **Signature of Surveyor:** | **Date:** |

**Followup to Survey Completed on:** 11/6/2014

**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: KELI

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Facility ID: 00903

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2.STATE VENDOR OR MEDICAID NO.
(L2) **722519900**

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(L3) **GOOD SAMARITAN SOCIETY - STILLWATER**
(L4) **1119 OWENS STREET NORTH**
(L5) **STILLWATER, MN** (L6) **55082**

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 **11/06/2014** (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 **94** (L18)

13.Total Certified Beds **94** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 94 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE Date :
Karen Beskar, HFE NE II 12/01/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 12/18/2014 (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
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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**05/01/1976**
(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
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**00140**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Electronically Delivered: November 17, 2014

Mr. Nathan Pearson, Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, Minnesota 55082

RE: Project Number S5207025

Dear Mr. Pearson:

On November 6, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

**Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**
**Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.**

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

**DEPARTMENT CONTACT**

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 201-3790

**OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 16, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

**ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

**PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

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

**VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

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

**Original deficiencies not corrected**

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

**Original deficiencies not corrected and new deficiencies found during the revisit**

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

**Original deficiencies corrected but new deficiencies found during the revisit**

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

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

If substantial compliance with the regulations is not verified by February 6, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 6, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**INFORMAL DISPUTE RESOLUTION**

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified

for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245207 | A. BUILDING _____ B. WING _____ | 11/06/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - STILLWATER | 1119 OWENS STREET NORTH STILLWATER, MN 55082 |

| (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<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. | F 280 | | 12/5/14 |

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

Electronically Signed | 11/26/2014

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245207 | A. BUILDING _____ B. WING _____ | 11/06/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - STILLWATER | 1119 OWENS STREET NORTH STILLWATER, MN 55082 |

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| F 280 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on document review and interview, the facility did not revise the comprehensive plan of care regarding hospice care for 1 of 1 resident (R4) reviewed for hospice.<br><br>Findings include:<br><br>Record review revealed an Admission Record showing the resident was admitted on 6/6/13, and a Certification Statement for first 90-day period form showing that the resident was admitted to hospice care on 4/5/14, with diagnoses of Alzheimer's dementia and cerebrovascular disease. The record contained a completed Physician's Orders/Plan of Care form from the hospice provider, dated 10/2/14. There was also a current plan of care completed by the facility, dated 6/18/13, in the record. The facility's plan of care did not contain any reference to the fact that the resident had been placed on hospice care.<br><br>When interviewed on 11/6/14, at 12:20 p.m., registered nurse (RN)-D, the manager of R4's unit, stated that she completed much of the care plan for R4, but there had been interdisciplinary team input for the care plan. She acknowledged the fact that the facility's care plan did not contain a reference to hospice care for R4. | F 280 | 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 the federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. All deficiencies will be reviewed by the Quality Assurance Committee on 12/17/2014 for appropriate recommendations.<br><br>F280<br>The care plan for resident R4 was corrected to include the words hospice care. Care plans of all residents currently on hospice have been reviewed to ensure the words hospice care are present. A checklist related to admission to hospice will be developed. All parts of care plan compliance will be included on this checklist and audit tool will be developed by the QA committee to monitor compliance. Audits will be completed, monthly x6 months, then quarterly x1 year. All care plan team members will be re-educated on the process. The social | |

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| F 280 | Continued From page 2 | F 280 | services director or designee will be responsible to ensure compliance. | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, document review and interview, the facility failed to provide services in accordance with the resident's written plan of care for 1 of 3 residents (R61) in the sample who required assistance with repositioning.<br><br>Findings include:<br><br>R61 was assessed to require assistance with repositioning, and did not receive assistance in accordance with the plan of care interventions.<br><br>R61's care plan dated 10/21/14, directed staff to assist R61 to "cueing to turn and reposition with A'1 (assist of 1) q (every) 2hrs and prn (whenever necessary). R61 is cognitively intact according to the minimum data set (MDS) completed 10/17/14.<br><br>During continuous observation on 11/3/14, from 4:00 p.m. until 7:00 p.m. R 61 remained seated in his wheel chair for 3 hours without a position change and again on 11/5/14, from 7:09 a.m. until 10:30 a.m. (Three hours and twenty one minutes) | F 282 | F282<br>We will continue to follow every resident□s plan of care. We will also continue to respect a resident□s right to refuse treatment and to participate in activities of their choosing. We will also continue to monitor resident□s skin integrity with all cares. All nursing staff will be re-educated on the importance of following and updating resident□s plan of care. All nursing staff will be re-educated on the importance of repositioning and its importance related to skin integrity. The QA committee will develop an audit tool to ensure compliance with repositioning audits and will be completed monthly x6 months, then quarterly x1 year. The DNS or designee will be responsible to ensure compliance. | 12/5/14 |

