August 15, 2018

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

Subject: Good Samaritan Society - Albert Lea - IDR
CMS Certification Number (CCN) 245441
Project # S5441027

Dear Ms. Davis:

This is in response to your letter of April 2, 2018, in regard to your request of an informal dispute resolution (IDR) for the federal deficiency at tag F686 issued pursuant to the survey event MEUN11, completed on March 2, 2018.

The information presented in the telephone meeting, the CMS 2567 dated March 2, 2018 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F686 S/S – (G) 42 CFR § 483.25(b)(1)(i)(ii): Treatment/Services to Prevent/Heal Pressure Ulcer

Summary of the facility's reason for IDR of this tag: Good Samaritan Society-Albert Lea is requesting a reduction in the severity of the citation from a G to a D level because the facility feels R12's pressure ulcers were unavoidable due to health status of the resident. The facility reported R12's health status declined and she developed a stage 3 pressure ulcer on the left heel and an unstageable pressure ulcer on the right heel. Once R12 developed the pressure ulcers, they feel appropriate interventions for floating the heels were put in place to promote healing of the pressure ulcers. The facility acknowledged the staff were not consistently implementing floating of R12's heels, but feel that did not cause the pressure ulcers. The facility acknowledged documentation of pressure ulcer monitoring in R12's record was inconsistent for measurements and staging of the pressure ulcers, and have conducted extensive training for staff on pressure ulcer monitoring and documentation related to pressure ulcers.

Summary of findings: R12's admission Minimum Data Set, dated 11/27/17, identified R12 required extensive assistance with bed mobility, toileting, dressing and had functional limitations of both lower extremities, and was at risk for developing pressure ulcers. On 2/7/18, facility staff identified R12 had developed pressure ulcers on both heels, and at that time R12's physician ordered to float R12's heels

when in bed or up in chair to avoid pressure or friction and to elevate legs when up in chair. On 2/27/18, R12's pressure ulcers had worsened to a stage 3 pressure ulcer on the left heel and an unstageable pressure ulcer on the right heel, with R12 experiencing pain at both heels. During multiple days, R12 was seated in her wheelchair with both heels resting directly on the foot pedals and straps of her wheelchair. In addition, R12 was also observed lying in bed, with her heels pressing into the mattress of the bed. Facility staff were not aware of pressure relief interventions to utilize for R12 when she was in her wheelchair. The facility failed to consistently implement pressure relieving interventions for R12, whose left heel stage 3 pressure ulcer and right heel unstageable pressure ulcer worsened.

This is a valid deficiency at this tag and at the correct scope and severity of G.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Gail Anderson, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 218-332-5140 Fax: 218-332-5196

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Licensing and Certification File
Holly Krantz, Mankato District Office Unit Supervisor

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MEUN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00131

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245441**

2.STATE VENDOR OR MEDICAID NO.
(L2) **418840300**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/26/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **95** (L18)

13.Total Certified Beds **95** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	95			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 05/01/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/01/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00140 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245441

May 4, 2018

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

Dear Ms. Davis:

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

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

Effective April 10, 2018 the above facility is certified for:

95 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 95 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
May 4, 2018

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

RE: Project Number S5441027

Dear Ms. Davis:

On March 20, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective March 25, 2018. (42 CFR 488.422)

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 21, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on March 2, 2018. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 26, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 2, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 10, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 2, 2018, as of April 10, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective April 10, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of March 20, 2018:

- Discretionary Denial of Payment for new Medicare and Medicaid admissions effective effective May 21, 2018 be rescinded as of April 10, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 21, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 21, 2018, is

to be rescinded.

In our letter dated March 20, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 21, 2018, due to Discretionary Denial of Payment for new admissions. Since your facility attained substantial compliance on April 10, 2018, the original triggering remedy, discretionary denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MEUN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00131

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245441**

2.STATE VENDOR OR MEDICAID NO.
(L2) **418840300**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/02/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	95			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NE II 03/30/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Debby Baker, Enforcement Specialist 04/05/2018 (L20)

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

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

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21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5441

On March 2, 2018 a standard survey was completed at the above-referenced facility. The most serious deficiency (F686) was cited at a S/S level of G. Therefore, the Department is imposing the Category 1 remedy of State Monitoring, effective March 25, 2018.

