DEPARTMENT OF HEALT						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: L4XR
		TO BE COMPI	LETED BY T	HE SIA	TE SURVEY AGENCY	Facility ID: 00900
1. MEDICARE/MEDICAID PROVID (L1) 245221	ER NO.	3. NAME AND AI (L3) GOOD SAM	IARITAN SOC	CIETY - M	IAPLEWOOD	4. TYPE OF ACTION: <u>7 (</u> L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID (L2) 861017700	NO.	(L4) 550 EAST R (L5) MAPLEWO		VENUE	(L6) 55117	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU			<u>02</u> (L7)	7. On-Site Visit 9. Other 8. Full Survey After Complaint
	16/2015 (L34) (L10)	01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct	05 HHA 06 PRTF 07 X-Ray	09 ESRD 10 NF 11 ICF/III	13 PTIP 22 CLIA 14 CORF 0 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY		AS:		
From (a):		X A. In Complia	nce With equirements		And/Or Approved Waivers Of 2. Technical Personnel	The Following Requirements:
To (b):			e Based On:			6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds	96 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code	
13.Total Certified Beds	96 (L17)		pliance with Prog ents and/or Appli		* Code: A*	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
96 (L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Susanne Reuss, Superviso	or	0	4/24/2015	(L19)	Anne Kleppe, Enforce	ment Specialist 04/24/2015 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	
19. DETERMINATION OF ELIGIBI	LITY		IPLIANCE WITH	I CIVIL		ncial Solvency (HCFA-2572)
X 1. Facility is Eligible to	Participate	RIGH	ITS ACT:		 Ownership/Control Both of the Above 	ol Interest Disclosure Stmt (HCFA-1513) e :
2. Facility is not Eligible	e (L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	I. LTC AGREEN	IENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION 04/01/1978	BEGINNINC	6 DATE	ENDING DAT	ΓE	VOLUNTARY 00 01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	-
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind St	spension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00140				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE		
	(L32)	04/09/2015		(L33)	DETERMINATION APP	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5221

Electronically Delivered: April 24, 2015

Ms. Susan Jensen, Administrator Good Samaritan Society - Maplewood 550 East Roselawn Avenue Maplewood, Minnesota 55117

Dear Ms. Jensen:

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

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

Effective April 6, 2015 the above facility is certified for:

96 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 96 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,

Ame Klagge

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 24, 2015

Ms. Susan Jensen, Administrator Good Samaritan Society - Maplewood 550 East Roselawn Avenue Maplewood, Minnesota 55117

RE: Project Number S5221026

Dear Ms. Jensen:

On March 9, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 26, 2015. 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 April 16, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 24, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 26, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 6, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 26, 2015, effective April 6, 2015 and therefore remedies outlined in our letter to you dated March 9, 2015, will not be imposed.

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

Sincerely,

Ame Klagse

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

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245221	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/16/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
G	DOD SAMARITAN SOCIETY - MAPLE	EWOOD	550 EAST ROSELAWN AVENU MAPLEWOOD, MN 55117	E

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. # LSC	F0279 483.20(d), 483.20(k)	Correction Completed 04/06/2015		F0282 483.20(k)(3)(ii)	Correction Completec 04/06/2015			F0327 483.25(i)		Correction Completed 04/06/2015
ID Prefix Reg. # LSC	F0329 483.25(I)	Correction Completed 04/06/2015	ID Prefix Reg. # LSC	F0428 483.60(c)	Correction Completec 04/06/2015		ID Prefix Reg. #			Correction Completed 04/06/2015
ID Prefix Reg. # LSC	F0465 483.70(h)	Correction Completed 04/06/2015				1				
ID Prefix Reg. # LSC			Reg. #			I	Reg. #			Correction Completed
Reg. #						I				
Reviewed B State Agen Reviewed B CMS RO		К	Date: 04/24/20 Date:	15 Signature of Signature of			16022		Date: 04/1 Date:	6/2015
Followup t	o Survey Completed 2/26/2015	l on:		Check for any U Uncorrected	Incorrected Del Deficiencies (C				YES	NO

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245221	(Y2) Multiple Cons A. Building B. Wing		IN BUILDING 01	(Y3) Date of Revisit 4/24/2015	
Name of Facility				Street Address, City, State, Zip Code		
G	DOD SAMARITAN SOCIETY - MAPLE	WOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117	Ξ	

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		Correction Completed 04/06/2015	ID Prefix		Correction Completed	ID Prefix		Correction Completed
-	NFPA 101 K0020		Reg. # LSC			Reg. # _ LSC _		
Reg. #		Correction Completed	Reg. #		Correction Completed	Dog #		Correction Completed
ID Prefix Reg. # LSC		Correction Completed			Correction Completed			
Reg. #			Reg. #		Correction Completed			Correction Completed
Reg. #								
Reviewed E State Agen Reviewed E CMS RO	cy PS/AK		Date: 04/24/2015 Date:	Signature of Sur Signature of Sur	•	12424	Date: 04/2 Date:	24/2015
Followup t	o Survey Completed or 2/25/2015	1:	C	Check for any Uncor Uncorrected Defic				NO

DEPARTMENT OF HEALTH	I AND HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: L4XR
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00900
1. MEDICARE/MEDICAID PROVIDE (L1) 245221	R NO.	3. NAME AND AD (L3) GOOD SAM			APLEWOOD	 TYPE OF ACTION: <u>2</u>(L8) Initial 2. Recertification
2.STATE VENDOR OR MEDICAID N (L2) 861017700	0.	(L4) 550 EAST R (L5) MAPLEWO		VENUE	(L6) 55117	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF C (L9)	WNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEC	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 02/26 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 	96 (L18)	Compliance	nce With equirements e Based On: cceptable POC		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	6. Scope of Services Limit 7. Medical Director
13.Total Certified Beds	96 (L17)		ents and/or Appli		* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKDOV	WN				15. FACILITY MEETS	
18 SNF 18/19 SNF 96	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Sue Miller, HFE NE II		0	3/23/2015	(L19)	Anne Kleppe, Enforcen	nent Specialist 04/08/2015 (L20
PAR	T II - TO BE	COMPLETED H	BY HCFA RF	EGIONAI	COFFICE OR SINGLE S	TATE AGENCY
 DETERMINATION OF ELIGIBILI 1. Facility is Eligible to Pa 2. Facility is not Eligible 			IPLIANCE WITH ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) :
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 04/01/1978	BEGINNINC	G DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	n <u>OTHER</u> 07-Provider Status Change
(L27)		n of Admissions: uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00140				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	. DATE		
	(L32)			(L33)	DETERMINATION APPE	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 9, 2015

Ms. Susan Jensen, Administrator Good Samaritan Society - Maplewood 550 East Roselawn Avenue Maplewood, Minnesota 55117

RE: Project Number S5221026

Dear Ms. Jensen:

On February 26, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Email: <u>susanne.reuss@state.mn.us</u> 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 April 7, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

Good Samaritan Society - Maplewood March 9, 2015 Page 4

in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 26, 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 August 26, 2015 (six months after the

Good Samaritan Society - Maplewood March 9, 2015 Page 5

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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: <u>pat.sheehan@state.mn.us</u> Telephone: (651) 201-7205 Fax: (651) 215-0525

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

Good Samaritan Society - Maplewood March 9, 2015 Page 6

Sincerely,

Are Klegge

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				E SURVEY IPLETED
		245221	B. WING _			02/	26/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD			50 EAST ROSELAWN AVENUE IAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	00			
F 279 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificant Upon receipt of an on-site revisit of your validate that substar regulations has beet your verification. 483.20(d), 483.20(k COMPREHENSIVE A facility must use to to develop, review a comprehensive plan The facility must deplan for each reside objectives and time medical, nursing, an needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident.	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with (1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's n of care. Evelop a comprehensive care ent that includes measurable tables to meet a resident's nd mental and psychosocial tified in the comprehensive tables to meet a resident's nd mental and psychosocial tified in the comprehensive tables to meet a resident's nd mental and psychosocial tified in the comprehensive	F 21	79			4/6/15
LABORATOR	UIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURF		TITLE		(X6) DATE
	ically Signed	0000					03/19/2015

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

PRINTED: 03/20/2015

		AND HUMAN SERVICES				PRINTED: 03/20/2015 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245221	B. WING	ì		02/26/2015
NAME OF F	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE	-
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD			550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTION
F 279	Continued From pa	ge 1	F	279		
	by: Based on observat review, the facility fi individualized plan of (R147) reviewed fo Findings include: R147 was at risk fo chronic diarrhea, m properties and abn indicative of dehydr lacked monitoring t recommended and prevent dehydration R147 was observed centimeter] of fluids 2/23/15, at 6:00 p.m During an interview p.m. observation of appeared dry. R147 more fluids, I get so in the morning my r R147 had a signific assessment (MDS) indicated an alterat impaired. The care further read, "Resic to day decisions bu	of care for 1 of 1 residents r dehydration. r dehydration related to edications with anticholinergic formal laboratory (lab) values ration. However, the facility o ensure R147 received the punt of fluids per day to n. d to drink 360 cc's [cubic s with the evening meal tray on n. with R147 on 2/25/15, at 2:30 mouth, lips, tongue and teeth 7 stated, "Yes I need to drink o dry at night and when I wake mouth is bone dry." ant change minimum data completed 12/2/14, and ion in cognition to severely area assessment (CAA) lent is able to make some day t does present with onfusion at times." The CAA			Plan of Correction General Disclaimer Preparation and execution of this response and plan of correction d constitute an admission or agreen the provider of the truth of the fact alleged or conclusions set forth in statement of deficiencies. The pla correction is prepared and/or exec solely because it is required by the provisions of Federal and State la the purposes of any allegation tha facility is not in substantial complia with Federal requirements of parti this response and plan of correction compliance in accordance with se 7305 of the State Operations Man F279 483.20 (d), 483.20(k)(1)Dev Comprehensive Care Plans Corrective Action for resident R14 R147 has had a thorough review a re-development of individualized p care to address fluid intake and por risks for dehydration. R147 has be placed on a fluid intake monitoring How to identify other residents wit same issue The facility will assess residents to others having the potential to be a	nent by ts the n of cuted e w. For t the ance cipation, on n of ction uual. elop 7 and blan of ossible een g record. h the
	According to the nu	tritional assessment dated			upon admission, quarterly, and winchange of condition. All residents	th

Facility ID: 00900

PRINTED: 03/20/2015

MENT OF HEALTH		1				APPROVE 0938-039
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
	245221	B. WING _			02/2	26/2015
PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP COD	ЭЕ	
AMARITAN SOCIETY	- MAPLEWOOD					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		(EACH CORRECTIVE ACTION SH	HOULD BE	(X5) COMPLETIO DATE
12/1/14, the dietitia 2100-2500 cc/day (according to individ information was no were no quantifying received the recom day. Document review fr 12/9/14, read, "The incontinence poten diarrhea E/B [episo frequent bowel inco did not address the toxigenic clostridiur causes diarrhea] or for clostridium diffic for chronic diarrhea R147 received che neoplasm of the bla for the chemothera of care lists but was nausea, lips dry an intervention read, " Medications R147 nd depression, which I effects which includ diarrhea, dry mouth Gabapentin for per side effects include mouth, dry throat a Aricept for cognitive	n recommended R147 receive (centimeter per) of fluid lual body weight. This t on the plan of care and there g records to support R147 imended cc's of fluid intake per or R147's plan of care dated e resident has bowel tial R/T [related to] chronic des/bouts] occasional to ontinence." The plan of care e stool sample tested for the m difficile [bacterium that n 4/27/13 which was negative cile to rule out a possible cause a. motherapy for malignant adder. One of the side effects py and addressed on the plan s not limited to diarrhea, d or cracked lips. An Drink plenty of fluids." received, included Prozac for had a warning for adverse ded but was not limited to n, and nausea. R147 received ipheral neuropathy and the ed but were not limited to dry nd nausea. R147 had taken e function and the side effects	F 27	receive addre dehyd asses and v asses dehyd fluid i Recu Follow proce place risks diurei A carr found for flu Re-ed staff a comp devel intake policy Thes follow The I and I reside devel comp for or result	ess fluid intake and possi dration, as indicated throus soment, upon admission, with change of condition. seed with increased risk for dration will have monitoring intake per care plan. Intrence will be prevented wing and using facility po- edure, systematic change to identify residents for f such as potential for deh tic use, renal disease, dia e plan will be developed d to be at risk and will be uid intake per care plan. ducation will be given to a and dietician. Audits will be pleted to ensure care plar loped for residents at risk e is monitored as assess y for compliance as outling e issues will be monitore ving manner Director of Nursing, Nurse Dietician will audit care pla- ents at risk for dehydratic lopment of comprehensiv- pletion weekly for one mo- ne quarter, and then quar- ts will be brought to the q	ble risks for ugh quarterly, Residents for ng of their by licy and es will be in fluid intake pydration, arrhea, etc. for residents monitored all nursing be all nursing be a and fluid ed per hed below. d in the e Managers, ans for on and ve care plan onth, monthly terly. Audit juality	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa 12/1/14, the dietitia 2100-2500 cc/day (according to individ information was no were no quantifying received the recomd day. Document review fa 12/9/14, read, "The incontinence potendiarrhea E/B [episo frequent bowel incoddid not address the toxigenic clostridium causes diarrhea] of for clostridium diffic for chronic diarrhea R147 received che neoplasm of the bla for the chemothera of care lists but was nausea, lips dry an intervention read, " Medications R147 I depression, which I effects which includ diarrhea, dry mouth Gabapentin for per side effects include mouth, dry throat a Aricept for cognitive were not limited to	DF CORRECTION IDENTIFICATION NUMBER: 245221 PROVIDER OR SUPPLIER AMARITAN SOCIETY - MAPLEWOOD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 12/1/14, the dietitian recommended R147 receive 2100-2500 cc/day (centimeter per) of fluid according to individual body weight. This information was not on the plan of care and there were no quantifying records to support R147 received the recommended cc's of fluid intake per	COP DEFICIENCIES PF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTI A. BUILDIN 245221 B. WING	COP DEFICIENCIES PF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONS' A. BUILDING 245221 B. WING PROVIDER OR SUPPLIER STREET A AMARITAN SOCIETY - MAPLEWOOD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 F 279 12/1/14, the dietitian recommended R147 receive 2100-2500 cc/day (centimeter per) of fluid according to individual body weight. This information was not on the plan of care and there were no quantifying records to support R147 received the recommended cc's of fluid intake per day. F 279 Document review for R147's plan of care dated 12/9/14, read, "The resident has bowel incontinence potential R/T [related to] chronic diarrhea E/B [episodes/bouts] occasional to frequent bowel incontinence." The plan of care did not address the stool sample tested for the toxigenic clostridium difficile [bacterium that causes diarrhea] on 4/27/13 which was negative for chornic diarrhea. Recu for flu R147 received chemotherapy for malignant neoplasm of the bladder. One of the side effects for the chemotherapy and addressed on the plan of care lists but was not limited to diarrhea, intak, nausea, lips dry and or cracked lips. An intervention read, "Drink plenty of fluids." Thes follow Medications R147 received, included Prozac for depression, which had a warning for adverse effects which included but was not limited to diarrhea, dry mouth, and nausea. R147 received Gabapentin for peripheral ne	CP DEFICIENCIES (X1) PROVIDERSUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 245221 B. WING 2760VIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COL 50 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECOBED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIX TAG PROVIDERS ALL OCONFICTIVE ACTION S (EACH DEFICIENCY WIST (EACH DEFICIENCY BE PRECOBED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREVIX TAG PROVIDERS ALL OCONFICTIVE ACTION S (EACH DEFICIENCY BEGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 12/1/14, the dietitian recommended R147 receive 2100-2500 cc/day (centimeter per) of fluid according to individual body weight. This information was not on the plan of care dated 12/9/14, read, "The resident has bowel incontinence potential R/T (related to) chronic diarrhea E/B (episodes/bouts) occasional to frequent bowel incontinence," The plan of care did not address the stool sample tested for the toxigenic clostridium difficile to rule out a possible cause for chronic diarrhea. Recurrence will be prevented Following and using facility po procedure, systematic change place to identify residents for risks such as potential for defi diuritake per care plan. R147 received chemotherapy and addressed on the plan of care lists but was not limited to diarrhea, dry mouth, and nausea. R147 received Gabapentin for peripheral neuropathy and the side effects whic included but was not limited to diarrhea, dry mouth, and nausea. R147 received Gabapentin for peripheral neuropathy and the side effects to include but was not limited to diarrhea, dry mouth, and nausea. R147 had taken Aric	35 FOR MEDICARE & MEDICAID SERVICES OMB NO. 07 DEFICIENCIS (X1) PROVIDERSUPPLIERCIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATA COMB 245221 B. WING 027 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117 027 SUMMARY STREMENT OF DEFICIENCES (EACH ORDERDISCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREFIX (EACH ORDERDISCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREFIX (FAC PREFIX (FAC PROVIDERS PLAN OR CORRECTION MAPLEWOOD, MN 55117 Continued From page 2 12/1/14, the dietitian recommended R147 received the recommended CC's of fluid according to individual body weight. This information was not on the plan of care dated 12/9/14, read, "The resident has bowel incontinence, potential T/T (related to lchronic diarrhea 2/B [episodes/bouts] occasional to frequent bowel incontinence." The plan of care ddi not address the stool sample tested for the toxigenic clostridium difficile to rule out a possible cause for chronic diarrhea, nausea, lips dry and or cracked lips. An intervention read, "Drink plenty of fluids." Recurrence will be monitored by Following and using facility policy and procedure, systematic changes will be in place to identify residents for fluid intake risks such as potential for delydration, diuretic use, renal disease, diarrhea, etc. A care plan will be developed for residents a risk and fluid intake is monitored as assessed etpir policy for compliance as outlined below. These issues will be monitored in the following manner the origentar a nisk and fluid intake is mon