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| F 282 | Continued From page 3<br>When interviewed on 11/3/14, at 5:06 p.m. R61 expressed at times sitting for too long and would like to try and stand more. R61 indicated there was pain in his buttocks and he had an open area on his buttocks that was causing discomfort. Family (F)-A member present and verified there was an open area that developed last week possibly on Thursday or Friday but neither were sure of the date.<br><br>Interview with licensed practical nurse (LPN)-A, on 11/3/14, at 5:24 p.m. revealed she did not know there was an open area but nursing assistants (NA) were putting Calmoseptic barrier cream on the "bottom, to protect the skin." against breakdown. LPN-A verified R61 was to have a position change every two hours according to the plan of care.<br><br>Interviews with nursing assistant (NA)-A and (NA)-B on 11/4/14, at 9:44 a.m. verified R61 required every two hour repositioning. | F 282 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide the necessary | F 309 | F309<br>The care plan for resident R4 was | 12/5/14 |

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| F 309 | Continued From page 4<br>care and services for repositioning for 1 of 3 residents (R61) in the sample who was at mild risk for skin breakdown and failed provide a comprehensive plan of care regarding hospice care for 1 of 1 resident (R4) reviewed for hospice.<br><br>Findings include:<br><br>During observation on 11/4/14, from .6:45 a.m. until 9:48 a.m. (three hours) R 61 remained seated in his wheel chair without an offer for position change and again on 11/5/14, from 7:09 a.m. until 10:30 a.m. (Three hours and twenty one minutes).<br><br>The form titled Braden Scale for Predicting Pressure Sore Risk and dated 10/14/14, indicated , mild risk for developing pressure ulcers.<br>A review of R61's care plan dated 10/17/14, read "limited physical mobility, bed mobility needs ques [sic] q (every) 2h (hours)." R61's care plan dated 10/21/14, directed staff to assist R61 to "cueing to turn and reposition with A'1 (assist of 1) q (every) 2 hrs and prn (whenever necessary). According to the minimum data set (MDS) completed 10/17/14, R61 was cognitively intact.<br><br>When interviewed on 11/3/14, at 5:06 p.m. R61 expressed, at times, sitting for too long and would like to try and stand more often. R61 indicated there was pain in his buttocks and he had an open area on his buttocks that was causing discomfort. Family (F)-A member was present and verified there was an open area that developed last week possibly on Thursday or Friday but neither were sure of the date.<br><br>Interview with licensed practical nurse (LPN)-A, on 11/3/14, at 5:24 p.m. revealed, she did not | F 309 | corrected to include the words hospice care. Care plans of all residents currently on hospice have been reviewed to ensure the words hospice care are present. A checklist related to admission to hospice will be developed. All parts of care plan compliance will be included on this checklist and audit tool will be developed by the QA committee to monitor compliance. Audits will be completed, monthly x6 months, then quarterly x1 year. All care plan team members will be re-educated on the process. The social services director or designee will be responsible to ensure compliance. | |

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| F 309 | Continued From page 5<br>know there was an open area, but nursing assistants (NA) were putting Calmoseptic barrier cream on, "his [R61] bottom, to protect the skin."<br><br>During observations on 11/4/14, at 9:44 a.m. R61 requested assistance for the bathroom. Nursing assistant (NA)-A and NA-B transferred R61 using the mechanical lift into the bed at 9:48 a.m. R61 was continent.<br><br>Interviews with nursing assistant NA-C and NA-D on 11/4/14, at 9:56 a.m., verified R61 was up in the wheel chair at 6:45 a.m. because he liked to get up early and no position change had occurred since getting up in the wheel chair at 6:45 a.m.<br><br>During observation on 11/5/14, at 7:09 a.m. R61 was sitting at a dining room table after having a bath. R61 finished breakfast and remained in the dining room seated in the wheel chair until an activity began at 9:00 a.m. At 10:00 a.m. R61 propelled himself in the wheel chair into his bedroom. At 10:10 a.m. R61 wheeled himself out to the dining room to participate in exercises/music with the activity department. At 10:30 a.m. NA-C and NA-D put R61 into the bed. The buttocks were viewed with LPN-B,who verified there were deep red crevices and craters in the skin surrounding the buttocks and posterior thigh areas. LPN-A verified two small open areas on the left buttock covered with a clear bandage.<br><br>During an interview with on 11/5/14, at 2:07 p.m. RN-A validated R61 had "two abrasions'" to the left buttock and the measurements were .4 by .2 centimeter (C) and .6 by .2 C. RN-A further validated R61 required every two hour position changes with education and counseling for the importance of the position change for skin | F 309 | | |