In addition, we are recommending the following enforcement remedy to the CMS RO for imposition:
- DDPNA effective May 21, 2018

Electronically delivered

March 20, 2018

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

RE: Project Number S5441027

Dear Ms. Davis:

On March 2, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required. This letter provides important information regarding your response to these deficiencies and addresses the following issues:

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

Appeal Rights - the facilty rights to appeal imposed remedies; and

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

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

DEPARTMENT CONTACT

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

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; **OR**
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; **OR**
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective March 25, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition. CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 21, 2018

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 21, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 21, 2018.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Good Samaritan Society - Albert Lea is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 21, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

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 remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

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 June 2, 2018 (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 September 2, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at: https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145
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Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING _____ B. WING _____	03/02/2018

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

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E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 2/26/18 through 3/02/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On February 26th through March 2, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care	F 677	F677: Plan of Correction: Preparation and execution of this	4/10/18

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

Electronically Signed | 03/29/2018

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F 677	Continued From page 1 and/or shaving assistance was offered or provided for 2 of 3 residents (R12 and R59) reviewed for activities of daily living, who were dependent upon staff for assistance with grooming. Findings include: R12's admission Minimum Data Set (MDS) dated 11/27/17, identified a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition, and limited assistance of one staff member with with personal hygiene. R12's Care Area Assessment (CAA) for activities of daily living (ADLs) dated 11/30/17, identified R12 required limited to extensive assist with all ADLs except eating. R12's care plan revised 2/28/18, identified an ADL self-care performance deficit requiring set-up and limited assist of one staff for personal hygiene and bathing. During observation on 02/27/18, at 10:12 a.m., R12 was noted to have a black/brown substance under her fingernails on both hands as well as long hair on chin and upper lip. During observation on 2/28/18, at 8:00 a.m., R12 was observed in the dining room, with dirty nails and long facial hair. During observation on 3/1/18, at 9:45 a.m., R12 was observed sitting in her room in her wheelchair, with dirty fingernails and facial hair present. During interview on 3/1/18, at 11:00 a.m., nursing assistant (NA) - A verified R12's nails were dirty and stated R12's bath day was Tuesday. She stated she should have had her nails done with her bath. NA-A also verified the presence of long chin and facial hair. She state people should be shaved everyday as needed. During interview on 3/1/18, at 11:05 a.m. R12 was asked about the facial hair. R12 stated, "Well, I	F 677	response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. CNA supervisors reviewed R12 and R59 to ensure that they had been assisted with activities of daily living appropriately, including nail care and shaving. All residents in the building who are dependent upon staff for assistance with grooming were reviewed to ensure they had been assisted appropriately with ADL tasks, including nail care and shaving. Care plans and "task lists" were reviewed for R12, R59, and all residents who are dependent upon staff for grooming to ensure that direction is given to staff to assist with nail care on bath/shower days. To enhance current compliant operations and under direction of the Director of Nursing, nursing staff will be educated on the facilities process for assisting with shaving daily with routine grooming tasks and nail care on bath/shower days and prn via a meeting to be held on 4/4/18 and 4/5/18; with all nursing staff to be educated by 4/10/18. Random audits to ensure compliance will	

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F 677	Continued From page 2 would have taken care of it but I can't see them so I can't do it." R12 showed the surveyor a set of tweezers she had on her bedside table and stated "I would use this if I could, but I can't. I need help with that." During interview on 3/2/18, at 10:51 a.m., the director of nursing stated fingernails are to be trimmed and facial hair shaved weekly with the resident's bath and more often if needed. She also stated shaving or assist with shaving should be offered daily with cares. R59's quarterly MDS, dated 1/30/18, identified R59 required extensive assistance with personal hygiene, and had severe cognitive impairment with active diagnoses including Alzheimer's disease and Parkinson's disease. R59's care plan, revised 10/30/14, directed assistance of 2 for transfer onto shower chair and nursing assistant to assist with washing and drying body, and directed nail care to be completed with the shower. During observation on 2/26/18, at 3:57 p.m.,. R59 was observed to have very long fingernails. During an observation on 3/01/18, at 10:09 a.m., R59 was sitting in a wheelchair with long fingernails on both hands, which were noted to be curling over at the ends. When asked about the length of the fingernails, R59 looked at them and stated they were long. During an observation and interview on 3/1/18, at 10:49 a.m., registered nurse (RN)-A reported R59 had had a bath at 7 a.m. on 3/1/18. At 11:16 a.m., RN-A verified the fingernails were long and	F 677	be conducted by nursing management or their designee for R12, R59, and four other residents in the facility that are dependent upon staff for grooming. Audits will be conducted weekly x 4, then monthly x 3. Audit results will be brought to the Quality Assurance Performance Improvement Committee for review and further recommendations.	