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
		045001	B. WING			
	PROVIDER OR SUPPLIER	245221		STREET ADDRESS, CITY, STATE, ZIP CODE	02/	26/2015
	AMARITAN SOCIETY	- MAPLEWOOD	Ę	MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 279	 urea nitrogen (indic dehydration) The al addressed on the ir which could be an i A review of the faci titled, Intake and O choose to initiate in at risk for imbalanc dehydration, diureti diarrhea. When interviewed of registered nurse (R and NA-C did not k requirements were number of cc's they encouraging fluids. had bouts of diarrhea 	scle metabolism) and blood eator of kidney disease and/or bnormal lab values were not ndividual plan of care for R147 ndicator for dehydration. lity policy dated 11/13, and utput, indicated a nurse could take and output on a resident es such as potential for c use, renal disease and on 2/25/15, at 2:00 p.m. N)-C, nursing assistant NA-B now what the minimum fluid per day for R147 or the / should strive for when All three staff verified R147 ea.	F 279			4/6/15
F 282 SS=D	PERSONS/PER C/ The services provic must be provided b	RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility by qualified persons in ach resident's written plan of	F 282			4/6/15
	by: Based on interview facility failed to ens antiarrhythmic and	NT is not met as evidenced y and document review, the ure the plan of care for psychoactive medication s were monitored for 1 of 5 the sample.		F282 483.20 (k)(3)(ii) SERVICE QUALIFIED PERSONS/PER CA Corrective Action for residents R Adverse side effect monitoring h put in place for R137 per the car	RE PLAN 137 as been	

Facility ID: 00900

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TATEN/EN'T					MB NO.	SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		PLETED
		245221	B. WING _		02/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIESID(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG		FIX (EACH CORRECTIVE ACTION SHOULD BE			
F 282	Continued From pa	ge 4	F 28	32		
	reviewed; the care that R137 was on a goal indicated R137 reactions related to The care plan intermonitor for adverse medications which dizziness, nausea, box warning signs a nurse practitioner. On 02/26/15, at 8:5 felt dizzy, R137 stat the time and the diz my head to the righ wheelchair she use due to being dizzy. nauseated, R137 statinght from nausea a pan to throw up in." happened quite offer she informed her nuidentified the nurse further stated that s problems and had I day; R137 voiced fr	s medical record was plan dated, 05/09/14 reflected intiarrhythmic therapy and the 7 would be free from adverse digoxin and Amiodarone use. ventions directed staff to e reactions of these two included hypothyroidism, and vomiting and the black and report to the physician or 1 a.m., when asked if R137 ted, "oh, yes, I feel dizzy all of eziness increases when I tilt t side." R137 added the d kept her from falling down When asked if she felt tated, "I wake up during the and they bring me my plastic R137 explained that it en during the night and that urse practitioner(R137 practitioner by name.)R137 the experienced stomach oose stools at least twice a ustrations of not feeling well		 antiarrhythmic medication Digoxin. Antiarrhythmic medication Amioda was decreased from 200mg to 100 1- 27-15, with a plan to discontinue medication once the resident adjust the decrease. This medication was discontinued on 2-26-15. R137 do take psychoactive medication. How to identify other residents with same issue All residents who receive antiarrhy and psychoactive medications will care plan initiated and side effect monitoring in place upon admissio when beginning these medication plans will be reviewed and updated needed quarterly and with changes condition or changes in medication Recurrence will be prevented by Re-education will be given to all nu regarding the side effect monitorin system and following care plans re antiarrhythmic and psychoactive medications. Audits will be comple assure monitoring of side effects a plans in place as outlined below. 	rone Omg on e this sted to ses not n the thmic have a n or s. Care d as s of n use. urses g elated to ind care	
	medications that sh On 02/26/15, at 9:3 (RN)-A stated after medical record that other documentatio of heart rate and blue the nurses docume	told the nurses who give her ne did not feel well. 0 a.m. registered nurse r reviewing R137's electronic she was unable to find any n, other than daily monitoring ood pressure, to show whether nted on potential medication N-A indicated the nurses were		following manner The Director of Nursing, Nurse Ma will audit resident records for side monitoring as per the care plan we one month, then monthly for one of and then quarterly. Audit results w brought to the quality assurance committee for further review as ne	inagers effect eekly for juarter ill be	

Facility ID: 00900

If continuation sheet Page 5 of 36

STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED	
		245221	B. WING			00/0015	
NAME OF	PROVIDER OR SUPPLIER		D. mild	STREET ADDRESS, CITY, STATE, ZIP CODE	02/	26/2015	
	AMARITAN SOCIETY	- MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 282	trained to follow the document on any n inform the physicia in depth electronic copy of NP's docur which, licensed pra to NP of R137 com and vomited in the additional nursing p through 11/19/14, in complained of feeli refusing to eat due lightheadedness ar were the only docu related to potential further added, the n Black Box warnings document and repo- physician. On 02/26/15, at 10 R137 was alert and nurses if she was n R137, " is one of th to bother anyone w indicated typically s unit how they were nursing progress n unusual. She state administering her n blood pressure and physician ordered i medication adminis they would hold R1 pulse and/or blood and notify the phys current plan of care therapy for R137, L	e care plan, monitor and nedication side effects and n promptly. After reviewing of progress notes, RN-A provided nentation, dated 1/27/15, in actical nurse (LPN)-B reported plaining of feeling nauseated past week. RN-A provided orogress notes, dated 10/09/14 n which R137 repeatedly ng nauseated, not feeling well, to upset stomach, feeling nd dizzy. RN-A stated these mentation in R137's record medication side effects. RN-A hurses needed to read the s listed on R137's care plan, ort anything unusual to the coo a.m. LPN-C indicated d capable of informing the not feeling well; however, nose residents who didn't want rith her complaints," LPN-C she would ask residents on her feeling and documented in the otes if there was anything	F 2	82			

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TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NO. 0938-039) DATE SURVEY COMPLETED		
		245221	B. WING		02/26/2015		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/20/2015		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIO DATE		
F 282 F 327 SS=D	the adverse reaction use and needed more added these finding in the nursing progra needed to be notified aware R137 had be dizziness, nausea of The facility policy/pr titled, "Administration 11/14, directed staff adverse reactions of Drug Handbook as policy/procedures, f Change And Obser directed staff to not resident's status. 483.25(j) SUFFICIE HYDRATION The facility must pre- sufficient fluid intake and health. This REQUIREMENT by: Based on observation review, the facility france for the facility facility facility france for the facility	ns of digoxin and amiodarone onitoring each shift. She gs needed to be documented ress notes and the physician ed. LPN-C stated she was not een experiencing any or loose stools. rocedures, n of Medication," revised f to be familiar with action and of medications and to use a	F 282		e		
	R147 was at risk fo chronic diarrhea, m	r dehydration related to ledications with anticholinergic lormal laboratory (lab) values		re-development of individualized plan care to address fluid intake and possik risks for dehydration and is being monitored for fluid intake. R147 s			

Facility ID: 00900

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO.	E SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:		VG	· · /	PLETED		
		245221	B. WING _		02/2	26/2015		
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE				
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE		
F 327	Continued From pa	ige 7	F 32	27				
	lacked monitoring t	ration. However, the facility o ensure R147 received the punt of fluids per day to n.		physician will review resident status by 3-19-15. How to identify other residents same issue The facility will assess resident	with the			
	p.m. observation of appeared dry. R147	with R147 on 2/25/15, at 2:30 mouth, lips, tongue and teeth 7 stated, "Yes I need to drink o dry at night and when I wake mouth is bone dry."		others having the potential to b per policy upon admission, qua with change of condition. Resic receive a comprehensive care address fluid intake and possib dehydration, as indicated throu	e affected interly, and lents will plan to le risks for			
	assessment (MDS) indicated an alterat impaired. The care further read, "Resid to day decisions bu	onfusion at times." The CAA		assessment, upon admission, and with change of condition. assessed with increased risk for dehydration will have monitorin fluid intake per care plan. Recurrence will be prevented b Following and using facility poli procedure, systematic changes place to assess residents for fl risks such as potential for dehy	quarterly, Residents or g of their y cy and s will be in uid intake			
	monitoring accordir assessment dated R147 receive 2100 per] of fluid accordi There was no accu intake numbers to s	ve adequate fluid intake ng to the nutritional 12/1/14, which recommended -2500 cc/day [cubic centimeter ng to individual body weight. rate quantifying data for fluid support R147 received the of fluid intake per day.		diuretic use, renal disease, dia Residents found to be at risk w monitored for fluid intake per c Re-education will be given to a staff and dietician. Audits will b completed to ensure care plans developed for residents at risk; is monitored and provided as a per policy for compliance as ou	rrhea, etc. ill be are plan. Il nursing e s are fluid intake ssessed			
	month in the month of 2014 and in Jan February 2015 ther diarrhea. The medi following the bouts	pisodes of diarrhea each is of November and December uary of 2015. The month of e were 6 recorded episodes of cation Imodium was given of diarrhea, and the adverse um were not limited to but did and nausea.		These issues will be monitored following manner The Director of Nursing, Nurse and Dietician will audit resident dehydration for development of comprehensive care plan, intal monitoring completion and ade	in the Managers, s at risk for f ke			

Facility ID: 00900

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		& MEDICAID SERVICES	(X2) MI II T	TIPLE CONSTRUCTION		E SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG	· · ·	PLETED	
		245221	B. WING _		02/	26/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 327	 16, 17, and 20/2013 cc's recorded on thall fell below the as of 2100-2500 cc's of cc's for R147 on the documented were; 1010cc's, 2/11/14, 2/17/15, 1320 cc's During an interview RN-B verified she of data R147 took in of a twenty-four hour pcould see R147 conthroughout the day, water pitcher at R1 survey. R147 received che neoplasm of the bla for the chemothera of care, listed but winausea, lips dry an intervention read, " On 1/10/15, R147 r Dry Mouth Gel afte complaints of dry minimer com	a for diarrhea February 4, 9, 11, 5. The number of fluid intake e Food and Fluid Intake form sessed requirement for R147 of fluid per day. Fluid intake e days diarrhea was 2/4/15, 400 cc's, 2/9/15, 1260 cc's, 2/16/15, 1070 cc's, and 2/20/15, 650 cc's. on 2/26/15, at 9:45 a.m. could not prove with quantifying orally 2100-2500 cc's of fluid in period but the staff visually nsumed pop and fluids . There was observation of the 47's bedside each day of the emotherapy for malignant adder. One of the side effects py, and addressed on the plan vas not limited to diarrhea, d or cracked lips. An Drink plenty of fluids." received an order for Biotene r the family requested due to nouth. R147 was receiving tion 1.4% 2 drops in both eyes	F 32	27 hydration weekly for one for one quarter, and ther results will be brought to assurance committee fo needed.	n quarterly. Audit the quality		
	Medications R147 I depression which h effects which includ diarrhea, dry mouth Gabapentin for per adverse effects inc	had taken included Prosac for ad a warning for adverse de but was not limited to n, and nausea. R147 received ipheral neuropathy and the lude but are not limited to dry nd nausea. R147 had taken					

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		AND HUMAN SERVICES				FORM	03/20/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245221	B. WING			02/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD			550 EAST ROSELAWN AVENUE		
	1				MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 327	effects are not limit diarrhea and dehyd The blood creatinir molecule that is ge metabolism) had b admission at 1.21 r range of 0.60 to 1. continues to rise cu The blood urea nitr kidney disease and was 25 with a expe mg/dL. The BUN o range at 27 mg/dL 2/3/15, exceeded t mg/dL. R147 was seen at 2/3/15, by a certifie who reviewed the I "Worsening kidney "Encourage her to also elevated sugg	e function and the adverse ted to but do include nausea, dration. The blood level (chemical waste enerated from muscle een above normal since mg.dLwith the expected value 10. The 2/3/15, creatinine urrently at 1.97 mg/dL. Trogen (BUN) (indicator of d/or dehydration) on 9/12/13, ected value range of 8 to 28 in 12/5/14, remained within . The most recent BUN on the expected value range at 40 the Medical Oncology clinic On ed nurse practitioner (CNP-A) abs and wrote on the referral, function." Under the Plan #4. drink more fluids. Her BUN is the sting at least partly	F	327			
	increase in the diat urinary frequency, fully empty her blac Clinic Referral date read, "Hemoglobin creatinine 1.97-like order section of the orders, but on page her to drink more fi suggesting at least When interviewed	ermore, the CNP addressed an rrhea, and complaints of urgency, and not being able to dder. The returned form titled ed 2/3/15, signed by CNP-A 10.7 Kidney function ely dehydrated." Under the e referral was written no new e 2, the plan read, "Encourage luids. Her BUN is also elevated t partly dehydration." on 2/25/15, at 2:00 p.m. RN-C, JA-B and NA-C did not know					

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PRINTED: 03/20/2015 FORM APPROVED

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP			0938-039 E SURVEY
ND PLAN C	F CORRECTION	DENTIFICATION NUMBER:			à	СОМ	IPLETED
		245221	B. WING			02/26/2015	
NAME OF I	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 327	Continued From pa	age 10	F3	327	7		
	day for R147 or the strive for when end	fluid requirements were per e number of cc's they should couraging fluids. All three staff pouts of diarrhea and had					
	When interviewed on 2/26/15, at 9:45 a Registered Nurse (RN-B) produced a f Food and Fluid Intake, and designated 2/25/15, R147 was added into the com section so that the staff would record th of fluid cc's R147 consumed in a twen hour period. The number recorded was which was 720 cc's less than the minin recommended fluid intake for R147.	RN-B) produced a form titled, ake, and designated on added into the computer task staff would record the number consumed in a twenty four umber recorded was 1380 cc's s less than the minimum					
	2/26/15, at 9:45 a.r the plan of care said did not need to be RN-B acknowledge quantifying data for and stated, "We se Furthermore, RN-E notes and plan by s	about R147's fluid intake on m. RN-B expressed, because id to encourage fluids, there any further direction for staff. ed there was not accurate r R147's fluid intake per day be her taking fluids all the time." B discredited CNP-A's progress saying the nurse practitioner because this was the first time 1147 in the clinic.					
	titled, Intake and O choose to initiate in at risk for imbalance	lity policy dated 11/13, and utput, indicated a nurse could ntake and output on a resident ses such as potential for ic use, renal disease and					
	September 2012, a hydration status by	ydration of Residents, dated addressed maintaining the the registered dietitian (RD) ne individual fluid requirements					

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	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MEILTIPI	E CONSTRUCTION		. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			· · /	MPLETED
		245221	B. WING		02	/26/2015
IAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIET	- MAPLEWOOD	5 N			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 327		ent weight in kilograms times	F 327			
F 329 SS=D	30 millimeters give requirements. Wh 2:00 p.m. the RD v recommending 21 to maintain hydrati	es the estimated resident ien interviewed on 2/25/15, at verified R147's assessment 00 to 2500 cc's of fluid per day on was accurate. EGIMEN IS FREE FROM	F 329			4/6/15
	unnecessary drugs drug when used in duplicate therapy); without adequate r indications for its u adverse conseque	ug regimen must be free from s. An unnecessary drug is any excessive dose (including or for excessive duration; or monitoring; or without adequate use; or in the presence of nces which indicate the dose or discontinued; or any e reasons above.				
	resident, the facilit who have not used given these drugs therapy is necessa as diagnosed and record; and reside drugs receive grad behavioral interver	ehensive assessment of a y must ensure that residents d antipsychotic drugs are not unless antipsychotic drug ary to treat a specific condition documented in the clinical nts who use antipsychotic lual dose reductions, and ntions, unless clinically an effort to discontinue these				
	by:	INT is not met as evidenced w and document review, the		F329 483.25(I) DRUG REGIME		

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		AND HUMAN SERVICES	•		OM		APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (· /	E SURVEY PLETED
		245221	B. WING			02/2	26/2015
NAME OF	PROVIDER OR SUPPLIER	-		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
good s	AMARITAN SOCIETY	- MAPLEWOOD			50 EAST ROSELAWN AVENUE IAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETIC DATE
F 329	clinical indications f antiarrhythmic med for 1 of 5 (R137) re Findings include: R137's physician (N 4/9/13 indicated R1 and amiodarone for heart rate); howeve for continued use a monitoring of these On 02/26/15, at 8:5 stated, "Oh, yes, I fi the dizziness increat right side." R137 at kept her from falling Regarding feeling n up during the night me my plastic pan t indicated it happend and had informed th she experienced stat loose stools at leas frustrations of not fe told the nurses who she did not feel wel R137 was admitted admission history a had diagnoses that congestive heart fa chronic kidney dise	quately identify and monitor for continued use of ications and adverse effects sidents in the sample. MD)'s documentation dated, 37 had been taking digoxin r atrial fibrillation (to control er, the facility lacked indication nd potential adverse effects e medications. 11 a.m., alert resident, R137 eel dizzy all of the time and ases when I tilt my head to the dded the wheelchair she used g down due to being dizzy. hauseated, she stated, "I wake from nausea and they bring to throw up in." R137 ed quite often during the night he NP. R137 further stated omach problems and had t twice a day; R137 voiced eeling well and stated she had o gave her medications that	F 3	29	REVIEW IS FREE FROM UNNECESSARY DRUGS: Corrective Action for residents R137 Adverse side effect monitoring has b put in place for R137 per the care pl antiarrhythmic medication Digoxin. Antiarrhythmic medication Amiodaro was decreased from 200mg to 100m 1- 27-15 with a plan to discontinue th medication once the resident adjuste the decrease. This medication was discontinued on 2-26-15. Administra and Director of Nursing met with Me Director (R137 s Physician) on 3-1 to discuss F-329. Medical Director w complete a medical review of R137 Antiarrhythmic medications of contin use as well as possible adverse effe How to identify other residents with t same issue All residents who use Antiarrhythmic medications for continued use and po adverse effects of these medications upon admission, quarterly, and with change of condition. Possible adver effects will be care planned and monitoring in effect upon admission, quarterly, and with change of conditi Medications will be reviewed quarter and with change of condition for reduction. Recurrance will be prevented by Re-education to all nurses will be provided. Auditing will be completed review records for adequate identific and monitoring of clinical indications	been an for one ng on his ed to ator edical 2-15 vill s r ued ects. the s sical ossible s rse , ion. rly,	