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| F 309 | Continued From page 6<br>healing. RN-A further verified if R61 had been sitting without a position change since 6:45 a.m., then the plan of care was not being followed.<br><br>Record review revealed an Admission Record showing the resident was admitted on 6/6/13, and a Certification Statement for first 90-day period form showing that the resident was admitted to hospice care on 4/5/14, with diagnoses of Alzheimer's dementia and cerebrovascular disease. The record contained a completed Physician's Orders/Plan of Care form from the hospice provider, dated 10/2/14. There was also a current plan of care completed by the facility, dated 6/18/13, in the record. The facility's plan of care did not contain any reference to the fact that the resident had been placed on hospice care.<br><br>When interviewed on 11/6/14, at 12:20 p.m., registered nurse (RN)-D, the manager of R4's unit, stated that she completed much of the care plan for R4, but there had been interdisciplinary team input for the care plan. She acknowledged the fact that the facility's care plan did not contain a reference to hospice care for R4. | F 309 | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections | F 441 | | 12/5/14 |

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| F 441 | Continued From page 7<br>in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and review of facility policy, the facility failed to ensure a suction machine, located in 1 of 3 dining rooms, was covered and properly stored, according to facility policy to prevent possible cross contamination. This had the potential to affect 35 residents in the secured memory care unit of 81 residents who resided at the facility.<br><br>Findings include: | F 441 | F441<br>The suction machine on the memory care unit has been relocated to the Garden room, also located on the memory care unit. A different type of cover for the suction machine has been applied. Suction tubing will remain closed in its packaging until use. An audit tool will be developed to ensure compliance. The ICN and QA committee will be responsible for | |

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| F 441 | Continued From page 8<br><br>During the evening meal on the memory care unit on 11/3/14 at 5:30 p.m. a suction machine was observed on a cart, in the back of the main dining room. The cart was located within approximately 3 feet of a table which seated 4 residents. The machine was uncovered, the suction machine tubing was connected to the machine and the tubing was inside an open suction catheter package. The suction machine remained in the dining room uncovered on 11/4/14 and 11/5/14.<br><br>When brought to the attention of the infection control nurse (ICN) on 11/5/14 at 2:30 p.m., the machine was promptly covered with a towel.When interviewed, ICN explained that the machine had always been stored in the dining room for easy accessibility. When asked about cleanliness of the tubing and suction machine due to the residents that wander and touch things on the secured memory care unit, the ICN commented that there was no assurance that the tubing had not been touched by residents who wander.<br><br>During observations at various times on all days of the survey 11/3/14, 11/4/14, 11/5/14, and 11/6/14 residents were observed in the memory care unit to wander around the unit, into other residents rooms, into the lounge area, into the dining room and were observed to touch and grab various items that were left out.<br><br>11/6/14 at 9:34 a.m. registered nurse (RN)-D was interviewed regarding the storage of the suction machine in the dining room. RN-D explained that if a resident needed to be suctioned, the resident would be removed from the dining room and said that no one has ever been and never would be | F 441 | monitoring compliance. Nursing staff will be re-educated on the correct P&P for the suction machine storage. | |

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| F 441 | Continued From page 9<br>suctioned in the dining room in front of other residents. RN-D agreed with ICN that there was no guarantee that residents that wander would stay away from the machine stored in the dining room and indicated that another area would be looked at for storage of the machine.<br><br>The policy and procedure titled, Suction Machine Cleaning, revised 2/2005, identified the purpose was to prevent cross contamination. The process included covering the unit. An undated addendum to the policy indicated, suction machines in the dining room would remain covered. All suction machine tubing and connections would remain in sterile packaging in baskets or bins and remain covered. | F 441 | | |

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| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society Stillwater was found 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.<br><br>Good Samaritan Society Stillwater is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1966 and was determined to be of Type II(111) construction. In 1968, an addition was constructed to the South side of the building that was determined to be of Type II(111) construction. In 1995, an addition was constructed to the East side of the building that was determined to be of Type II(111) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building.<br><br>The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 99 beds and had a census of 81at the time of the survey.<br><br>The requirement at 42 CFR Subpart 483.70(a) is MET. | K 000 | | |

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| K 000 | Continued From page 1<br><br>*TEAM COMPOSITION*<br>Tom Linhoff, Life Safety Code Spc. | K 000 | | |