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F 677	Continued From page 3 would have expected them to be trimmed weekly with the bath. During an interview on 3/1/18, at 11:17 a.m., nursing assistant (NA)-B reported that she usually provides nail care with the weekly bathing for R59, however, she got busy and denied providing nail care. The policy entitled Activities of Daily Living, revised 6/14, identified any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene.	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor and assess heel wounds, and failed to ensure appropriate positioning of the extremities to prevent development of, and/or promote healing of,	F 686	F686 Plan of Correction: It is the policy of the Good Samaritan Society, Albert Lea that based on a resident's comprehensive assessment, the location will use prevention and	4/10/18

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F 686	Continued From page 4 pressure ulcers for 1 of 2 residents (R12) reviewed for pressure ulcers. This resulted in actual harm for R12, who developed bilateral pressure ulcers on her heels. Findings include: R12's Admission Minimum Data Set (MDS) dated 11/27/17, identified R12 had diagnoses including chronic venous insufficiency, heart failure and arthritis. The MDS identified R12 was cognitively intact, needed extensive assist of one with bed mobility, had functional limitations of lower extremities on both sides, and was at risk for pressure ulcer development. The MDS also identified R12 did not currently have a pressure ulcer, but utilized a pressure relieving device on the bed and chair. R12's pressure ulcer Care Area Assessment (CAA) dated 11/30/17, also indicated R12 had no current pressure ulcer, or known history of pressure ulcers, but identified R12 as at risk for pressure ulcer development related to decreased mobility and lower extremity edema. R12 was further identified as needing assist with bed mobility/repositioning and as having a pressure reducing mattress and redistribution cushion in wheel chair. Pressure ulcer risk factors were identified to include: pressure, need for special mattress or seat cushion to reduce or relieve pressure, edema, and functional limitation in range of motion. R12's care plan dated 11/21/17, identified a problem of venous insufficiency. Staff were directed to: monitor R12's extremities for signs/symptoms of injury, infection or ulcers, elevate legs when sitting or sleeping, encourage	F 686	assessment interventions to ensure that a resident entering the location without pressure ulcers does not develop a pressure ulcer unless the individual's clinical condition demonstrates that this was unavoidable. Nursing management reviewed R12's care plan and treatment plan to ensure appropriate interventions were in place. Intervention to float heels was added to the care plan on 3/1/18. Care plans for residents who were identified to have Braden scores have 18 or less were reviewed to ensure appropriate interventions were in place to promote skin integrity and/or wound healing. To enhance current compliant operations and under direction of the Director of Nursing, nursing staff will be provided with re-education of the facility's policies and procedures related to wound protocols and prevention via meetings to be held on 4/4/18 and 4/5/18; with all staff to receive the training by 4/10/18. Random audits including observation to ensure compliance will be conducted by nursing management or their designee for R12 and all residents in the facility identified to be at risk for the development at pressure ulcers. Audits will be completed weekly x 4, then monthly x 3. Results will be brought to the Quality Assurance Performance Improvement Committee for review and further recommendations.	

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F 686	Continued From page 5	F 686		

resident to change position frequently so as to not sit in one position for long periods of time, monitor extremities for signs/symptoms of injury, infections or ulcers. On 12/6/17, R12's care plan was revised to include a problem area of: impairment to skin integrity related to decreased mobility, right upper extremity and lower extremity edema. Staff were directed to observe skin weekly by licensed nurse and provide pressure reducing mattress and pressure redistribution cushion in wheel chair. The 12/6/17 revised care plan also identified a focus problem area of limited physical mobility with decreased strength/balance and pain. On 1/3/18, interventions were added to the care plan directing staff to turn and reposition R12 in bed and recliner every two hours and as needed. On 3/1/18, an intervention of blue boots on while in bed to float heels was added.