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		& MEDICAID SERVICES				0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED	
		245221	B. WING			02/26/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE		
good s	AMARITAN SOCIETY	- MAPLEWOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 329	warning for amioda potentially fatal toxi toxicity (lung dama damage), hypothyr blood), exacerbatic heart failure (worse Potential adverse e formation or exace bradycardia (low he (difficulty breathing pressure), nausea, The nursing staff fa consistently monito physician on these adverse effects. The nursing progreathrough 11/19/14 re nauseated numero complained of bein dated 11/19/14, rev "I'm so hot. I feel lik "feeling dizzy, feels Nauseated. Had a mucous mixed with this date the nurse on omeprazole 20 nausea without pro potential adverse e amiodarone use. F documentation lack indications for the o amiodarone. Review of NP's door	ministration (FDA) black box arone use as: "Risk of icities including pulmonary ge) and hepatic injury (liver oidism (low thyroid levels in the on of existing arrhythmia and e heart beat problems). effects include arrhythmia rbation (heart rate problems), eart rate), dizziness, dyspnea), hypotension (low blood visual disturbances, vomiting." ailed to follow the care plan and or, document and inform the identified serious and fatal ess notes dated, 10/9/14 evealed, R137 had been us times, refused meals and g unwell. A progress noted vealed R137 had complained: ke I am going to throw up," and a sick to her stomach. small emesis of thick yellow n a small amount of blood;" On practitioner (NP) started R137 mg due to gastric reflux and operly assessing R137 for offects of digoxin and	F 32		sultant ary team will gradual dose ed in the e Managers or one month, and then se Audits will be ace		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/20/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245221	B. WING			02/;	26/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD			50 EAST ROSELAWN AVENUE IAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	naps, and stated, "I night," The docume resident complained area. The NP orde urinary tract infection mg daily for upset s documented R137's and,"can find nothin was uncertain what dizziness. On 11/19 level to be checked were documented a the nursing progress The quarterly Minim assessment dated, being moderately in able to understand minimal difficulty. The current MD's o indicated R137 was antiarrhythmic med every day and digor rate control) 125 mi The pharmacy cons recommendation to to consider discontii had not used it in the review the use of ou causing pneumonia Evidence was lackii consulting pharmace related to the contin amiodarone, espect	<i>y</i> , usually when getting up from My head was so dizzy last entation further revealed the d of headache in the temple red a urinalysis to rule out on and ordered omeprazole 20 stomach and nausea. The NP is medications were reviewed ing that really stood out," and it caused nausea, vomiting and 9/14 NP ordered digoxin lab and on 11/20/14 the results as 1.3, within normal range, in is notes. hum Data Set (MDS) 1/15/15 identified R137 as npaired of cognition and was others and be understood with rders dated, 01/25/15 is to receive amiodarone (an ication) 100 milligrams (mg) xin (used for CHF and heart icrograms (mcg) daily.	F 3	29			

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		<u>D. 0938-039</u> ATE SURVEY	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	CC	MPLETED	
		245221	B. WING		0:	2/26/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE	
F 329	Continued From pa	age 15	F 3	29			
	a.m. the consulting conducted a medic but did not have he answer specific que indicated he remen amiodarone becaus Beta blocker drugs amiodarone and dig in geriatric populati caution because of effects. The pharm important for the nur residents closely th drugs and inform th side effects. He sta and physician's door medication reviews recommendations the During a phone inter p.m. R13's NP indic admitted to the faci amiodarone. The N promote amiodaror population because use in elderly popu a potential for serio added his focus ha amiodarone for pat this medication. He digoxin for R137 ar closely. The NP sta to consistently more	IP indicated he did not he or digoxin use in geriatric e it was not recommended for lation, was very toxic and had bus side effects. The NP d been to try to discontinue ients who were admitted on e said he would discontinue ated the nursing staff needed hitor and document any ts of these medications and ded.					

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	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT			. 0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		IPLETED
		245221	B. WING _		02/26/2015	
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 329	(RN)-A stated after medical record that other documentatic of heart rate and bl the nurses docume adverse effects. R trained to follow the document on any n inform the physicia in depth electronic copy of NP's docum which, licensed pra to NP of R137 com and vomited in the additional nursing p through 11/19/14, in complained of feeli refusing to eat due lightheadedness ar were the only docu related to potential further added, the r Black Box warnings document and repor physician. On 02/26/15, at 100 R137 was alert and nurses if she was r R137, " is one of th to bother anyone w indicated typically s unit how they were nursing progress no unusual. She state administering her n blood pressure and physician ordered i	r reviewing R137's electronic t she was unable to find any on, other than daily monitoring ood pressure, to show whether ented on potential medication N-A indicated the nurses were e care plan, monitor and nedication side effects and n promptly. After reviewing of progress notes, RN-A provided nentation, dated 1/27/15, in actical nurse (LPN)-B reported plaining of feeling nauseated past week. RN-A provided orogress notes, dated 10/09/14 n which R137 repeatedly ng nauseated, not feeling well, to upset stomach, feeling medication side effects. RN-A nurses needed to read these mentation in R137's record medication side effects. RN-A nurses needed to read the s listed on R137's care plan, ort anything unusual to the coo a.m. LPN-C indicated d capable of informing the not feeling well; however, nose residents who didn't want ith her complaints," LPN-C she would ask residents on her feeling and documented in the otes if there was anything		29		

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
		245221	B. WING		00	02/26/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02	20/2015	
good s	AMARITAN SOCIETY	- MAPLEWOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
F 329	they would hold R1 pulse and/or blood and notify the physic current plan of care therapy for R137, L nausea/vomiting an the adverse reaction use and needed me added these finding in the nursing progra needed to be notifie aware R137 had be dizziness, nausea of According to the Ge 12th edition, dated "potentially inappro geriatrics," this med increased risk with problems (high or le dizziness, fatigue, H anorexia, CHF, abo extreme caution an In addition, it may in the physicians were dose by 50% and n closely. For digoxin caution in patients patients with advan adverse effects incre weakness, dizzines abdominal pain, an with amiodarone us on heart rate; there 50% was recomments The facility policy/p titled,"Administration	37's heart medications if the pressure were out of range ician. After reviewing the e related to antiarrhythmic PN-C stated, the dizziness, and diarrhea could potentially be ans of digoxin and amiodarone onitoring each shift. She gs needed to be documented ress notes and the physician ed. LPN-C stated she was not een experiencing any or loose stools. eriatric Dosage Handbook, 2007, amiodarone was, priate medication for dication was associated with heart rate problems, thyroid ow levels), liver problems, neadache, nausea, vomiting, dominal pain and needed id close monitoring of patients. Increase the digoxin levels and e advised to decrease digoxin nonitor digoxin blood levels in use, it indicated to use it with with thyroid problems and iced heart failure. The luded heart block, headache, as, nausea, vomiting, diarrhea, orexia (lack of appetite), and se it may have additive effects fore, reducing digoxin dose by ended.	F 3				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		
	N OF CORRECTION IDENTIFICATION NUMBER:			G	(X3) DATE SURVEY COMPLETED	
		245221	B. WING _		02/2	26/2015
AME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
iood s	AMARITAN SOCIETY	- MAPLEWOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117		
(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) COMPLETIO DATE
F 329	adverse reactions of Drug Handbook as policy/procedure, til Change And Obser directed staff to not change in resident	of medications and to use a needed. Another tled, "Notification of Condition vation," dated 9/2012, ify the physician of any	F 32 F 42			4/6/15
SS=D	reviewed at least or pharmacist. The pharmacist mu the attending physic	ON of each resident must be nce a month by a licensed est report any irregularities to cian, and the director of reports must be acted upon.				
	by: Based on interview facility's consulting and/or act upon ide of 5 residents (R14 R147 had a physici tablet 325 mg, give hours as needed fo 9/4/13. There was a acetaminophen tab mouth every 4 hour pain with a start dat order which read, N (Hydrocodone-acet	NT is not met as evidenced y and document review, the pharmacist failed to identify ntified drug irregularities for 2 7, R137) in the sample. an order for acetaminophen 1 tablet by mouth every 4 yr mild pain. The start date was a second order that read, let 325 mg give 2 tablets by rs as needed for moderate te of 9/4/13. There was a third lorco tablet 5-325 MG aminophen) Give 1 tablet by rs as needed for pain with a		Plan of Correction General Disclaimer Preparation and execution of this response and plan of correction do constitute an admission or agreem the provider of the truth of the fact alleged or conclusions set forth in statement of deficiencies. The pla correction is prepared and/or exec solely because it is required by the provisions of Federal and State law the purposes of any allegation that facility is not in substantial complia with Federal requirements of partic	the the un of cuted w. For t the unce	

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		AND HUMAN SERVICES			0		APPROVEI 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245221	B. WING _			02/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD			50 EAST ROSELAWN AVENUE IAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIOI DATE
F 428	Continued From pa	age 19	F 42	28			
	start date of 4/1/14. These orders gave R147 the potential to take 7700 grams of acetaminophen in a twenty four hour period.				this response and plan of correction constitutes the facility s allegation of compliance in accordance with section 7305 of the State Operations Manual.		
	There were no consideration review roof acetaminophen. interviewed on 2/25			F428 483.60(c) Drug Regimen Rev			
	the acetaminophen parameter in a 24 h manufacturers reco			The facility s Administrator and Di of Nursing met with the Pharmacis 12-15 regarding the drug regimen F-428, and the identification of drug	rector t on 3- review,		
	(RN-B) on 2/26/15, nursing staff were e	with the registered nurse at 9:45 a.m. revealed that the educated on 8/15/14, during			irregularities for continued use of medications for R147 and R137. Pharmacist will review R147 and R	137 to	
	to have parameters	that the acetaminophen was s not to exceed 3000 grams (g) urces of medication containing			identify drug irregularities with next Regimen Review scheduled for 3-1 Clinical monitoring for the continue of antiarrhythmic medications and effects will be ongoing. Administrat Director of Nursing met with Medic	19-15. d use side tor and al	
	4/9/13 indicated R1 and amiodarone for heart rate); however for continued use a	MD)'s documentation dated, 37 had been taking digoxin r atrial fibrillation (to control er, the facility lacked indication and potential adverse effects e medications. The consulting			Director (R148 and R137 s Physic 3-12-15 to discuss drug regimen re report irregular, act on F-428. Med Director will complete a medical re R147 and R137 s medications an indications for use as well as adver effects. R147 had received one do	eview, ical view of d rse	
	pharmacist lacked to MD.	to communicate irregularities			Tylenol (625mg) in the month of Fe Parameters have been put in place that R147 receives no more than 3	ebruary. e so 000mg	
	stated, "Oh, yes, I f the dizziness increa right side." R137 a	a a.m., alert resident, R137 eel dizzy all of the time and ases when I tilt my head to the dded the wheelchair she used			per 24 hour period. Side effect more has been put in place for R137 per care plan for antiarrhythmic medication Digoxin. Antiarrhythmic medication	the ation	
	Regarding feeling r up during the night	g down due to being dizzy. hauseated, she stated, "I wake from nausea and they bring to throw up in." R137			Amiodarone, was decreased from to 100mg on 1- 27-15 with a plan to discontinue this medication once the resident adjusted to the decrease.	o ne	

Facility ID: 00900

A. BUIL 5221 B. WIN CONNUMBER: A. BUIL B. WIN CONNUMBER: ID DED BY FULL IFORMATION ID	STREET ADDRESS, CITY, STATE, ZIP CODE 550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLE' DATE F 428
D FIENCIES DED BY FULL IFORMATION) F	STREET ADDRESS, CITY, STATE, ZIP CODE 550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLE' DATE F 428
FIENCIES ID DED BY FULL PRE IFORMATION) TA	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117 ID REFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x5) COMPLET DATE F 428 F 428
FIENCIES ID DED BY FULL PRE IFORMATION) TA	MAPLEWOOD, MN 55117 ID REFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET DATE F 428 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET DATE
DED BY FULL PRE IFORMATION) TA	REFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLÉ DATE F 428 F 428
luring the night	mediantian was discontinued as 0.00.15
urther stated	medication was discontinued on 2-26-15.
ns and had R137 voiced	How to identify other residents with the same issue
stated she had lications that	Medical records will be reviewed for all residents in the facility taking Acetaminophen. Parameters for
on 4/29/13 the	Acetaminophen use will be put in place for all residents receiving Acetaminophen.
ted, 05/02/13 thyroidism,	Residents taking antiarrhythmic medications will be monitored for side
abetes mellitus, ortic valve inarv tract	effects per facility policy. The Pharmacist will review to identify any drug irregularities monthly and report these to
	the Physician and Director of Nursing. The facility will monitor that these are
DA) black box Risk of pulmonary	acted upon through audits. Gradual dose reductions will be completed per policy and per orders for all residents as indicated.
roid levels in the rhythmia and blems).	Recurrence will be prevented by Re-education to all nurses regarding the above procedure will be provided. Consultant Pharmacist, Medical Director,
ate problems), ness, dyspnea (low blood	and interdisciplinary team will meet monthly for gradual dose reduction. Administrator and Director of Nursing met with the Consultant Pharmacist on
ne care plan and nd inform the bus and fatal	3-12-15 to review deficiencies and pharmacist expectations for monthly reviews. Medical Director, Consultant Pharmacist and interdisciplinary team will
, 10/9/14 nad been ed meals and	meet monthly for medication review and gradual dose reduction. Auditing will be completed to review drug regimen reports for pharmacist identification of drug irregularities and that physicians/nurse
	inary tract sted the U.S. DA) black box Risk of pulmonary c injury (liver roid levels in the rhythmia and blems). arrhythmia ate problems), ness, dyspnea (low blood nces, vomiting." ne care plan and nd inform the pus and fatal

Facility ID: 00900

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TATEMENT	OF DEFICIENCIES F CORRECTION	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
-				G		
		245221	B. WING			26/2015
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO 550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 428	"feeling dizzy, feels Nauseated. Had a mucous mixed with this date the nurse on omeprazole 20 r nausea without pro potential adverse e amiodarone use. F documentation lack indications for the c amiodarone. Review of NP's doc indicated R137 con vomited bile in a pla indicated the reside dizzy during the day naps, and stated, "I night," The docume resident complaine area. The NP orde urinary tract infection mg daily for upset s documented R137's and,"can find nothin was uncertain what dizziness. On 11/19 level to be checked were documented a the nursing progress The quarterly Minim assessment dated, being moderately ir able to understand minimal difficulty.	te I am going to throw up," and sick to her stomach. small emesis of thick yellow a small amount of blood;" On practitioner (NP) started R137 mg due to gastric reflux and perly assessing R137 for ffects of digoxin and furthermore, the ted evidence identifying clinical continued use of digoxin and sumentation dated 11/19/14, mplained of nausea and had astic bin. The documentation ent had complained of being y, usually when getting up from My head was so dizzy last entation further revealed the d of headache in the temple red a urinalysis to rule out on and ordered omeprazole 20 stomach and nausea. The NP is medications were reviewed ng that really stood out," and it caused nausea, vomiting and 9/14 NP ordered digoxin lab and on 11/20/14 the results as 1.3, within normal range, in	F 42	8 reports and that these reports upon. These issues will be monitore following manner Director of Nursing and Nurse will complete audits to review recommendations made by th Pharmacist to ensure the abor procedure is being followed a appropriate documentation h obtained by Physician. Audits completed weekly for one mon for one quarter, and then quar results will be brought to the assurance committee for furt needed.	ed in the Managers the ne ove and that as been will be onth, monthly rterly. Audit quality	

If continuation sheet Page 22 of 36

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245221		B. WING		02	02/26/2015	
NAME OF I	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP COD	θE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 428	Continued From pa	-	F 428				
	indicated R137 was to receive amiodarone (an antiarrhythmic medication) 100 milligrams (mg) every day and digoxin (used for CHF and heart rate control) 125 micrograms (mcg) daily. The pharmacy consultant made a recommendation to the MD on 2/24/15, indicating to consider discontinuing Robitussin since R137 had not used it in the past three months, and to review the use of omeprazole which was linked to						
	causing pneumonia Evidence was lack consulting pharma related to the conti amiodarone, espec	a and bone fractures. ing to reflect whether the cist had noted any irregularities nued use of digoxin and cially when R137 had voiced sea, vomiting and headaches					
	a.m. the consulting conducted a medic but did not have he answer specific qu indicated he remer amiodarone becau Beta blocker drugs	erview on 02/25/15, at 9:00 pharmacist indicated he had cation regimen review for R137; er record in front of him to estions. The pharmacist nbered R137 was on se she did not tolerate any c. The pharmacist added					
	amiodarone and di in geriatric populati caution because of effects. The pharn important for the nu residents closely th drugs and inform th side effects. He st	goxin were not recommended ion and should be used with if the high risk of fatal adverse nacist stated it was very ursing staff to monitor nat were using these potent ne physician of any potential ated he reviewed the nursing cumentation during his monthly					