Review of the facility's admission assessment, Braden Scale for Predicting Pressure Sore Risk dated 11/20/17, identified slightly limited mobility, adequate nutrition, and a potential problem with friction and shear. The Braden Scale identified a score of 19 indicating no risk (very high risk 9 or below, high risk 10-12, moderate risk 13-14, mild risk 15-18, and no risk 19-23). A quarterly Braden Scale dated 2/20/18, identified R12 as being chair fast, having very limited mobility, and having a problem with friction and shear. The 2/20/18 Braden Scale score was 16 (mild risk). A Braden Scale assessment conducted 2/27/18, identified: skin occasionally moist, chairfast, very limited mobility and problem with friction and shear. That assessment indicated a score of 15, indicating mild risk.

Review of the facility's skin observation tool for

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F 686	Continued From page 6	F 686		

R12, dated 1/30/18, identified a small area above the left ankle.

Review of the nursing notes dated 2/7/18, identified bilateral (BL) heels were assessed. The left heel was described as purple and boggy to touch. The right heel was described as purple, boggy, and has having a dry scab in the center of the purple area. The nursing notes indicated there was no indication of pain when the areas were touched and indicated R12 does have wraps on her legs for edema, was encouraged to not wear shoes but to just wear gripper socks and make sure the heels are floated.

Review of a physician's video encounter note dated 2/7/18, indicated: "elevate legs when in chair, float heels when in bed or up in chair to avoid pressure or friction, ace wraps to lower extremities on in AM (morning) off in PM (evening). Cleanse wounds daily with betadine. Cover with border foam dressing for protection-change daily." The note also indicated R12's daughter was notified of the new orders and R12's condition.

Review of an Incident Report dated 2/7/18, indicated R12's bilateral heels were soft. "Left heel area spot circular measures 0.2 x 0.2 centimeters (cm). Right heel has purple area 2 cm x 5 cm with scab in middle that measures 1 cm x 0.8 cm. Complains of heel pain bilaterally." Immediate action taken indicated to float heels on pillows. Predisposing factors identified, "resident refused to have heels floated on pillows prior to this." On 2/9/18, Prosource (a protein supplement) 1 ounce twice daily for wound healing was added. On 2/9/18, the physician was notified of the areas on heels.

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F 686	Continued From page 7	F 686		

R12's 2/16/18 skin observation identified slightly red coccyx, suspected deep tissue injury (SDTI), dark scabbed area BL heels. No treatments were identified.

R12's skin observation documentation dated 2/18/18, identified SDTI (suspected deep tissue injury) with dark scab to right heel, and SDTI with small scab to left heel. Treatments identified included: assist with mobility and transfers, weekly skin checks and vital sign monitoring, offer biweekly showers, as needed (PRN) lotion to dry skin twice daily.

A physician order dated 2/19/18, identified an order including: "ok for heel protector dressing to bilateral heels change every 5 days and as needed, discontinue (D/C) when healed."

A physician's Order Summary Report dated 3/2/18, identified orders that had been initiated: 2/7/18 "Elevate legs when up in chair and float heels when in bed or up in chair to avoid pressure or friction," and 3/1/18 "Copa Island (a type of foam dressing) to bilateral heels apply and change every other day and as needed to bilateral heels, D/C when healed."

R12's registered nurse wound assessment dated 2/28/18, indicated R12 had a SDTI to left heel, full thickness tissue loss, 90% slough inside wound, purple around the open area. Modifications to intervention were identified to include: nutritional, wound treatment, pain management. Physician was notified and indicated to continue with current plan of treatment. Prior assessments from 2/18/18 indicated the left heel had a full thickness tissue loss and a wound measuring 1.0 cm x 8

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F 686	Continued From page 8	F 686		

cm x 0.2 cm. On 2/19/18, the right heel measured 1.5 cm x 1.2 cm x 0.1 cm, modifications were made to wound treatments. Assessments on 2/25 and 2/27/18 lacked wound measurements for the right or left heel.

Review of R12's Wound Data Collection flowsheets included the following:

-2/8/18, left heel SDTI small open area. No measurements of area documented, ulcer described as small open area, no signs of infection, no complaints of pain, wound margins intact. Treatment betadine, Copa island foam dressing. Right heel SDTI dark scab. No measurements of area documented, ulcer described as dark scab, no signs of infection, no complaints of pain, wound margins intact. Treatment betadine, Copa island foam dressing.