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	<u>RS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES). 0938-039	
	ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245221	B. WING _		02	2/26/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 428	p.m. R13's NP india admitted to the fact amiodarone. The N promote amiodaron population because use in elderly popu a potential for seric added his focus ha amiodarone for pat this medication. He digoxin for R137 ar closely. The NP st to consistently mor potential side effec update him as need On 02/26/15, at 9:3 (RN)-A stated after medical record that other documentation of heart rate and bit the nurses document adverse effects. R trained to follow the document on any m inform the physicia in depth electronic copy of NP's document and vomited in the additional nursing p through 11/19/14, in complained of feelin refusing to eat due lightheadedness an	cated the resident had been lity on digoxin and IP indicated he did not he or digoxin use in geriatric e it was not recommended for lation, was very toxic and had bus side effects. The NP d been to try to discontinue tients who were admitted on e said he would discontinue the nursing staff needed nitor and document any ts of these medications and ded. 30 a.m. registered nurse r reviewing R137's electronic t she was unable to find any on, other than daily monitoring ood pressure, to show whether ented on potential medication N-A indicated the nurses were a care plan, monitor and nedication side effects and n promptly. After reviewing of progress notes, RN-A provided nentation, dated 1/27/15, in actical nurse (LPN)-B reported plaining of feeling nauseated past week. RN-A provided orogress notes, dated 10/09/14 n which R137 repeatedly ng nauseated, not feeling well, to upset stomach, feeling nd dizzy. RN-A stated these mentation in R137's record	F 42				

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		AND HUMAN SERVICES				FORM	: 03/20/2015 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		PLE CONSTRUCTION		E SURVEY IPLETED
		245221	B. WING	i		02/	26/2015
NAME OF I	PROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD			550 EAST ROSELAWN AVENUE		
					MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	Black Box warning document and repo- physician. On 02/26/15, at 10 R137 was alert and nurses if she was r R137, " is one of th to bother anyone w indicated typically s unit how they were nursing progress nu- unusual. She state administering her n blood pressure and physician ordered i medication administ they would hold R1 pulse and/or blood and notify the phys current plan of care therapy for R137, L nausea/vomiting ar the adverse reaction use and needed ma added these finding in the nursing progra needed to be notifie aware R137 had be dizziness, nausea of According to the Ga 12th edition, dated "potentially inappro geriatrics," this med- increased risk with problems (high or L dizziness, fatigue, L	s listed on R137's care plan, ort anything unusual to the coo a.m. LPN-C indicated d capable of informing the not feeling well; however, iose residents who didn't want ith her complaints," LPN-C she would ask residents on her feeling and documented in the otes if there was anything ed for R137 prior to nedications they obtained d heart rate because the t and documented in the stration record. LPN-C stated 37's heart medications if the pressure were out of range ician. After reviewing the e related to antiarrhythmic .PN-C stated, the dizziness, nd diarrhea could potentially be ons of digoxin and amiodarone onitoring each shift. She gs needed to be documented ress notes and the physician ed. LPN-C stated she was not een experiencing any	F	428	3		

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PRINTED: 03/20/2015

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COM	IPLETED
		245221	B. WING		02/	26/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 428	In addition, it may it the physicians were	ige 25 Id close monitoring of patients. Increase the digoxin levels and e advised to decrease digoxin nonitor digoxin blood levels	F 428	3		
	closely. For digoxic caution in patients patients with advan adverse effects inc weakness, dizzines abdominal pain, an with amiodarone us	n use, it indicated to use it with with thyroid problems and loced heart failure. The luded heart block, headache, ss, nausea, vomiting, diarrhea, orexia (lack of appetite), and se it may have additive effects fore, reducing digoxin dose by				
F 441 SS=E	11/14, directed staf adverse reactions of Drug Handbook as policy/procedure, ti Change And Obser directed staff to not change in resident'	n of Medication," revised f to be familiar with action and of medications and to use a needed. Another tled, "Notification of Condition vation," dated 9/2012, ify the physician of any	F 44	1		4/6/15
	Infection Control Pr safe, sanitary and c	stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ction.				
	Program under whi (1) Investigates, co in the facility;	stablish an Infection Control				

Facility ID: 00900

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TATEMENT	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		<u>. 0938-039</u> E SURVEY	
ND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:	A. BUILDIN	IG	COM	IPLETED	
		245221	B. WING _		02/	26/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 441	Continued From pa	age 26	F 44	1			
		to an individual resident; and ord of incidents and corrective nfections.					
	determines that a r prevent the spread isolate the resident (2) The facility must communicable dise from direct contact direct contact will th (3) The facility must hands after each d hand washing is im professional practic	tion Control Program esident needs isolation to of infection, the facility must t. st prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. st require staff to wash their irect resident contact for which dicated by accepted					
	transport linens so infection.	as to prevent the spread of					
	by: Based on interview facility failed to dev screening of reside documentation of t skin test (TST); an R252) newly admit to consistently doc	NT is not met as evidenced w and document review, the relop a policy on Tuberculosis ents, which included he induration of the tuberculin d for 4 of 5 (R224, R170, R52, ted residents the facility failed ument either the results of the policy and/or the induration of		F441 483.65, Infection Cont Corrective Action for residen R170, R52, R252 The policy and procedure hat re-developed for tuberculosi residents including documer results of skin tests including Nurses involved have been immediately regarding chart	its R224, as been s screening of ntation of g induration. retrained		

Facility ID: 00900

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	AND HUMAN SERVICES				03/20/201 APPROVE <u>0938-039</u>
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	245221	B. WING _		02/2	26/2015
OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
N SOCIETY	- MAPLEWOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117		
CH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETIO DATE
ility's 11/14 creening of d that a two l for the tub indicated that tered upon fter administ be administ e, one to the test. The s ours after a id not indica be recorde as admitted nunization eHR) revea tered on 12 tion administ tered on 12 tion administ tered on 12 tion admitted as negati er (mm) ind as admitted zation secti I was admi IAR found i /15, but the	revised policy and procedure Resident for Tuberculosis o-step Mantoux method was to erculin skin test (TST.) The tt the TST was to be admission and read 48-72 stration; and a second TST ered if the first TST was ree weeks after placement of econd test was to be read administration. However, the ate the induration of the results d as part of the TST. d to the facility on 12/12/14. section of the electronic health aled the first TST was 2/14/14. According to the stration record (MAR) found in was read on 12/16/14, as re was no indication as to the ea read. A second TST was ve on 12/21/14, with a 0 duration on 12/21/14.	F 44	 results for their most recent tub skin test and these have been How to identify other residents same issue An audit was completed of all r admitted residents to identify or residents who may have the sate Going forward, weekly audits we completed to ensure that nursii charting results of tuberculin ski including induration for resident have received a tuberculin test Re-education will be given to n ongoing as needed. Recurrence will be prevented to Re-education will be given to a regarding the policy and proceed tuberculin skin testing and chart for tuberculin skin tests includir induration. Audits will continue compliance with the policy and as outlined below. These issues will be monitored following manner The Director of Nursing, and N Managers, will complete audits one month, then monthly for or and then quarterly. Audit result 	recorded. with the newly ther ame issue. <i>i</i> ll be ng staff are kin tests ts who urses by Il nurses dure for rting results ng to assure procedure l in the urse weekly for ne quarter, ts will be	
	MEDICARE IENCIES CTION OR SUPPLIER AN SOCIETY SUMMARY STICH DEFICIENC ULATORY OR L Led From particles Summary STICH DEFICIENC ULATORY OR L Led From particles Cultory on L Led From particles Led From particles Cultory on L Led From particles Led From particles Led From particles Cultory on L Led From particles Cultory on L Led From particles Led From particles Cultory on L Led From particles Led From particles Cultory on L Led From particles Led From particles Led From particles Cultory on L Led From particles Led From particle	MEDICARE & MEDICAID SERVICES IENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221	MEDICARE & MEDICAID SERVICES IENCIES TTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221 (X2) MULT A. BUILDIN OR SUPPLIER 245221 B. WING_ OR SUPPLIER AN SOCIETY - MAPLEWOOD ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Ied From page 27 F 44 sility's 11/14 revised policy and procedure creening of Resident for Tuberculosis ed that a two-step Mantoux method was to d for the tuberculin skin test (TST.) The ndicated that the TST was to be stered upon admission and read 48-72 (fter administration; and a second TST be administration; and a second TST be administration. However, the lid not indicate the induration of the results be recorded as part of the TST. vas admitted to the facility on 12/12/14. (eHR) revealed the first TST was stered on 12/14/14. According to the tion administration record (MAR) found in R, the TST was read on 12/16/14, as we", but there was no indication as to the on of the area read. A second TST was ed as negative on 12/21/14. with a 0 ter (mm) induration on 12/21/14. vas admitted to the facility on 1/20/15. The ization section of the eHR revealed the T was administered on 1/20/15. According MAR found in the eHR, the TST was read /15, but there was no indication as to r the results were positive or negative; and as no indication as to the induration of the	MEDICARE & MEDICAID SERVICES IENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING OR SUPPLIER 245221 B. WING NN SOCIETY - MAPLEWOOD STREET ADDRESS, CITY, STATE, ZIP CODE 550 EAST ROSELAWN AVENUE MAPLEWOOD, NN 55117 SUMMARY STATEMENT OF DEFICIENCIES OF DEFICIENCY MUST BE PRECEDED BY FULL ULATIONY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED 10 THE APP DEFICIENCY MUST BE PRECEDED BY FULL ULATIONY OR LSC IDENTIFYING INFORMATION) ULATIONY OR LSC IDENTIFYING INFORMATION) F 441 results for their most recent tut skin test and these have been creating of Resident for Tuberculosis ad that a two-step Mantoux method was to d for the tuberculin skin test (TST.) The dicated that the TST was be, one to three weeks after placement of itest. The second test was to be read iours after administration, and a second TST be administration. However, the lid not indicate the induration of the results be recorded as part of the TST. F 441 read admitted to the facility on 12/16/14, as we", but there was no indication as to the on of the area read. A second TST was tered on 12/21/14. With a 0 ter (mm) induration on 12/21/14. Recurrence will be prevented to Re-education will be given to a orgarding the policy and proce- tuberculin skin tests includin induration. Audits will continue compliance with the policy and proce- tuberculin skin tests includin induration on 12/21/14. ras admitted to the facility on 1/20/15. According AR found in the HR, the TST was read //1	MEDICARE & MEDICAID SERVICES OMB NO. IENCIES (X) PROVIDERSUPPLERCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATA OR SUPPLER 245221 B. WING (22) MULTIPLE CONSTRUCTION A BUILDING (23) DATA NSOCIETY - MAPLEWOOD STREET ADDRESS, CTTY, STATE, ZIP CODE 550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117 (24) DATA SUMMARY STATEMENT OF DEFICIENCIES OUMDARY STATEMENT OF DEFICIENCIES ULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY UEd From page 27 F 441 results for their most recent tuberculin skin test and these have been recorded. Idea ta two-step Mantoux method was to 16 of the tuberculin skin test (TST.). The dicated that the TST was to be administration, and a second TST be administration. However, the id not indicate the induration of the results be recorded as part of the TST. F 441 Recurrence will be given to nurses ongoing as needed. Recurrence will be reveated by R*, but here was no indication as to the on of the area read. A second TST was tead an egative on 12/21/14, with a 0 ter (mm) induration on 12/21/14. Recurrence will be provented by Re-education will be given to all nurses regarding the policy and procedure for tuberculin skin tests including induration. Addits will be orevented by Re-education will be given

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/20/2015 APPROVED 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DAT	E SURVEY PLETED
		245221	B. WING			02/2	26/2015
NAME OF PR	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SAI	MARITAN SOCIETY	- MAPLEWOOD			550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441 (Continued From pag	ge 28	F 4	441			
F F F F F F F F F F F C F F F C F F F F F F F F F F F F F	According to the eH admissions to the fa ecorded as 11/14/1 ound in the eHR th 11/16/14, as negative ecorded. A second as negative on 11/2 R52 was then disch acility on 1/30/15. A he eHR the first TS negative on 2/1/15, ecorded. A second as negative on 2/8/1 was not recorded. R252 was admitted mmunization section irst TST was admir o the MAR found in and recorded as ne was no indication as ead. According to t second TST was re on 2/18/15, but agai o the induration of the cond 2/24/15 at 12:00 stated the results of nduration of the read locumentation was or first and second R170, R52, R252. Dn 2/25/15, at 10:00 eviewed the facility Residents for Tuber	IR R52 had several acility. The first admission was 4, and according to the MAR e first TST was read on ve, but the induration was not TST was read and recorded 1/14, with a 0 mm induration. arged and readmitted to the According the MAR found in 5T was read and recorded as but the induration was not TST was read and recorded as but the induration was not TST was read and recorded 15, but again, the induration to the facility on 2/9/15. The on of the eHR revealed the histered on 1/20/15. According the eHR, the TST was read gative on 2/11/15, but there is to the induration of the area he MAR found in the eHR, a ad and recorded as negative in, there was no indication as					

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			(3) DATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED
		245221	B. WING _		02/26/2015
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 550 EAST ROSELAWN AVENUE	
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		MAPLEWOOD, MN 55117	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 441	Continued From pa induration of the TS	ge 29 T's were to be documented.	F 44	1	
F 465 SS=E	PointClickCare-TB Order Entry and Tra directions for record review of the policy PointClickCare com include instructions the TST. The Point directed the staff to in the eHR and reco "negative" or "positi related to a chest x- information in the "N directions to staff to TST's. 483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pro- sanitary, and comfor residents, staff and This REQUIREMEN by: Based on observat review, the facility fa- room environment f R83); and failed to of well maintained env- resident rooms and shower rooms revie- rooms 14 through 2	IT is not met as evidenced ion, interview and document ailed to ensure a comfortable or 2 of 82 residents (R26, ensure a clean, attractive and ironment in 7 out of 34 bathrooms, 1 of 4 tub and wed and the hallway with 5 and the laundry processing potential to impact 22 of 82	F 46	5 GENERAL DISCLAIMER Preparation and execution of this response and plan of correction does constitute an admission or agreemen the provider of the truth of the facts alleged or the conclusions set forth in statement of deficiencies. The plan of correction is prepared and/or execute solely because it is required by the provisions of Federal and State law.	nt by n the of ed

Facility ID: 00900

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ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	MB NO. (X3) DATE	E SURVEY
ID PLAN C	F CORRECTION	DENTIFICATION NUMBER:				COM	PLETED
		245221	B. WING			02/2	26/2015
IAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD			50 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 465	Continued From pa	ge 30	F 4	165			
	Findings include: Two residents, R26 windows which wer in a cold draft which On 2/23/15 at 4:56 broken piece of gla frame. A cold draft	and R83, had personal room e poorly maintained, resulting n impacted their comfort. p.m. in room 007, a small ss was noted in the window was noted coming from the draft was felt several feet away			the purposes of any allegation that facility is not in substantial complia with Federal requirements of partic this response and plan of correctio constitutes the facilities allegation of compliance with section 7305.	nce ipation, n	
	from the window wh asked if the room fe "yes." R26's annual R26's cognitive stat	here R26 was seated. When elt drafty, R26 responded I MDS assessment noted tus as severely impaired, as ith short and long term			F465 483.70h Other Environmenta Conditions- The facility must provid safe, functional, sanitary, and comp environment for residents, staff and public.	le a fortable	
	room 103 was note resulted in a cold di were noted along th draft could still be for opened. R83 was in temperature of the expressed concern [MA], nursing assis cold room and the R83 stated her fam blankets and a nurs towels along the bar draft. R83's most re [MDS], dated 12/11 cognitively intact. During an environm	p.m. the outside window in d to not close properly, which raft being felt. Several towels he base of window, but the elt when the curtains were nterviewed regarding the room, and stated she had s to the maintenance assistant tants and her family about the window not closing properly. ily had brought in extra sing assistant had placed the se of the window to stop the ecent minimum data set /14, indicated she was			 Corrective Action: Additional weather stripping been installed on windows in room 103. b. the bathroom walls in room (not 111 as stated) was repainted a one color. c. cracked wall in room 17 bed repaired and repainted. d. bathroom floor is being replated and repainted. d. bathroom floor is being replated and stain removed. e. ceiling tiles in bathrooms 15 and 10&12 have been replaced. f. The tape on the toilet assist I was removed in restroom 15&17. 	s 7 and 107 all in 1 was aced in 12 was &17 oars	
	between 1:29 p.m. confirmed there wa window in Room 10 place. The outside DES also confirmed	ices [DES] on 2/24/15 and 2:30 p.m. the DES s a draft coming from the 03, even with the towels in window did not shut fully. The d the draft coming from the 7, which could be felt a few window			g. unfinished repairs in bathroo have been finished and restroom repainted. h. wall in room 103 containing mark was repainted. i. The N.E shower room has be deep cleaned however after assess will be getting a full modernization.	brown een	

Facility ID: 00900

If continuation sheet Page 31 of 36

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE CONSTRUCTION	OMB NO.	E SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:			()	PLETED	
		245221	B. WING		02/2	26/2015	
AME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP C	ODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 465	Continued From pa	ae 31	F4	65			
		e survey, there were several		j. The issue with the wat	ter fountain in		
		ling concerns with the		the NE hall has been correc			
		ing attractive, clean or well		stains cleaned.			
	maintained.			k. The entire floor of the	laundry will		
		p.m. the wall behind the toilet		be retiled.			
		room 111 had a square patch nately two feet		2. Other Residents:			
	which was unpainte			2. Other Residents.			
		p.m. peeling paint was noted		An audit will be completed of	on all resident		
c i F r		n of the wall behind the toilet,		rooms and bathrooms to ide			
	in the bathroom used by room 107. The area of			further issues, and repaired			
	peeling paint was also a different color than the						
	rest of the wall.			3. Recurrence will be prever	nted by:		
		p.m. a large crack, ength of half the wall, was		A meeting was held with all	onvironmontal		
		the two beds in room 17. The		services staff to re-educate			
		with room 15 had a large rust		issues/ or repair needs to Er			
	-	d the toilet, which resulted in a		Services Director so action			
		d not be cleaned. The grab		immediately. Audits will cont			
		had pieces of tape on them		specified below, and repairs	completed as		
		brown. The wall by bed one		needed.			
		ontained peeling paint. p.m. two patched and		4. These issues will be mon	itored in		
		easuring approximately four by		following manner:			
		oted by the towel rack in the		· · · · · · · · · · · · · · · · · · ·			
		y rooms 101. These patched		Periodic audits will be de			
		i sanded and prepped for		Director of Environmental S			
	painting.	a an in the least second of the		monthly for one quarter and			
		p.m. in the bathroom shared and room 17 soiled tape was		after to ensure compliance. brought to the Q.A. committe			
		bars by the toilet and a brown					
	5	vas noted above the toilet.		5. Completion dates			
		tal tour with the director of					
	environmental serv	ices [DES] on 2/24/15,		All corrective actions wil			
		and 2:30 p.m. the following		completed by April 6, 2015 v			
		ed, which were confirmed by		exception of the NE shower			
	the DES.			walls. The NE shower floor a			
				be completed by CFS Floori	ng by way 15		

Facility ID: 00900

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONS	TRUCTION	(X3) DAT	. 0938-039 E SURVEY
ID PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG		CON	IPLETED
		245221	B. WING _			02	/26/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD			roselawn avenue NOOD, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO ROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 465	Continued From pa	lge 32	F 40	65			
		nd the area was a different of the wall. The DES reported of the concern.			ver funding has been appro cially and signed off for co		
	wall. R83 reported	wn mark was noted on the the mark had been there since The DES was unaware of the					
	room 101 had beer prepped for paintin	d the wall in the bathroom of n patched, but not sanded or g. The DES explained the wall had not been finished. The e of the concern.					
	bars near the toilet base and the dark bathroom between reported the tape o	d soiled tape on the toilet grab the red ring around the toilet spot on the ceiling in the rooms 15 and 17. The DES n the handle bars was not a and was not sure why it would					
	toured with the DES corner. The black r peeling off. There v grout between the shower. Cracks we the floor. The DES	b room on the North Unit was S. Cobwebs were found in the non-skid tape on the floor was vere brownish/red marks in the tiles of the floor and wall of the re found in several tiles near reported he was unaware of nd cleanliness issues.					
	line coming from th floor. A small reddi	rth Unit had a reddish brown e water fountain, down to the sh brown mark was on the ater fountain. The DES					

If continuation sheet Page 33 of 36

STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CON	IPLETED
		245221	B. WING		02/26/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 465	reddish brown ring round brown mark The DES reported ceiling tiles, but the On 2/24/15, the DE preventative mainten directed staff to per maintenance in the basis only. None ha DES explained whe department change were not completed responsible for the preventative mainten were done for resid rooms and was una of any audits or resi inspections. The Whirlpool-Shor November 2006, di all sills and ledges disinfectant cleaned doors and partitions soft, clean cloth wit and wipe dry. 4. Da outside of cabinets clean cloth and disi Wipe dry to avoid s faucets chrome are wipe to shine with of hard floor surfaces Using a damp floor solution, damp mog Repeat if floor is he	was found on the floor. A was found on the ceiling tiles. he had previously repaired the ry returned. S reported there was a enance schedule posted on the ance room. This document	F 4	65		

If continuation sheet Page 34 of 36

		AND HUMAN SERVICES			FORM	03/20/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
		245221	B. WING		02/:	26/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	Continued From pa	ıge 34	F 465			
	November 2006, di toilet bowls; place of bowl cleaner in toilet time. 3. Spray all fix solution. Wipe dry w light fixtures, pipes stands; use disinfed and/or polish with s to the swab/brush a Wipe top bottom of dispensed from spr supplies: paper tow soap and dispensin mop floor, see Sect follow Damp Moppi Notify supervisor if attention. 9. Once a in the restrooms wit solution." The DES was not a housekeeping or pr procedures. On 2/25/15, at 8:30 laundry processing, were observed to b or missing, exposin On 2/25/15, at 9:20 interviewed regardin floor tiles in the laundry. On 2/26/15, at 11:1	aning Procedure, last revised rected staff to: "2. Sanitize disinfectant cleaners/or toilet et bowl; do not scrub at this ktures with disinfectant cleaner with clean cloth. Include mirror, under sink, etc. 4. Clean wash ctant cleaner solution. Dry soft rag. 5. Apply bowl cleaner and vigorously scrub the bowl. seats with disinfectant cleaner ray bottle. 6. Replenish vels, toilet paper, liquid or bar ing machine supplies. 7. Dust tion II. L. 8. Damp mop floor; ing Procedure (Section II. M). floor requires additional a week, clean the mop boards th a solution of neutral cleaner able to provide any additional reventative maintenance 0 a.m. the floor tiles in the , storage, soiled linen area be peeling away from the floor ing the concrete beneath. 0 a.m. the DES was ng the missing and peeling ndry. The DES stated "I guess ed." the condition of the floor				

If continuation sheet Page 35 of 36

CENTERS FOR MEDICARE & MEDICARD SERVICES OME INC. 0938-6391 AND PLAN OF CORRECTION (Y1) PROVIDENT PURPLY (Y2) MULTIPLE CONSTRUCTION ADD PLAN OF CORRECTION 245221 (Y1) PROVIDENT CORE GOOD SAMARITAN SOCIETY - MAPLEWOOD STREET ADDRESS, CITY, STATE, ZIP CODE 02/26/2015 GOOD SAMARITAN SOCIETY - MAPLEWOOD STREET ADDRESS, CITY, STATE, ZIP CODE 02/26/2015 FREET ADDRESS, CITY, STATE, ZIP CODE SUMMAY STATEMENT OF DEFICIENCES 0 CALL SUMMAY STATEMENT OF DEFICIENCES 0 PREFX CALL SUMMAY STATEMENT OF DEFICIENCES 0 PREFX TAG REGULATORY OR LSC DENTIFICATIONS PREFX CORRECTION NOT SHOULD BE COMPLETED TO THE APPROPRIATE COMPLETED TAG SUMMAY STATEMENT OF DEFICIENCES 0 PREFX CORRECTION NOLL BE CONTROL TO THE APPROPRIATE COMPLETED TAG Continued From page 35 TAG TAG TAG Implementer of the APPROPRIATE COMPLETED Isoundry room floor tiles. Isoundry room floor tiles. F 465 Implementer Implementer Implementer			AND HUMAN SERVICES			FORM	APPROVED			
N. BOILDING 245221 B. WING 02/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE S50 EAST ROSELAWN AVENUE MAPLEWOOD (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE F 465 Continued From page 35 F 465 F 465	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(X3) DATE	E SURVEY			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - MAPLEWOOD 550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117 (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 465 Continued From page 35 F 465	AND I LAN O	I GOTTILE TION	IDENTIFICATION NOMBER.	A. BUILDI	IG	00101				
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GOOD SAMARITAN SOCIETY - MAPLEWOOD MAPLEWOOD, MN 55117 (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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE F 465 Continued From page 35 F 465 F 465	NAME OF F	ROVIDER OR SUPPLIER								
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLÉTION DATE F 465 Continued From page 35 F 465 F 465 F 465	GOOD SA	AMARITAN SOCIETY	- MAPLEWOOD							
	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE				
	F 465	-	-	F 46						

Facility ID: 00900

If continuation sheet Page 36 of 36

PRINTED: 03/20/2015

SATE MENT OF DEPROSENCES (X1) PROVIDERSUPPLIERLA UDENTIFICATION NUMBER (X2) ANTE EURVEY A BUILDING 01 - MAIN BUILDING 01 A BUILDING 01 - MAIN BUILDING 01 BUILDING 01 - BUILDING 01 BUILDING 01 BUILDING 01 - BUILDING 01 BUILDING 01	1000 State (1990)		AND HUMAN SERVICES & MEDICAID SERVICES	4	5221021	FORM	APPROVED . 0938-0391
MARE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - MAPLEWOOD STREET ADDRESS, CITY, STATE, ZIP CODE PRETIX SUMMARY STATEMENT OF DEFICIENCES BY THE SAME OF DEFICIENCES DEFICIENCES PRETIX REGULATIONY OR LSC IDENTIFYING MFORMATION) FIRE SAFETY PRETIX THE FACILITY'S POC WILL SERVE AS YOU ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTON OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE WITH THE UPON RECEIPTS OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTATIAL COMPLIANCE WITH THE BUILDING 1 - 1985, 1993 AND 1996 ADDITIONS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey. GOOD Samarita Society Magae A Totton N COR THE FIRST DEFICIENCIES (K TAGS) TO. PLEASE RETURN THE PLAN OF CORRECTION FOR THE SAFETY DEFICIENCIES (K TAGS) TO. HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 STATE FIRE MARSHAL DIVISION HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION <tr< td=""><td>STATEMENT</td><td>OF DEFICIENCIES</td><td>(X1) PROVIDER/SUPPLIER/CLIA</td><td>• •</td><td>IPLE CONSTRUCTION</td><td>(X3) DAT</td><td>E SURVEY</td></tr<>	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	• •	IPLE CONSTRUCTION	(X3) DAT	E SURVEY
Set East ROSELAWA MENUE SUMMARY STATEMENT OF DEFICIENCIES EAST DEFICIENCY MUST de PROCENCIES MARY SUMMARY STATEMENT OF DEFICIENCIES EAST DEFICIENCY MUST de PROCENCIES Image: Colspan="2">PROCENCIES OF ANY OCORRECTION SHOULD BE EAST DEFICIENCY K 0000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOU ALLEGATION OF COMPLANCE UPON THE DEFARTMENT'S ACCEPTANCE UPON THE REGULATION OF COMPLIANCE UPON THE DEFARTMENT'S ACCEPTANCE UPON THE REGULATION OF COMPLIANCE UPON THE REGULATION SHIT REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTATTIAL COMPLANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. BUILDING 1 - 1985, 1993 AND 1996 ADDITIONS A Life Safety Code Survey was conducted by the Minnescia Department of Public Safety. At the time of this survey. Good Samarian Society Maplewood was found not in substantial compliance with the requirements for participation in Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medicare/Medica			245221	B. WING		02/	25/2015
GODD SAMARITAN SOCIETY - MAPLEWOOD MAPLEWOOD, MN 55117 (%1) D PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) RESULTIONY OR LSC DENTIFIANCE MEDIANCE UPON RESULTIONY OR LSC DENTIFIANCE MEDIANCE RESULTIONY OR LSC DENTIFIANCE MEDIANCE RESULTIONY OR LSC DENTIFIANCE MEDIANCE PRETX TAG PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY) 000 (EACH DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOU ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. K 000 UPON RECEIPTS 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 ACCCORDANCE WITH YOUR VERIFICATION. BUILDING 1 - 1985, 1993 AND 1996 ADDITIONS A Life Safety Code Survey was conducted by the Minesotal Department of Public Safety, At the Minesotal The Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. FEEDERCOC PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUTE 145 STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUTE 145 STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUTE 145 THE 200 ME	NAME OF I	PROVIDER OR SUPPLIER				1014	
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FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOU ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPTS 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. BUILDING 1 - 1985, 1993 AND 1996 ADDITIONS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society Maplewood was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpat 483, 70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION <t< td=""><td>PREFIX</td><td>(EACH DEFICIENC)</td><td>MUST BE PRECEDED BY FULL</td><td>PREFIX</td><td>(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI</td><td>D BE</td><td>COMPLETION</td></t<>	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETION
THE FACILITY'S POC WILL SERVE AS YOU ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPTS 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. BUILDING 1 - 1985, 1993 AND 1996 ADDITIONS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society Maplewood was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpat 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHALD DIVISION AS MINNESSOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 ADDAMAGY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE MADE AND	K 000	INITIAL COMMENT	ſS	K 00	00		
ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2667 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPTS 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. BUILDING 1 - 1985, 1993 AND 1996 ADDITIONS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society Maplewood was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 OFR, Subpart 483.70(a). Life Safety Tom Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 ADDRATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE THE WAS A DIVENTIONED TO A STREET, SUITE 145 ST. PAUL, MN 55101-5145		FIRE SAFETY					
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. BUILDING 1 - 1985, 1993 AND 1996 ADDITIONS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society Maplewood was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 ABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (10) PLAN (M) DATE		ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS				
A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society Maplewood was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		AN ONSITE REVIS BE CONDUCTED SUBSTANTIAL CO REGULATIONS HA	TOF YOUR FACILITY MAY TO VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN				
Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society Maplewood was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X8) DATE		BUILDING 1 - 1985	, 1993 AND 1996 ADDITIONS				
HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		Minnesota Departm time of this survey, Maplewood was fou compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F (NFPA) Standard 10	ent of Public Safety. At the Good Samaritan Society and not in substantial e requirements for participation id at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),			1	
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		CORRECTION FOI DEFICIENCIES (K	R THE FIRE SAFETY TAGS) TO:		EPOC		
		STATE FIRE MARS 445 MINNESOTA	SHAL DIVISION STREET, SUITE 145				
			ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE		(X6) DATE 03/19/2015

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

PRINTED: 03/24/2015

		AND HUMAN SERVICES & MEDICAID SERVICES	z			FORM	03/24/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 11 - MAIN BUILDING 01		E SURVEY PLETED
		245221	B. WING			02/2	25/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- MAPLEWOOD			APLEWOOD, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	K 00	00			
	Or by email to: Angela.Kappenmar Marian.Whitney@s						
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the deficient	vhat has been, or will be, done ency.					
	2. The actual, or pro	oposed, completion date.					
		r title of the person ection and monitoring to ence of the deficiency.					
	building with no bas constructed at three nursing home was lo of Type II(111) cons was constructed to that was determined construction. In 199 to the south and we was determined to I Because the original meet the construction buildings, the facility building.	Samaritan Center is a 2-story sement. The building was e different times. In 1965 the built and was determined to be struction. In 1967 an addition the south of the main building, d to be of Type II(111) 97 an addition was constructed est of the 1967 building that be of Type II(111) construction. al building and the 2 additions on type allowed for existing y was surveyed as one	a				
	fire alarm system w corridors and space monitored for auton notification. Other h	sprinkler protected and has a with smoke detection in the es open to the corridors that is natic fire department azardous areas have either moke detection that are on the					

Facility ID: 00900

If continuation sheet Page 2 of 4

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIE	LE CONSTRUCTION	(X3) DATI	E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		01 - MAIN BUILDING 01		PLETED
		245221	B. WING		02/:	25/2015
AME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OOD S	AMARITAN SOCIETY	- MAPLEWOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
K 000	Continued From pa	ge 2	K 000			
K 020 SS=D	Minnesota State Fir in the 1997 addition that annunciate out nurse's station in ac State Fire Code. The facility has a ca census of 80 at the The requirement at NOT MET as evide NFPA 101 LIFE SA Stairways, elevator shafts, chutes, and between floors are having a fire resista	42 CFR, Subpart 483.70(a) is need by: FETY CODE STANDARD shafts, light and ventilation other vertical openings enclosed with construction ince rating of at least one ay be used in accordance with	K 020			4/6/15
	Based on observat has failed to mainta as required by NFP 19.3.1.1. This defic residents within the Findings include:	s not met as evidenced by: tion and interview, the facility in vertical opening protection A 101 - 2000 edition, section tiency could affect 10 smoke compartment.		K-020 Stairways, elevator shafts, and ventilation shafts, chutes, and vertical openings between floors a enclosed with construction having resistance rating of at least on hou atrium may be used in accordance 8.2.5.6 19.3.1.1 A. How corrective action will be	other re a fire r. An	
	on 02/25/2015, it was the 2nd floor soiled	linen chute across from room atically close and positive latch		A. How corrective action will be accomplished for those residents f have been affected by the deficien practices- The latch mechanism w replaced by Whitebear Locksmith March 10, 2015 so that the door w a positive latch after each use.	t as on	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00900

If continuation sheet Page 3 of 4

		AND HUMAN SERVICES & MEDICAID SERVICES		0	FORM	03/24/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	E SURVEY PLETED
		245221	B. WING		02/2	25/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 020	Continued From pa of Environmental S		K 020			
	of Environmental S	ervices (JK).		 B. What measures will be put if place, or systemic changes made, the ensure that the deficient practice will not recurmaintenance department was instruct to include both of the laundry chute in the monthly inspection of the hald doors as well as demonstrated how inspect specifically both laundry chute doors in the building. C. Date of correction- 	to - The Jucted doors Ilway / to	
Ŷ						

Event ID: L4XR21

Facility ID: 00900

If continuation sheet Page 4 of 4



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 9, 2015

Ms. Susan Jensen, Administrator Good Samaritan Society - Maplewood 550 East Roselawn Avenue Maplewood, Minnesota 55117

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5221026

Dear Ms. Jensen:

The above facility was surveyed on February 23, 2015 through February 26, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Good Samaritan Society - Maplewood March 9, 2015 Page 2

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

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

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

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

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

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

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

Sincerely,

Are Kleggse

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

Minneso	ta Department of He	ealth			-	_
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY PLETED
		00900	B. WING		02/2	26/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		T ROSELAWI VOOD, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surver found that the defice herein are not corrected shall with a schedule of fit the Minnesota Depu- Determination of wit corrected requires requirements of the number and MN Ru When a rule contait comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	p participate in the electronic insure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SK	GNATURE	TITLE		(X6) DATE 03/19/15

6899

If continuation sheet 1 of 40

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00900	B. WING		02/	02/26/2015	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
GOOD S	AMARITAN SOCIETY		T ROSELAWN VOOD, MN 55 ⁻				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 000	Continued From pa	age 1	2 000				
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th	Alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for n indicate in the electronic cess, under the heading ne date your orders will be electronically submitting to the nent of Health.					
	of this Department provider and the fo issued. Please ind correction that you	4, 25 and 26, 2015, surveyors 's staff, visited the above llowing correction orders are licate in your electronic plan of have reviewed these orders, te when they will be completed					
	the State Licensing federal software. Ta	nent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for					
	column entitled "IE statute/rule out of of "Summary Stateme and replaces the "T correction order. The findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.					
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. AR ON EACH PAGE.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3)	DATE SURVEY COMPLETED	
		00900	B. WING		02/26/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		T ROSELAW			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 560	MN Rule 4658.0405 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560		4/6/15	
	comprehensive plan objectives and time long- and short-tern and mental and psy identified in the com assessment. The c must include the inc	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, rchosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on observati review, the facility fa	of care for 1 of 1 residents		"corrected"		
	Findings include:					
	chronic diarrhea, m properties and abn indicative of dehydr lacked monitoring to	r dehydration related to edications with anticholinergic ormal laboratory (lab) values ation. However, the facility o ensure R147 received the ount of fluids per day to n.	;			
		d to drink 360 cc's [cubic with the evening meal tray or ז.	ı			