-2/9/18, left heel pressure area. No measurements of area documented, ulcer described as "pressure area", no signs of infection, complaints of pain, wound margins intact. Interventions scheduled pain med, heels floated. Treatment iodine wash, Copa foam secured over heel. Right heel pressure area. No measurements of area documented, ulcer described as pressure, drainage on dressing, no signs of infection, complaints of pain, wound margins intact. Interventions float heels and give pain med. Treatment iodine wash, Copa foam. Subsequent documentation related to the right and left heel wounds between 2/9 and 2/25/18 lacked measurements of the wounds, indicating the sites were pressure areas that were not draining, R12 had no complaints of pain and the heel foam Copa dressing was intact.

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F 686	Continued From page 9	F 686		

-2/25/18, measurements indicated the left heel pressure area was: 0.7 cm length by 1.1 cm width 0 depth, ulcer described as pressure area, no drainage present, no signs of infection, no complaints of pain, wound margins intact and reddened. Treatment to heel: foam dressing change q (every) 5 days and PRN (as needed) for soiling. Right heel pressure area: Length 1 cm by 1.4 width 0 depth, ulcer described as pressure area, no drainage present, no signs of infection, no complaints of pain, wound margins intact and reddened.

-2/26/18, the right heel measurements included: length 1.5 cm by 0.8 cm by 0.2 depth, and on 2/27/18 indicated: SDTI to left heel. Length 1.0 by 0.8 width by 0.2 depth, no description of ulcer, minimum amount of purulent drainage to dressing, no signs of infection, complaints of pain, wound margins reddened and purple.

During observation 2/26/18, at 5:30 p.m., R12 was observed sitting in the dining room in her wheelchair, with gripper socks on both feet. R12's feet were resting on the wheelchair footrest with the heels pressed into a strap that ran along the back edge of the footrest.

During observation and interview on 2/27/18, at 10:18 a.m., R12 was observed sitting in wheelchair in room. R12 stated, "My heels, they hurt". Both feet were resting on her footrests, with the heels resting against a strap on the back of the footrests. R12 had gripper socks on. Nurse manager (NM)-A stated she needed to look at the resident's feet and accompanied survey staff back to R12's room. Both heels had dressings present, with drainage noted on both. Open areas were noted to the upper area back of

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F 686	Continued From page 10	F 686		

both left and right heels. NM-A measured the areas and replaced the dressings. Later that day at 2:30 p.m., R12 was observed sitting in her room in her wheel chair. Both feet were resting on the footrests, with the heels resting against the strap on the back of footrests. R12's gripper socks were on, her legs were not elevated. R12 complained her heels still hurt, and stated she had not laid down. R12 stated, "Sometimes they put me in the recliner, it just depends on who it is."

Observations on 2/28/18, at 8:20 a.m., 9:14 a.m., and 11:50 a.m. revealed R12 was observed sitting up in her wheelchair with both feet resting directly on the footpedals, with gripper socks on, and her heels resting against the straps on the footrests. At 1:00 p.m. that day, R12 was observed in her room sitting up in her wheelchair with feet resting on footrests, heels resting on the back of the footrest, with gripper socks on, and resident was complaining of foot/heel pain. R12 stated they were going to lie her down, but did not know when they would get to it. At 1:30 p.m., R12 stated her feet hurt on the bottoms, arches and heels, and remained in the same position with her heels resting against the straps on the back of the pedals and her feet directly in contact with the bottom of the foot pedals.

During observation on 3/1/18 at 7:40 a.m., R12 was observed lying in bed. R12 had a pillow under her calves and knees, with the heels pressing into the mattress. NM-A was shown R12's position and stated, "Oh that's not right, her heels are supposed to be floated". NM-A moved the pillow down and placed it just above the heels.

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F 686	Continued From page 11	F 686		

During interview on 3/1/18, at 8:19 a.m. nursing assistant (NA)-D stated R12 did not have anything special for her feet to relieve the pressure while R12 up in the wheelchair. NA-D stated, "We usually put a pillow under her knees if she is in the recliner."

During interview on 3/1/18, at 8:25 a.m. NA-B stated R12 often refuses to go in her recliner and won't lay down in her bed till bed time. NA-B stated yesterday she wouldn't go in her recliner. NA-B stated R12 did not have anything special for her feet to reduce pressure in the wheelchair.

During observations on 3/1/18 at 9:30 a.m., 10:50 a.m., and 11:50 a.m., R12 was in her wheelchair with her heels directly in contact with the footpedals while pressed against the back of the footrest straps. Gripper socks were being worn.

During observation on 3/1/18, at 1:00 p.m. R12 was observed to receive wound care while lying in bed. NM-A unwrapped the ace wrap to R12's left leg which was wrapped around the lower leg and top of foot with just the heel sticking out. R12 cried out, "Ouch, that hurts," when the back of her heel was touched. The left heel ulcer area was no longer draining, and the heel was mushy and dark red/purple in color. NM-A removed the right leg ace wrap, and R12 complained again of the area hurting when the dressing was removed. The area on the upper back area of R12's right heel had necrotic tissue in the wound bed, with a reddened area around the wound that R12 indicated was tender to touch, drainage was noted on the dressing that was removed, and the area appeared to be 1.5-2.0 cm in length. R12 was given a pain pill by staff at that time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING _____ B. WING _____	03/02/2018

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

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F 686	Continued From page 12 During observation on 3/2/18 at 8:03 a.m., R12 was observed in the dining room sitting in a wheelchair, with both feet resting on the footrests and the heels resting against the strap, with gripper socks on her feet. During interview on 3/2/18, at 11:05 a.m. the director of nursing (DON) stated she expected R12 to have her heels offloaded at all times. The DON stated R12 should have blue offloading boots on in bed, as well as in the wheelchair or recliner, and said when weekly skin observations were done, the nurse should be notified immediately if any areas of concern were noted. The DON also stated when staff were holding up R12's legs to apply acewraps, they should have noticed the areas of concern developing on R12's heels, and implemented interventions to prevent breakdown. The facility's policy Pressure Ulcers revised 1/17/17, included: "Based on the resident's comprehensive assessment, the location will use prevention and assessment interventions to ensure that a resident entering the location without pressure ulcers does not develop a pressure ulcer unless the individuals clinical condition demonstrates that this was unavoidable."	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must	F 692		4/10/18

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F 692	Continued From page 13 ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to address unplanned weight loss for 1 of 3 residents (R67) reviewed for nutrition. In addition, the facility failed to provide adequate assistance with fluid intake for 1 of 2 residents (R12) reviewed for hydration, and failed to follow physician ordered fluid restrictions for 1 of 1 resident (R48) who received dialysis. Findings include: R67's Admission Diagnosis List dated 12/26/17, included: altered mental status, major depressive disorder, gastro-esophageal reflux disease and Parkinson's disease. R67's admission Minimum Data Set (MDS) dated 1/2/18, indicated the resident was independent with eating with set-up help, and had no swallowing problems. R67's weight was identified	F 692	F692: Plan of Correction: Nursing management reviewed R67's record to ensure that a provider had been notified of her weight loss and that appropriate interventions were in place to address the unplanned weight loss. An order was received on 3/1/18 for SLP evaluation and treatment and also for a nutritional supplement. All residents who were identified as having a significant weight loss in the past 30 days were reviewed by nursing management to ensure a provider had been notified of the weight loss and to ensure that appropriate interventions were in place to address this weight loss. CNA supervisors audited R12 and all residents in the facility to ensure that fresh water was available, if appropriate. CNA supervisors reviewed R48 and all residents in the facility on fluid restrictions to ensure that they did not have water pitchers in their room. The	