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00900	B. WING		02/	26/2015
AME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE	02/	20/2013
GOOD S	AMARITAN SOCIETY		T ROSELAWN /OOD, MN 55 ⁻			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 560	Continued From pa	ige 3	2 560			
	p.m. observation of appeared dry. R147 more fluids, I get so in the morning my r R147 had a signific assessment (MDS) indicated an alterat impaired. The care further read, "Resic to day decisions bu forgetfulness and c	with R147 on 2/25/15, at 2:30 mouth, lips, tongue and teeth 7 stated, "Yes I need to drink o dry at night and when I wake mouth is bone dry." cant change minimum data o completed 12/2/14, and ion in cognition to severely area assessment (CAA) dent is able to make some day it does present with onfusion at times." The CAA r's Disease of other				
	12/1/14, the dietitia 2100-2500 cc/day (according to individ information was no were no quantifying	Itritional assessment dated n recommended R147 receive (centimeter per) of fluid lual body weight. This t on the plan of care and there g records to support R147 mended cc's of fluid intake pe				
	12/9/14, read, "The incontinence potent diarrhea E/B [episo frequent bowel inco did not address the toxigenic clostridiur causes diarrhea] or	or R147's plan of care dated resident has bowel tial R/T [related to] chronic des/bouts] occasional to ontinence." The plan of care stool sample tested for the m difficile [bacterium that n 4/27/13 which was negative cile to rule out a possible cause a.				
	neoplasm of the bla	motherapy for malignant adder. One of the side effects py and addressed on the plan				

ND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00900	B. WING		02/	26/2015
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
GOOD S	AMARITAN SOCIETY		T ROSELAWN VOOD, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 560	Continued From pa	age 4	2 560			
	nausea, lips dry an	s not limited to diarrhea, d or cracked lips. An Drink plenty of fluids."				
	depression, which effects which includ diarrhea, dry mouth Gabapentin for per side effects include mouth, dry throat a Aricept for cognitive	received, included Prozac for had a warning for adverse ded but was not limited to n, and nausea. R147 received ipheral neuropathy and the ed but were not limited to dry nd nausea. R147 had taken e function and the side effects but did include nausea, dration.				
	creatinine (chemica generated from mu urea nitrogen (indic dehydration) The a addressed on the in	al laboratory values for al waste molecule that is iscle metabolism) and blood cator of kidney disease and/or bnormal lab values were not ndividual plan of care for R147 indicator for dehydration.				
	titled, Intake and O choose to initiate in at risk for imbalanc	lity policy dated 11/13, and utput, indicated a nurse could take and output on a resident es such as potential for ic use, renal disease and				
	nursing assistant N what the minimum day for R147 or the	on 2/25/15, at 2:00 p.m. RN-C IA-B and NA-C did not know fluid requirements were per e number of cc's they should ouraging fluids. All three staff pouts of diarrhea.	,			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE : COMPL	
		00900	B. WING		02/2	6/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		OOD, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
2 560	Continued From pa	ge 5	2 560			
	facility should review residents at the tim change and/or quar revise the resident of ensure the care pla the resident's needs the time of the quar ensure the accurac plan. The monitorin nursing staff respor resident care confe	HOD OF CORRECTION: The w the assessments for e of admission, a significant terly and then review and care plan as necessary to n is an accurate reflection of s. Monitoring could be done at terly care conference to y of the care plan the care g could be assigned to the nsible for attending the rence.				
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care personnel involved in the	2 565			4/6/15
	by: Based on interview facility failed to ensi antiarrhythmic and	ent is not met as evidenced and document review, the ure the plan of care for psychoactive medication s were monitored for 1 of 5 the sample.		"corrected"		
	On 02/25/15 R137's reviewed; the care	s medical record was plan dated, 05/09/14 reflected ntiarrhythmic therapy and the				

STATE FORM

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00900	B. WING	B. WING		26/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		T ROSELAWN /OOD, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 6	2 565			
	reactions related to The care plan inter- monitor for adverse medications which dizziness, nausea, box warning signs a nurse practitioner. On 02/26/15, at 8:5 felt dizzy, R137 sta the time and the dia my head to the righ wheelchair she use due to being dizzy. nauseated, R137 s night from nausea pan to throw up in.' happened quite ofte she informed her n identified the nurse further stated that s problems and had day; R137 voiced fit	7 would be free from adverse o digoxin and Amiodarone use. ventions directed staff to e reactions of these two included hypothyroidism, and vomiting and the black and report to the physician or 51 a.m., when asked if R137 ted, "oh, yes, I feel dizzy all of zziness increases when I tilt at side." R137 added the ed kept her from falling down When asked if she felt tated, "I wake up during the and they bring me my plastic ' R137 explained that it en during the night and that urse practitioner (R137 e practitioner by name.)R137 she experienced stomach loose stools at least twice a rustrations of not feeling well told the nurses who give her ne did not feel well.				
	(RN)-A stated after medical record that other documentation of heart rate and bl the nurses document adverse effects. R trained to follow the document on any n inform the physicia in depth electronic	30 a.m. registered nurse r reviewing R137's electronic t she was unable to find any on, other than daily monitoring ood pressure, to show whethe ented on potential medication N-A indicated the nurses were e care plan, monitor and nedication side effects and n promptly. After reviewing of progress notes, RN-A provided nentation, dated 1/27/15, in				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00900	B. WING		02/26/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		T ROSELAWN			
		MAPLEV	VOOD, MN 55		0000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 7	2 565			
	and vomited in the additional nursing p through 11/19/14, in complained of feeli refusing to eat due lightheadedness ar were the only docu related to potential further added, the n Black Box warnings document and repo- physician.	plaining of feeling nauseated past week. RN-A provided progress notes, dated 10/09/14 n which R137 repeatedly ng nauseated, not feeling well, to upset stomach, feeling nd dizzy. RN-A stated these mentation in R137's record medication side effects. RN-A nurses needed to read the s listed on R137's care plan, ort anything unusual to the				
	R137 was alert and nurses if she was r R137, " is one of th to bother anyone w indicated typically s unit how they were nursing progress n unusual. She state administering her n blood pressure and physician ordered i medication adminis they would hold R1 pulse and/or blood and notify the phys current plan of care therapy for R137, L nausea/vomiting ar the adverse reaction use and needed me added these finding in the nursing prog needed to be notified	:00 a.m. LPN-C indicated d capable of informing the not feeling well; however, nose residents who didn't want with her complaints," LPN-C she would ask residents on her feeling and documented in the otes if there was anything ed for R137 prior to medications they obtained d heart rate because the t and documented in the stration record. LPN-C stated 37's heart medications if the pressure were out of range ician. After reviewing the e related to antiarrhythmic LPN-C stated, the dizziness, and diarrhea could potentially be ons of digoxin and amiodarone onitoring each shift. She gs needed to be documented ress notes and the physician ed. LPN-C stated she was not een experiencing any				

L4XR11

If continuation sheet 8 of 40

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00900	B. WING		02/26/2015	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD	T ROSELAWN VOOD, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 8	2 565			
	11/14, directed staf adverse reactions of Drug Handbook as policy/procedures, Change And Obser	n of Medication," revised f to be familiar with action and of medications and to use a				
	The director of nurs could monitor the p then review the car is an accurate refle The care plan shou ensure continual ac resident care. Staff could then be educ	THOD OF CORRECTION: ses or assigned designee provision of patient care and e plan to ensure the care plan action of a resident's needs. Id be revised as necessary to occuracy in the provision of providing care to the resident ated on the care plan revision ntinual accuracy in the nt care.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 940	MN Rule 4658.052	5 Subp. 9 Rehab - Hydration	2 940			4/6/15
	and receive adequa	 Residents must be offered ate water and other fluids to dration and health, unless 				
	by: Based on observat	ent is not met as evidenced ion, interview and document ailed to adequately monitor		"corrected"		

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00900	B. WING		02/	26/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY		T ROSELAWN VOOD, MN 55 [.]			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 940	Continued From pa	age 9	2 940			
		ommended fluid intake for 1 of lentified as at risk for				
	Findings include:	Findings include:				
	R147 was at risk for dehydration related to chronic diarrhea, medications with anticholinergic properties and abnormal laboratory (lab) values indicative of dehydration. However, the facility lacked monitoring to ensure R147 received the recommended amount of fluids per day to prevent dehydration.					
	p.m. observation of appeared dry. R14	v with R147 on 2/25/15, at 2:30 f mouth, lips, tongue and teeth 7 stated, "Yes I need to drink o dry at night and when I wake mouth is bone dry."				
	assessment (MDS) indicated an alterat impaired. The care further read, "Resid to day decisions bu forgetfulness and c	cant change minimum data) completed 12/2/14, and ion in cognition to severely area assessment (CAA) dent is able to make some day it does present with confusion at times." The CAA r's Disease of other				
	monitoring accordin assessment dated R147 receive 2100 per] of fluid accordin There was no accur intake numbers to a	ve adequate fluid intake ng to the nutritional 12/1/14, which recommended -2500 cc/day [cubic centimeter ing to individual body weight. Irrate quantifying data for fluid support R147 received the of fluid intake per day.	r			
	R147 averaged 5 e	pisodes of diarrhea each				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00900	B. WING		02/	02/26/2015	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		20,2010	
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD	T ROSELAWN /OOD, MN 55 [.]				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 940	month in the month of 2014 and in Jan February 2015 ther diarrhea. The medi following the bouts reactions for Imodiu include, dry mouth Imodium was given 16, 17, and 20/2013 cc's recorded on th all fell below the as of 2100-2500 cc's of cc's for R147 on the documented were; 1010cc's, 2/11/14, 2/17/15, 1320 cc's During an interview RN-B verified she of data R147 took in of a twenty-four hour could see R147 con throughout the day water pitcher at R1 survey. R147 received che neoplasm of the bla for the chemothera of care, listed but w nausea, lips dry an intervention read, " On 1/10/15, R147 r Dry Mouth Gel afte complaints of dry m	as of November and December nuary of 2015. The month of re were 6 recorded episodes of cation Imodium was given of diarrhea, and the adverse um were not limited to but did and nausea. In for diarrhea February 4, 9, 11 5. The number of fluid intake re Food and Fluid Intake form sessed requirement for R147 of fluid per day. Fluid intake e days diarrhea was 2/4/15, 400 cc's, 2/9/15, 1260 cc's, 2/16/15, 1070 cc's, and 2/20/15, 650 cc's. If on 2/26/15, at 9:45 a.m. could not prove with quantifying orally 2100-2500 cc's of fluid in period but the staff visually nsumed pop and fluids . There was observation of the 47's bedside each day of the emotherapy for malignant adder. One of the side effects py, and addressed on the plan vas not limited to diarrhea, d or cracked lips. An Drink plenty of fluids." received an order for Biotene r the family requested due to nouth. R147 was receiving tion 1.4% 2 drops in both eyes					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	CONSTRUCTION		E SURVEY PLETED
		00900	 B. WING		02/26/2015	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		02/	20/2013
		550 FAS	T ROSELAWN			
OOD S	AMARITAN SOCIETY	- MAPLEWOOD MAPLEV	VOOD, MN 55	117		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 940	Continued From pa	age 11	2 940			
	depression which I effects which inclu- diarrhea, dry mout Gabapentin for per adverse effects inc mouth, dry throat a Aricept for cognitiv	had taken included Prosac for had a warning for adverse de but was not limited to h, and nausea. R147 received ripheral neuropathy and the clude but are not limited to dry and nausea. R147 had taken the function and the adverse ted to but do include nausea, dration.				
	molecule that is ge metabolism) had b admission at 1.21 range of 0.60 to 1.	ne blood level (chemical waste enerated from muscle been above normal since mg.dLwith the expected value 10. The 2/3/15, creatinine urrently at 1.97 mg/dL.				
	kidney disease and was 25 with a expe mg/dL. The BUN o range at 27 mg/dL	rogen (BUN) (indicator of d/or dehydration) on 9/12/13, ected value range of 8 to 28 on 12/5/14, remained within . The most recent BUN on he expected value range at 40				
	2/3/15, by a certifie who reviewed the I "Worsening kidney "Encourage her to also elevated sugg dehydrated." Furth increase in the dia urinary frequency, fully empty her blac Clinic Referral date read, "Hemoglobin	the Medical Oncology clinic On ed nurse practitioner (CNP-A) abs and wrote on the referral, a function." Under the Plan #4. drink more fluids. Her BUN is jesting at least partly ermore, the CNP addressed an rrhea, and complaints of urgency, and not being able to dder. The returned form titled ed 2/3/15, signed by CNP-A 10.7 Kidney function ely dehydrated." Under the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED		
		00900	B. WING		02/	02/26/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		T ROSELAWN VOOD, MN 55 ⁻				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 940	Continued From pa	age 12	2 940				
	her to drink more f	e 2, the plan read, "Encourage luids. Her BUN is also elevated t partly dehydration."					
	nursing assistant N what the minimum day for R147 or the strive for when end	on 2/25/15, at 2:00 p.m. RN-C, NA-B and NA-C did not know fluid requirements were per e number of cc's they should couraging fluids. All three staff bouts of diarrhea and had	,				
	Registered Nurse (Food and Fluid Inta 2/25/15, R147 was section so that the of fluid cc's R147 hour period. The n	on 2/26/15, at 9:45 a.m. (RN-B) produced a form titled, ake, and designated on added into the computer task staff would record the number consumed in a twenty four umber recorded was 1380 cc's s less than the minimum d intake for R147.					
	2/26/15, at 9:45 a.r the plan of care sa did not need to be RN-B acknowledge quantifying data for and stated, "We se Furthermore, RN-E notes and plan by s	about R147's fluid intake on m. RN-B expressed, because id to encourage fluids, there any further direction for staff. ed there was not accurate r R147's fluid intake per day ee her taking fluids all the time. 3 discredited CNP-A's progress saying the nurse practitioner because this was the first time R147 in the clinic.	6				
	titled, Intake and C choose to initiate in at risk for imbalance	ility policy dated 11/13, and Dutput, indicated a nurse could ntake and output on a resident ces such as potential for ic use, renal disease and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00900		B. WING	B. WING		26/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD	T ROSELAWN VOOD, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 940	Continued From pa	age 13	2 940			
	September 2012, a hydration status by who will estimate th by taking the reside 30 millimeters give requirements. Who 2:00 p.m. the RD v	ydration of Residents, dated addressed maintaining the the registered dietitian (RD) he individual fluid requirements ent weight in kilograms times is the estimated resident en interviewed on 2/25/15, at erified R147's assessment 00 to 2500 cc's of fluid per day on was accurate.				
	dietary director cour assessments to ide dehydration. For an for dehydration the could review the ca resident's hydration and monitored. Nu educated on those dehydration and ho	THOD OF CORRECTION: The Id review the dietary entify residents at risk for by residents identified as at risk dietary director or designee are plan to ensure the in needs were being addressed ursing staff could then be residents at risk for to monitor the resident is uids to maintain adequate	x			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21390	MN Rule 4658.080	0 Subp. 4 A-I Infection Control	21390			4/6/15
	control program mu procedures which p A. surveillance	and procedures. The infection ust include policies and provide for the following: based on systematic data y nosocomial infections in				
		r detection, investigation, and				

L4XR11

If continuation sheet 14 of 40

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/26/2015	
		00900	B. WING			
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
OOD S	AMARITAN SOCIETY					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MAPLEY ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE	(X5) COMPLET DATE
				DEFICIENCY)		
21390	Continued From pa	age 14	21390			
	C. isolation and reduce risk of trans D. in-service e prevention and com E. a resident h immunization progr defined in part 465 procedures of resid the prevention and F. the develop employee health po practices, including defined in part 465 G. a system fo H. a system fo products which affe disinfectants, antis- incontinence produ I. methods for	ealth program including an ram, a tuberculosis program as 58.0810, and policies and dent care practices to assist in treatment of infections; ment and implementation of olicies and infection control g a tuberculosis program as 8.0815; or reviewing antibiotic use; r review and evaluation of ect infection control, such as eptics, gloves, and	5			
	by: Based on interview facility failed to dev screening of reside documentation of ti skin test (TST); and R252) newly admiti to consistently doct TST according to p the TST. Findings include: The facility's 11/14	ent is not met as evidenced y and document review, the yelop a policy on Tuberculosis ents, which included he induration of the tuberculin d for 4 of 5 (R224, R170, R52, ted residents the facility failed ument either the results of the policy and/or the induration of revised policy and procedure Resident for Tuberculosis		"corrected"		

Minnesc	ta Department of He	ealth			FORM APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00900	B. WING		02/26/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY		ROSELAW		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
21390	indicated that a two be used for the tub policy indicated that administered upon hours after administ was to be administ negative, one to the the first test. The s 48-72 hours after a policy did not indicat were to be recorded R224 was admitted The Immunization record (eHR) revea administered on 12 medication administ the eHR, the TST wither induration of the ar recorded as negati millimeter (mm) ind R170 was admitted Immunization secti first TST was admit to the MAR found i on 1/22/15, but the whether the results there was no indication	age 15 b-step Mantoux method was to erculin skin test (TST.) The at the TST was to be admission and read 48-72 stration; and a second TST ered if the first TST was ree weeks after placement of econd test was to be read administration. However, the ate the induration of the results d as part of the TST. d to the facility on 12/12/14. section of the electronic health aled the first TST was 2/14/14. According to the stration record (MAR) found in was read on 12/16/14, as re was no indication as to the ea read. A second TST was ve on 12/21/14, with a 0 duration on 12/21/14.			
	eHR, a second TS read on 1/29/15. H indication as to why positive or negative as to the induration According to the ef admissions to the f	T was given on 1/27/15, and owever, there was no ether or not the results were e, and there was no indication			
Minnesota D STATE FOR	epartment of Health	, <u>,</u> , , , , , , , , , , , , , , , , ,	6899 	L4XR11	If continuation sheet 16 of 40

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00900	B. WING	B. WING		02/26/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		T ROSELAWN VOOD, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21390	Continued From pa	age 16	21390				
	11/16/14, as negati recorded. A second as negative on 11/2 R52 was then discl facility on 1/30/15. the eHR the first TS negative on 2/1/15, recorded. A second	he first TST was read on live, but the induration was not d TST was read and recorded 21/14, with a 0 mm induration. harged and readmitted to the According the MAR found in ST was read and recorded as , but the induration was not d TST was read and recorded (15, but again, the induration					
	Immunization secti first TST was admi to the MAR found i and recorded as ne was no indication a read. According to second TST was re on 2/18/15, but aga to the induration of	to the facility on 2/9/15. The on of the eHR revealed the nistered on 1/20/15. According n the eHR, the TST was read egative on 2/11/15, but there is to the induration of the area the MAR found in the eHR, a ead and recorded as negative ain, there was no indication as the area read. 0 p.m. registered nurse (RN)-A					
	induration of the re documentation was	of TST's should include the adings, and verified this is not consistently documented if TST readings for R224,					
	reviewed the facility Residents for Tube policy and procedu	00 a.m. RN-A stated they had y's policy on Screening of erculosis. RN-A verified the re did not indicate the ST's were to be documented.					
	PointClickCare-TB	ne 1/15/15, policy for Two Step Mantoux Skin Test acking Purpose did not include	,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
	00900		B. WING	B. WING		02/26/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		T ROSELAWN VOOD, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
21390	directions for recom- review of the policy PointClickCare com- include instructions the TST. The Point directed the staff to in the eHR and rec "negative" or "posit related to a chest x information in the " directions to staff to TST's.	ding the induration of TST's. A y by the surveyor verified the nputer instructions did not s for recording the induration of ClickCare computer directions o go to the "Immunization" tab ord the results by selecting ive", and if there were results t-ray staff were to enter that Notes" field. There were no p include the induration of the	f				
	The director of infe revise as necessar procedure regardin of Tuberculin skin t induration of the inj for reading and rec educated on the re nursing or medical assigned the role to admitted residents	THOD OF CORRECTION: ction control could review and y the facility's policy and ig how to document the results ests (TST), to include the jected site. Staff responsible ord the TST reaction could be vised policy. A member of the records staff could be o randomly audit newly electronic health records aff are correctly documenting					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
21530	A. The drug regim reviewed at least m currently licensed b This review must b Appendix N of the s	0 A.B.C Drug Regimen Review ten of each resident must be nonthly by a pharmacist by the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service				4/6/15	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
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		00900	B. WING		02/	26/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	I		
GOOD S	AMARITAN SOCIETY		T ROSELAWN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21530	Continued From pa	ge 18	21530				
	the Department of I Health Care Finance This standard is in available through the system. It is not sue B. The pharma irregularities to the and the attending p must be acted upor physician visit, or sup pharmacist. For pu- upon'' means the ai- report and the sign of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believes being adversely affi- refer the matter to to if the medical direct physician. If the me- the attending physic justification for the physician does not must be referred fo- assessment and as by part 4658.0070. the medical direct must refer the matter assessment and as	ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is he Minitex interlibrary loan bject to frequent change. ucist must report any director of nursing services hysician, and these reports in by the time of the next boner, if indicated by the urposes of this part, "acted cceptance or rejection of the ng or initialing by the director and the attending physician. ing physician does not concur it's recommendation, or does te justification, and the s the resident's quality of life is ected, the pharmacist must he medical director for review for is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter r review to the quality surance committee required If the attending physician is or, the consulting pharmacist er directly to the quality asurance committee.					
	This MN Requirements by: Based on interview	ent is not met as evidenced		"corrected"			

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00900	B. WING	B. WING		02/26/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		T ROSELAWN /OOD, MN 55 [.]				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21530	Continued From pa	lge 19	21530				
	tablet 325 mg, give hours as needed for 9/4/13. There was a acetaminophen tab mouth every 4 hour pain with a start da order which read, N (Hydrocodone-acet mouth every 4 hour start date of 4/1/14	an order for acetaminophen 1 tablet by mouth every 4 or mild pain. The start date was a second order that read, let 325 mg give 2 tablets by rs as needed for moderate te of 9/4/13. There was a third lorco tablet 5-325 MG caminophen) Give 1 tablet by rs as needed for pain with a . These orders gave R147 the 00 grams of acetaminophen in period.					
	medication review of acetaminophen. interviewed on 2/25 the acetaminophen	sultant pharmacist's recommendations for the use The pharmacist was 5/15 at 3:15 p.m. and verified is to have a 3000 gram hour period according to the pommendations.					
	(RN-B) on 2/26/15, nursing staff were e mandatory training to have parameters	with the registered nurse at 9:45 a.m. revealed that the educated on 8/15/14, during that the acetaminophen was a not to exceed 3000 grams (g) urces of medication containing					
	4/9/13 indicated R1 and amiodarone fo heart rate); howeve for continued use a monitoring of these	MD)'s documentation dated, 37 had been taking digoxin r atrial fibrillation (to control er, the facility lacked indication and potential adverse effects e medications. The consulting to communicate irregularities					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00900	_	B. WING		02/26/2015	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		02/	20/2013	
	AMARITAN SOCIETY	550 EAS	T ROSELAWN				
3000 5	AMARITAN SOCIETY	- MAPLEWOOD MAPLEV	VOOD, MN 551	117			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21530	Continued From pa	age 20	21530				
	stated, "Oh, yes, I f the dizziness increa- right side." R137 a kept her from falling Regarding feeling r up during the night me my plastic pan- indicated it happen and had informed t she experienced st loose stools at leas frustrations of not f told the nurses who she did not feel we						
	admission history a had diagnoses that congestive heart fa chronic kidney dise	to the facility on 4/29/13 the and physical dated, 05/02/13 included hypothyroidism, illure (CHF), diabetes mellitus, ease stage II, aortic valve rtension and urinary tract					
	Food and Drug Adr warning for amioda potentially fatal toxi toxicity (lung dama damage), hypothyr blood), exacerbatio heart failure (worse Potential adverse e formation or exace	ated 05/9/14, listed the U.S. ministration (FDA) black box prone use as: "Risk of icities including pulmonary ge) and hepatic injury (liver oidism (low thyroid levels in the on of existing arrhythmia and e heart beat problems). effects include arrhythmia rbation (heart rate problems), eart rate), dizziness, dyspnea	9				
	(difficulty breathing pressure), nausea, The nursing staff fa), hypotension (low blood visual disturbances, vomiting. ailed to follow the care plan and or, document and inform the					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00900	B. WING	B. WING		26/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		T ROSELAWN VOOD, MN 55 [.]			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	age 21	21530			
	physician on these identified serious and fatal adverse effects.					
	nauseated numero complained of bein dated 11/19/14, rev "I'm so hot. I feel lik "feeling dizzy, feels Nauseated. Had a mucous mixed with this date the nurse on omeprazole 20 nausea without pro potential adverse e amiodarone use. F documentation lack indications for the o amiodarone.	ked evidence identifying clinica continued use of digoxin and				
	indicated R137 convomited bile in a plaindicated the resided dizzy during the danaps, and stated, " night," The docum resident complaine area. The NP order urinary tract infection mg daily for upset stated, "can find nothing was uncertain what dizziness. On 11/1 level to be checked	cumentation dated 11/19/14, nplained of nausea and had astic bin. The documentation ent had complained of being y, usually when getting up from My head was so dizzy last entation further revealed the d of headache in the temple ered a urinalysis to rule out on and ordered omeprazole 20 stomach and nausea. The NP s medications were reviewed ng that really stood out," and it t caused nausea, vomiting and 9/14 NP ordered digoxin lab d and on 11/20/14 the results as 1.3, within normal range, in				

Under CF PROVIDER OR SUPPLER STREET ADDRESS, CITV, STATE, ZIP CODE SOOD SAMARITAN SOCIETY - MAPLEWOOD S50 EAST ROSELAWN AVENUE MAPLEWOOD, NN 55117 (X4, ID PREFIX ESUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX (EACH OFFICIENCY MUST BE PRECEDED BY FULL FAG ID PREFIX CROSS REFERENCED TO THE APPROPRIATE OCMIT 21530 Continued From page 22 21530 21530 21530 21530 The quarterly Minimum Data Set (MDS) assessment dated, 1/15/15 identified R137 as being moderately impaired of cognition and was able to understand others and be understood with minimal difficulty. 21530 21530 The current MD's orders dated, 01/25/15 indicated R137 was to receive amiodarone (an antiarrhythmic medication) 100 milligrams (mg) every day and digoxin (used for CHF and heart rate control) 125 micrograms (mcg) daily. The pharmacy consultant made a recommendation to the MD on 2/24/15, indicating to consider discontinuing Robitussin since R137 had not used it in the past three months, and to causing pneumonia and bone fractures. Evidence was lacking to reflect whether the consulting pharmacist had noted any irregularities related to the continued use of digoxin and amiodarone, especially when R137 had voiced concerns with nausea, vomiting and headaches ID ID ID ID ID ID ID ID ID ID ID ID ID I		NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
BOOD SUMARITAN SOCIETY - MAPLEWOOD 550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117 (X4) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION BOULD BE (EACH DEFICIENCY MUST BE PRECEDEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION NOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION PROVIDE BY (EACH DEFICIENCY WITH APPROPRIATE DEFICIENCY) (x0) (x0) (x0) (EACH DEFICIENCY WITH APPROPRIATE DEFICIENCY) 21530 Continued From page 22 21530 The quarterly Minimum Data Set (MDS) assessment dated, 11/5/15 identified R137 as being moderately impaired of cognition and was able to understand others and be understood with minimal difficulty. The current MD's orders dated, 01/25/15 indicated R137 was to receive amiodarone (an antiarrhythmic medication) 100 milligrams (mg) every day and digoxin (used for CHF and heart rate control) 125 micrograms (mcg) daily. The pharmacy consultant made a recommendation to the MD on 2/24/15, indicating to consider discontinuing Robitussin since R137 had not used it in the past three months, and to review the use of omeprazole which was linked to casuing pneumonia and bone fractures. Evidence was lacking to reflect whether the consulting pharmacist had noted any irregularities related to the continued use of digoxin and amiodarone, especially when R137 had voiced			00900	B. WING		02/	26/2015
COUD SAMARHIAN SOCIE IY - MAPLEWOOD MAPLEWOOD, MN 55117 Image: Construct of the second	NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (XS) (CAMPLE DEFICIENCY) 21530 Continued From page 22 21530 21530 The quarterly Minimum Data Set (MDS) assessment dated, 1/15/15 identified R137 as being moderately impaired of cognition and was able to understand others and be understood with minimal difficulty. 21530 The current MD's orders dated, 01/25/15 indicated R137 was to receive amiodarone (an antiarrhythmic medication) 100 milligrams (mg) every day and digoxin (used for CHF and heart rate control) 125 micrograms (mcg) daily. The pharmacy consultant made a recommendation to the MD on 2/24/15, indicating to consider discontinuing Robitussin since R137 had not used it in the past three months, and to review the use of omeprazole which was linked to causing pneumonia and bone fractures. Evidence was lacking to reflect whether the consulting pharmacist had noted any irregularities related to the continued use of digoxin and amiodarone, especially when R137 had voiced	GOOD S	AMARITAN SOCIETY					
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		assessment dated, being moderately in able to understand minimal difficulty. The current MD's c indicated R137 was antiarrhythmic med every day and digo rate control) 125 m The pharmacy con recommendation to to consider discont had not used it in the review the use of o causing pneumonia Evidence was lack consulting pharma- related to the conti-	, 1/15/15 identified R137 as mpaired of cognition and was others and be understood with orders dated, 01/25/15 s to receive amiodarone (an dication) 100 milligrams (mg) win (used for CHF and heart dicrograms (mcg) daily. sultant made a to the MD on 2/24/15, indicating inuing Robitussin since R137 he past three months, and to omeprazole which was linked to a and bone fractures. ing to reflect whether the cist had noted any irregularities nued use of digoxin and cially when R137 had voiced	9			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00900	B. WING	B. WING		02/26/2015	
AME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		T ROSELAWN /OOD, MN 55 [.]				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21530	Continued From pa	ige 23	21530				
	and physician's doc medication reviews recommendations in During a phone inter- p.m. R13's NP india admitted to the faci- amiodarone. The N promote amiodaron population because use in elderly popu a potential for serior added his focus ha amiodarone for pat this medication. He digoxin for R137 ar closely. The NP st to consistently mor	IP indicated he did not he or digoxin use in geriatric e it was not recommended for lation, was very toxic and had us side effects. The NP d been to try to discontinue ients who were admitted on e said he would discontinue and monitor her amiodarone use ated the nursing staff needed litor and document any ts of these medications and					
	(RN)-A stated after medical record that other documentatic of heart rate and bl the nurses document adverse effects. R trained to follow the document on any n inform the physicia in depth electronic copy of NP's document which, licensed prat to NP of R137 com and vomited in the additional nursing p through 11/19/14, in	0 a.m. registered nurse r reviewing R137's electronic she was unable to find any on, other than daily monitoring ood pressure, to show whethe ented on potential medication N-A indicated the nurses were e care plan, monitor and nedication side effects and n promptly. After reviewing of progress notes, RN-A provided nentation, dated 1/27/15, in ctical nurse (LPN)-B reported plaining of feeling nauseated past week. RN-A provided orogress notes, dated 10/09/14 n which R137 repeatedly ng nauseated, not feeling well,	4				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00900	B. WING		02/	26/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S/	AMARITAN SOCIETY		T ROSELAWN VOOD, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21530	Continued From page 24		21530			
	lightheadedness ar were the only docu related to potential further added, the of Black Box warnings document and repo- physician. On 02/26/15, at 10 R137 was alert and nurses if she was r R137, " is one of th to bother anyone w indicated typically s unit how they were nursing progress n unusual. She state administering her n blood pressure and physician ordered i medication adminis they would hold R1 pulse and/or blood	nedications they obtained d heart rate because the it and documented in the stration record. LPN-C stated 37's heart medications if the pressure were out of range	r			
	current plan of care therapy for R137, L nausea/vomiting ar the adverse reaction use and needed m added these finding in the nursing prog needed to be notified	ician. After reviewing the e related to antiarrhythmic _PN-C stated, the dizziness, nd diarrhea could potentially be ons of digoxin and amiodarone onitoring each shift. She gs needed to be documented ress notes and the physician ed. LPN-C stated she was not een experiencing any or loose stools.				
	12th edition, dated "potentially inappro	eriatric Dosage Handbook, 2007, amiodarone was, priate medication for dication was associated with				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00900	B. WING		02/	26/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		roselawn 'OOD, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	age 25	21530			
	problems (high or I dizziness, fatigue, I anorexia, CHF, abo extreme caution ar In addition, it may i the physicians were dose by 50% and r closely. For digoxi caution in patients patients with advar adverse effects inco weakness, dizzines abdominal pain, ar with amiodarone us on heart rate; there 50% was recommended					
	11/14, directed stat adverse reactions Drug Handbook as policy/procedure, ti Change And Obset	on of Medication," revised ff to be familiar with action and of medications and to use a needed. Another itled, "Notification of Condition rvation," dated 9/2012, tify the physician of any				
	The administrator, consulting pharmar policies and proced medication usage. educated as neces pharmacist's review with the pharmacis	THOD OF CORRECTION: director of nursing (DON) and cist could review and revise dures for proper monitoring of Nursing staff could be sary to the importance of the w. The DON or designee, along t, could audit medication ar basis to ensure compliance.				
		R CORRECTION: Thirty (30)				

	ta Department of He	ealth (X1) PROVIDER/SUPPLIER/CLIA	(X2) MELTIPI	E CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00900	B. WING		02/	26/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY		T ROSELAWI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 26	21530	DEFICIEN	51)	
	days.					
21540	MN Rule 4658.131 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			4/6/15
	monitor each reside unnecessary drug i home's policies and pharmacist must re- resident's attending physician does not home's recommen- adequate justificati believes the reside adversely affected, matter to the medic director is the medical director physician does not the order and if the change the order, t review to the Quali (QAA) committee r the attending physic	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the eport any irregularity to the g physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the cal director for review if the not the attending physician. If or determines that the attending have adequate justification for attending physician does not the matter must be referred for ty Assurance and Assessment equired by part 4658.0070. If iscian is the medical director, rmacist shall refer the matter	9			
	by: Based on interview facility failed to ade clinical indications antiarrhythmic med	ent is not met as evidenced and document review, the equately identify and monitor for continued use of dications and adverse effects esidents in the sample.		"corrected"		
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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00900	B. WING		02/26/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		r Roselawn 100d, MN 55 [.]			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21540	Continued From pa	age 27	21540			
	4/9/13 indicated R and amiodarone for heart rate); howev for continued use a monitoring of these On 02/26/15, at 8:5 stated, "Oh, yes, I the dizziness incre- right side." R137 a kept her from fallin Regarding feeling n up during the night me my plastic pan indicated it happen and had informed t she experienced st loose stools at leas frustrations of not f	51 a.m., alert resident, R137 feel dizzy all of the time and ases when I tilt my head to the added the wheelchair she used g down due to being dizzy. hauseated, she stated, "I wake from nausea and they bring to throw up in." R137 led quite often during the night the NP. R137 further stated tomach problems and had st twice a day; R137 voiced eeling well and stated she had o gave her medications that				
	admission history a had diagnoses tha congestive heart fa chronic kidney dise	d to the facility on 4/29/13 the and physical dated, 05/02/13 t included hypothyroidism, ailure (CHF), diabetes mellitus, ease stage II, aortic valve rtension and urinary tract				
	Food and Drug Adu warning for amioda potentially fatal tox toxicity (lung dama damage), hypothyr blood), exacerbatic heart failure (worse	ated 05/9/14, listed the U.S. ministration (FDA) black box arone use as: "Risk of icities including pulmonary ge) and hepatic injury (liver oidism (low thyroid levels in the on of existing arrhythmia and e heart beat problems). effects include arrhythmia				