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F 692	Continued From page 14 on the MDS as 146 pounds (#), with no recent weight loss. A subsequent re-admission MDS, dated 2/1/18, identified R67 as requiring extensive assistance of staff with eating, and as having no swallowing problems. R67's weight was 138#, with a 5% or greater weight loss in the past month. Review of the Care Area Assessment (CAA) summary dated 2/1/18, indicated R67 had triggered for nutritional status. The CAA further indicated R67's nutritional needs would be identified in the plan of care. There was no further documentation in the CAA related to R67's nutritional needs. Review of R67's current care plan identified R67 as having a self-care performance deficit related to impaired memory and dementia, and requiring assistance of 1 staff with eating. The care plan further identified R67 as having a nutritional problem related to depression and dementia, as evidenced by depressed appetite and weight loss. Interventions were identified to include: modified texture diet and monitor weights weekly. Review of R67's dietician assessment dated 1/26/18, identified R67 as being able to feed herself independently, with no diet restrictions, and tolerating regular texture foods. The assessment indicated R67's weight was within the usual range and stable. Review of the dietician's assessment dated 2/2/18, indicated the resident required assistance with eating, as well as a level 2 food textured diet (moist soft foods). The assessment indicated R67 had a weight loss during a recent hospital stay	F 692	care plan and treatment record for R48 and all residents in the facility on fluid restrictions were reviewed to ensure that the appropriate interventions were included to support accurate documentation. No other residents were identified to be at risk. To enhance current compliant operations and under direction of the Director of Nursing, nursing staff will be provided to the nursing staff regarding the facility's process for reviewing weights daily at the end of their shifts and notifying a provider of significant weight loss, for R67 and for all residents identified for significant unplanned weight loss, and the facility process for completion of water pass twice daily to appropriate residents. This education will occur via a meeting to be held on 4/5/18; with all nursing staff to be educated by 4/10/18. Random audits to ensure compliance will be conducted by nursing management or their designee for R67, R12, R48 and residents who have been identified to have unplanned weight loss, who can have water pitchers in their room and who are on fluid restrictions. Audits will be completed weekly x 4, then monthly x 3. Results will be brought to the Quality Assurance Performance Improvement Committee for review and further recommendations.	

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F 692	Continued From page 15	F 692		

and indicated a recommendation to continue fortified foods, and a nutritional supplement at the nursing home upon re-admission. The assessment indicated the resident had been receiving these nutritional supplements at the hospital during her stay from 1/5/18 to 1/26/18, and identified a recommended goal of "no weight loss." The assessment indicated R67 had been eating 50% of her meals.

Review of R67's dietary assessment dated 2/14/18, indicated R67 had experienced a significant weight loss, having lost 10 pounds during her hospital stay, which had continued since her readmission 1/26/18. The assessment indicated a request would be made for a nutritional supplement, as well as a speech evaluation, with the possibility of advancing her diet texture.

During observation on 2/26/18, at 5:45 p.m., and again at the dinner meal on 2/27/18, at 11:30 a.m. R67 was observed to eat 50% of her meal when assisted and encouraged by staff. R67 received a level 2 diet (soft foods).

Review of the resident weight summary since admission included the following weight entries:
12/27/17-145#
12/29/17-147#
12/30/17-146#
1/2/18-146#
1/26/18-136#
1/29/18-138#
2/12/18-132#
2/14/18-130#
2/20/18-129#
2/24/18-128#

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F 692	Continued From page 16 Review of the Regina Medical Center re-admission physician orders, dated 1/26/18, included a diet of a level 2 mechanically altered, thin liquids, fortified foods whenever possible, super cereal with breakfast, super mashed potatoes in place of regular mashed potatoes, super milk in place of regular milk and magic cup for lunch and supper. Further review of R67's medical record lacked evidence R67's weight loss had been comprehensively assessed to determine nutritional interventions to maintain weight and/or prevent further weight loss. During a telephone interview on 3/1/18, at 10:23 a.m. the facility's dietician indicated she was aware of R67's significant weight loss, and verified R67 was not receiving any additional nutritional supplements. The dietician indicated R67 had been admitted to a hospital behavioral unit on 1/5/17 where she'd stayed through 1/26/17. The dietician indicated when R67 had returned from the hospital, the hospital notes indicated the resident had been receiving fortified foods as well as a nutritional supplement during her hospitalization. The dietician stated there had been no order to continue this at the facility on the re-admit orders. In addition, the dietician stated they were going to continue to monitor the resident's weights, and that the staff would give her snacks (standard for all residents) in between meals if the resident did not eat well however, she was not sure if the resident was receiving snacks or not. She further indicated that the staff are continuing to discuss options for R67 to improve intake and nutritional needs, so therefore nothing had been implemented at this time for R67's weight loss.	F 692		