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00900	B. WING	B. WING		26/2015
AME OF F	PROVIDER OR SUPPLIEF	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	• •	
OOD S	AMARITAN SOCIET		T ROSELAWN VOOD, MN 55 [.]			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21540	Continued From p	age 28	21540			
	bradycardia (low h (difficulty breathing pressure), nausea The nursing staff f consistently monit physician on these adverse effects. The nursing progra through 11/19/14 r nauseated numera complained of bein dated 11/19/14, re "I'm so hot. I feel li "feeling dizzy, feel Nauseated. Had a mucous mixed wit this date the nurse on omeprazole 20 nausea without pro potential adverse of amiodarone use.	erbation (heart rate problems), leart rate), dizziness, dyspnea g), hypotension (low blood , visual disturbances, vomiting, ailed to follow the care plan and or, document and inform the e identified serious and fatal ess notes dated, 10/9/14 revealed, R137 had been ous times, refused meals and ng unwell. A progress noted vealed R137 had complained: ike I am going to throw up," and s sick to her stomach. a small emesis of thick yellow h a small amount of blood;" On e practitioner (NP) started R137 mg due to gastric reflux and operly assessing R137 for effects of digoxin and Furthermore, the iked evidence identifying clinical continued use of digoxin and	d			
	indicated R137 co vomited bile in a p indicated the resid dizzy during the da naps, and stated,	cumentation dated 11/19/14, mplained of nausea and had lastic bin. The documentation ent had complained of being ay, usually when getting up fron "My head was so dizzy last	n			
	resident complaine area. The NP ord urinary tract infect mg daily for upset documented R137	nentation further revealed the ed of headache in the temple ered a urinalysis to rule out ion and ordered omeprazole 20 stomach and nausea. The NP "s medications were reviewed ing that really stood out," and it	,			

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00900	B. WING		02/26/2015	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		02/	20/2015
		550 FAS	T ROSELAWN			
iood S	AMARITAN SOCIETY	- MAPLEWOOD MAPLEV	VOOD, MN 55	117		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLE DATE
21540	Continued From pa	age 29	21540			
	dizziness. On 11/1 level to be checked were documented the nursing progres The quarterly Minir assessment dated being moderately in	t caused nausea, vomiting and 9/14 NP ordered digoxin lab d and on 11/20/14 the results as 1.3, within normal range, in ss notes. num Data Set (MDS) , 1/15/15 identified R137 as mpaired of cognition and was others and be understood with				
	minimal difficulty. The current MD's c indicated R137 wa antiarrhythmic mec every day and digo	orders dated, 01/25/15 s to receive amiodarone (an dication) 100 milligrams (mg) oxin (used for CHF and heart dicrograms (mcg) daily.	-			
	to consider discont had not used it in the review the use of of causing pneumonia Evidence was lack consulting pharma related to the conti amiodarone, espec	sultant made a to the MD on 2/24/15, indicating tinuing Robitussin since R137 he past three months, and to omeprazole which was linked to a and bone fractures. ing to reflect whether the cist had noted any irregularities nued use of digoxin and cially when R137 had voiced sea, vomiting and headaches				
	a.m. the consulting conducted a medic but did not have he answer specific qu indicated he remer amiodarone becau Beta blocker drugs	erview on 02/25/15, at 9:00 g pharmacist indicated he had cation regimen review for R137 er record in front of him to estions. The pharmacist nbered R137 was on se she did not tolerate any s. The pharmacist added goxin were not recommended	;			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
				B. WING		26/2015	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE	02/26/2		
GOOD S	AMARITAN SOCIETY		T ROSELAWN				
			/OOD, MN 55 ⁻	PROVIDER'S PLAN OF	CORRECTION	(V5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21540	Continued From pa	age 30	21540				
	caution because of effects. The pharm important for the nu- residents closely the drugs and inform the side effects. He state and physician's door medication reviews recommendations During a phone interport admitted to the fact amiodarone. The N promote amiodaron population because use in elderly popu a potential for serice added his focus has amiodarone for pat this medication. He digoxin for R137 ar closely. The NP state	IP indicated he did not ne or digoxin use in geriatric e it was not recommended for lation, was very toxic and had bus side effects. The NP id been to try to discontinue tients who were admitted on e said he would discontinue nd monitor her amiodarone use ated the nursing staff needed nitor and document any ts of these medications and					
	(RN)-A stated afte medical record that other documentation of heart rate and bl	30 a.m. registered nurse r reviewing R137's electronic t she was unable to find any on, other than daily monitoring lood pressure, to show whethe	r				
	adverse effects. R trained to follow the document on any n inform the physicia	ented on potential medication N-A indicated the nurses were e care plan, monitor and nedication side effects and n promptly. After reviewing of					
nnesota D		progress notes, RN-A provided nentation, dated 1/27/15, in					

AND PLAN OF CORRECTION		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		B. WING		02/	26/2015	
NAME OF I	PROVIDER OR SUPPLIER	00300				
GOOD S	AMARITAN SOCIETY		T ROSELAWN /OOD, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21540	Continued From pa	age 31	21540			
	to NP of R137 com and vomited in the additional nursing p through 11/19/14, in complained of feeli refusing to eat due lightheadedness ar were the only docu related to potential further added, the n Black Box warnings	actical nurse (LPN)-B reported plaining of feeling nauseated past week. RN-A provided progress notes, dated 10/09/14 n which R137 repeatedly ng nauseated, not feeling well, to upset stomach, feeling nd dizzy. RN-A stated these mentation in R137's record medication side effects. RN-A nurses needed to read the s listed on R137's care plan, ort anything unusual to the				
	R137 was alert and nurses if she was r R137, " is one of th to bother anyone w indicated typically s unit how they were nursing progress n unusual. She state administering her n blood pressure and physician ordered i medication adminis they would hold R1 pulse and/or blood and notify the phys current plan of care therapy for R137, L nausea/vomiting ar the adverse reaction use and needed m added these finding in the nursing progression	:00 a.m. LPN-C indicated d capable of informing the not feeling well; however, nose residents who didn't want with her complaints," LPN-C she would ask residents on her feeling and documented in the otes if there was anything ed for R137 prior to nedications they obtained d heart rate because the t and documented in the stration record. LPN-C stated 37's heart medications if the pressure were out of range ician. After reviewing the e related to antiarrhythmic .PN-C stated, the dizziness, nd diarrhea could potentially be ons of digoxin and amiodarone onitoring each shift. She gs needed to be documented ress notes and the physician ed. LPN-C stated she was not				

	ta Department of He		1		-	APPROVEI		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED		
	00900		B. WING		02/26/2015			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE				
GOOD S	AMARITAN SOCIETY							
			/OOD, MN 55 ⁻	PROVIDER'S PLAN OF CO	PRECTION	()(5)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE		
21540	Continued From pa	ige 32	21540					
	dizziness, nausea d	or loose stools.						
	12th edition, dated "potentially inappro- geriatrics," this med- increased risk with problems (high or le dizziness, fatigue, h anorexia, CHF, abc extreme caution an In addition, it may in the physicians were dose by 50% and n closely. For digoxin caution in patients of patients with advan adverse effects incl weakness, dizzines abdominal pain, an with amiodarone us on heart rate; there 50% was recomme							
	11/14, directed staf adverse reactions of Drug Handbook as policy/procedure, ti Change And Obser directed staff to not change in resident's SUGGESTED MET	n of Medication," revised f to be familiar with action and of medications and to use a needed. Another tled, "Notification of Condition vation," dated 9/2012, ify the physician of any						
	drug regimen for al ensure each medic	I residents in the facility to ation had appropriate that side effect monitoring						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	·		
00900		B. WING		02/	26/2015	
AME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
iOOD S	AMARITAN SOCIETY		T ROSELAW			
			/OOD, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLE DATE
21540	Continued From pa	age 33	21540			
	a resident was exp physician was notif educated on how to side effects and wh drug side effects to	ed per facility policy; and that if periencing side effects that the fied. Nursing staff could be o monitor and document drug nen to report the presence of the physician. R CORRECTION: Thirty (30)				
21665	MN Rule 4658.140	0 Physical Environment	21665			4/6/15
	functional, comfort environment, allow	ust provide a safe, clean, able, and homelike physical ring the resident to use is to the extent possible.				
	by: Based on observat review, the facility f room environment R83); and failed to well maintained en resident rooms and shower rooms revi rooms 14 through f room. This had the residents residing i Findings include: Two residents, R26 windows which we in a cold draft whic On 2/23/15 at 4:56 broken piece of gla frame. A cold draft window. This cold	tion, interview and document failed to ensure a comfortable for 2 of 82 residents (R26, ensure a clean, attractive and vironment in 7 out of 34 d bathrooms, 1 of 4 tub and ewed and the hallway with 25 and the laundry processing e potential to impact 22 of 82 in the building. 6 and R83, had personal room re poorly maintained, resulting h impacted their comfort. p.m. in room 007, a small ass was noted in the window was noted coming from the draft was felt several feet away here R26 was seated. When		"corrected"		

Minnesc	ota Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	-E CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COM	PLETED
			B. WING			
		00900	B. WING		02/	26/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD	T ROSELAW			
	1	MAPLEV	/OOD, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLETE DATE
21665	Continued From pa	age 34	21665			
	asked if the room f "yes." R26's annua R26's cognitive sta well as problems w memory. On 2/23/15 at 6:38 room 103 was note resulted in a cold d were noted along th draft could still be f opened. R83 was in temperature of the expressed concern [MA], nursing assis cold room and the R83 stated her fam blankets and a nurs towels along the ba draft. R83's most re [MDS], dated 12/11 cognitively intact. During an environm environmental serv between 1:29 p.m. confirmed there wa window in Room 10 place. The outside DES also confirme window in room 00 feet away from the During stage I of th observations revea environment not be maintained. On 2/23/15, at 2:10 in the bathroom of measuring approxim	elt drafty, R26 responded I MDS assessment noted tus as severely impaired, as ith short and long term p.m. the outside window in ed to not close properly, which raft being felt. Several towels ne base of window, but the elt when the curtains were nterviewed regarding the room, and stated she had is to the maintenance assistant tants and her family about the window not closing properly. ily had brought in extra sing assistant had placed the ase of the window to stop the ecent minimum data set /14, indicated she was nental tour with the director of tices [DES] on 2/24/15 and 2:30 p.m. the DES is a draft coming from the 03, even with the towels in window did not shut fully. The d the draft coming from the 7, which could be felt a few window. e survey, there were several ling concerns with the eing attractive, clean or well 0 p.m. the wall behind the toilet room 111 had a square patch mately two feet by two feet	t			
		p.m. peeling paint was noted				
Minnesota D	epartment of Health	n of the wall behind the toilet,				
STATE FOR			6899	L4XR11	lf continuati	on sheet 35 of 4

Minnesota Department (STATEMENT OF DEFICIENCIES (ND PLAN OF CORRECTION		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
	00900			02/	26/2015	
IAME OF PROVIDER OR SUPP		B. WING 02				
GOOD SAMARITAN SOC		ST ROSELAWN WOOD, MN 551				
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21665 Continued From	n page 35	21665				
 peeling paint w rest of the wall On 2/23/15, at approximately observed betw bathroom, sha colored stain a surface which bars near the t which were sta was gouged ar On 2/23/15, at plastered areas four inches we bathroom shar areas had not painting. On 2/23/15, at between room noted on the gi stained ceiling During environ environmental between 1:29 p concerns were the DES. In the bathroor the peeling pai color than the n he was not awa In room 103, a wall. R83 report 	3:08 p.m. a large crack, the length of half the wall, was een the two beds in room 17. The red with room 15 had a large rust round the toilet, which resulted in could not be cleaned. The grab bilet had pieces of tape on them ined brown. The wall by bed one ad contained peeling paint. 5:25 p.m. two patched and s, measuring approximately four b re noted by the towel rack in the ed by rooms 101. These patched been sanded and prepped for 6:04 p.m. in the bathroom shared 15 and room 17 soiled tape was rab bars by the toilet and a brown tile was noted above the toilet. mental tour with the director of services [DES] on 2/24/15, o.m. and 2:30 p.m. the following noted, which were confirmed by the of room 107, the DES confirmed are of the wall. The DES reported are of the concern. brown mark was noted on the ted the mark had been there sinc red. The DES was unaware of the	a ny d				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00900		B. WING	B. WING		26/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		T ROSELAWN /OOD, MN 55 ⁻			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	age 36	21665			
		ig. The DES explained the wall had not been finished. The e of the concern.				
	bars near the toilet base and the dark bathroom between reported the tape of	d soiled tape on the toilet grab t, the red ring around the toilet spot on the ceiling in the rooms 15 and 17. The DES on the handle bars was not a and was not sure why it would				
	toured with the DE corner. The black is peeling off. There grout between the shower. Cracks we the floor. The DES	b room on the North Unit was S. Cobwebs were found in the non-skid tape on the floor was were brownish/red marks in the tiles of the floor and wall of the ere found in several tiles near reported he was unaware of nd cleanliness issues.				
	line coming from the floor. A small reddi	orth Unit had a reddish brown ne water fountain, down to the sh brown mark was on the rater fountain. The DES cerns.				
	reddish brown ring round brown mark	etween rooms 10 and 12 a was found on the floor. A was found on the ceiling tiles. he had previously repaired the ey returned.				
	preventative maint wall in the mainten directed staff to pe maintenance in the basis only. None h	ES reported there was a enance schedule posted on the ance room. This document rform preventative e resident rooms on an annual ad been completed yet. The en staffing in the maintenance				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
	or connection	DENTRIOR NONDER.	A. BUILDING: _		-	
	00900		B. WING		02/	26/2015
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
GOOD S	AMARITAN SOCIETY		T ROSELAWN /OOD, MN 55 [.]			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	age 37	21665			
	were not completed responsible for the preventative mainted were done for reside rooms and was una of any audits or reside inspections. The Whirlpool-Sho November 2006, d all sills and ledges disinfectant cleane doors and partition soft, clean cloth with and wipe dry. 4. Date outside of cabinets clean cloth and dis Wipe dry to avoid st faucets chrome are wipe to shine with the hard floor surfaces Using a damp floor solution, damp motion Repeat if floor is here	ed, there were tasks which d as it was unclear who was m. The DES reported no enance audits or inspections dent bathrooms and resident able to provide documentation sident room/bathroom wer Room policy, last revised irected staff to: "2. Damp dust using a soft clean cloth and r solution. 3. Spot clean walls, s to remove smudges. Use th disinfectant cleaner solution amp dust all surfaces (the and storage areas with soft infectant cleaner solution. spotting. 5. Clean sink and eas with disinfectant cleaner, dry clean cloth. 6. Dust mop all with a clean dust mop. 7. r mop and neutral cleaner p all hard floor surfaces. eavily soiled. 8. If hard water ccur, use a neutral detergent				
	November 2006, d toilet bowls; place o bowl cleaner in toile time. 3. Spray all fit solution. Wipe dry	aning Procedure, last revised irected staff to: "2. Sanitize disinfectant cleaners/or toilet et bowl; do not scrub at this xtures with disinfectant cleaner with clean cloth. Include mirror	,			
	stands; use disinfe and/or polish with s to the swab/brush a Wipe top bottom of	under sink, etc. 4. Clean wash ctant cleaner solution. Dry soft rag. 5. Apply bowl cleaner and vigorously scrub the bowl. f seats with disinfectant cleane ray bottle. 6. Replenish				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		B. WING		02/26/2015			
NAME OF I	PROVIDER OR SUPPLIER	00300 02/					
GOOD S	AMARITAN SOCIETY		T ROSELAWN VOOD, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE	
ma			ind	DEFICIENC			
21665	Continued From pa	age 38	21665				
	supplies: paper towels, toilet paper, liquid or bar soap and dispensing machine supplies. 7. Dust mop floor, see Section II. L. 8. Damp mop floor; follow Damp Mopping Procedure (Section II. M). Notify supervisor if floor requires additional attention. 9. Once a week, clean the mop boards in the restrooms with a solution of neutral cleaner solution."						
		able to provide any additional reventative maintenance					
	laundry processing were observed to b) a.m. the floor tiles in the J, storage, soiled linen area be peeling away from the floor ng the concrete beneath.					
	interviewed regard floor tiles in the lau) a.m. the DES was ing the missing and peeling indry. The DES stated "I guess ed." the condition of the floor					
		5 a.m. the administrator stated re of the condition of the tiles.	E				
	administrator or de regarding the impo- functional and hom administrator or de maintenance and h and clean areas of audits of areas res	THOD OF CORRECTION:The esignee, could educate staff ortance of a safe, clean, nelike environment. The esignee, could coordinate with nousekeeping staff to repair concern and conduct periodic idents frequent to ensure a unal and homelike environment e extent possible.					

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00900		B. WING		02/26/2015	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		02/	20/2013
GOOD S	AMARITAN SOCIETY		T ROSELAWN VOOD, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	age 39	21665		·	
21665	•	age 39 R CORRECTION: Thirty (30)	21665			