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F 692	Continued From page 17 During interview on 3/1/18, at 10:37 a.m. the station 4 nurse manager (NM)-A confirmed R67 should have had an order for a nutritional supplement due to her declining weight identified on the 2/1/18 MDS following hospital readmission. NM-A confirmed R67 did not eat well and required assistance with eating. She stated R67 was not scheduled to have in-between meal snacks on a routine basis. Snacks were offered to all residents, however, she was not sure whether R67 received any. During interview on 3/1/18, at 1:56 p.m. the director of nursing (DON) stated she would expect staff to report R67's weight loss, which had been identified on R67's 2/1/18 re-admission MDS, to the physician to determine interventions to prevent continued weight loss. R12's admission Minimum Data Set (MDS), dated 11/27/17, identified a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition, independent after set up with eating, functional limitations of one upper extremity and active diagnoses including arthritis, heart failure and pain in the right shoulder. R12's Care Area Assessment (CAA) for activities of daily living (ADLs), dated 11/30/17, identified R12 required limited to extensive assistance with all ADLs except eating (set-up) during the assessment period and was cognitively intact. R12's physician's orders, dated 3/2/18 , listed medications including Spironolactone, 50 milligrams daily (a diuretic medication that helps you make more urine and lose salt and excess water from your body. This medicine is used to treat high blood pressure, and edema or swelling from heart, kidney, or liver disease) and Bumex 0.5 milligrams twice daily (also a diuretic	F 692		

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F 692	Continued From page 18	F 692		

medication that helps you make more urine and lose salt and excess water from your body. This medicine is used to treat high blood pressure, and edema or swelling from heart, kidney, or liver disease). Side effects of these medications included dry mouth and thirst.
R12's care plan, dated 12/6/18, identified R12 had congestive heart failure. Interventions included monitoring of hydration status, but otherwise independent after set up for eating.
During observation and interview on 2/27/18 at 10:08 a.m., R12 was noted to have a dry mouth and lips. The skin on her hands was observed to "tent" as well. (Tenting is when the skin is very slow to return to normal, or the skin "tents" up during a check. This can indicate dehydration). R12 also stated her mouth was dry, "I can't hardly move it." R12 stated, "If I want water I have to ask them for it." R12 had a water pitcher on table that was approximately one third full. R12 stated her "lips were so dry," and took a drink of water. After R12 took the drink, she stated, "I am still dry."
During observation on 2/28/18, at 8:20 a.m., R12 was at breakfast with a small glass of prune juice and coffee.
During observation on 2/28/18, at 9:18 a.m., R12 was sitting in her room. R12 had a quarter of a pitcher of water sitting on bedside table, which R12 stated was last filled yesterday. R12 stated her mouth was still dry, and was observed with a dry mouth and lips. At 11:30 a.m., fresh water was delivered to the room.
During observation on 3/1/18, at 1:35 p.m. R12 lying in bed, with a water pitcher approximately a quarter full that was noted on table beside bed on right side. R12 stated she was dry and would like a drink, but she couldn't reach the water pitcher. R12's mouth and lips were dry.

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F 692	Continued From page 19 Druing observation on 3/2/18, at 9:29 a.m. R12 was observed to be sitting in wheelchair in her room, with an empty water jug on the table in front of her. Nursing assistant (NA)-A entered room as R12 had call light on, R12 stated, "I'm so dry," and attempted to reach pitcher to take a drink but was unable. NA-A went to move pitcher closer to R12 and stated, "Oh, it's empty, let me get you some more water." During interview on 3/1/18, at 1:35 p.m., NA-C stated water was passed once a day, and had not been passed yet. She stated that evening shift would do that. During interview on 3/2/18, at 10:04 a.m., the certified dietary manager (CDM) stated she didn't think R12 was on any fluid restrictions at all and could have however many fluids she wanted. R12 stated the water pass policy was that staff from the rehabilitation facility picked up the dirty water pitchers and the station 4 (station R12 resided on) passed those. She stated fresh water and pitchers are filled once a day by the rehabilitation staff and filled a second time and passed by the station 4 staff. She stated on Tuesdays and Thursdays there are no rehabilitation staff and station 4 staff were responsible to pass fresh water twice on these days. She said staff should be checking with residents throughout the day and offering fresh water. During interview on 3/02/18, at 10:16 a.m., nurse manager (NM)-A stated staff were supposed to fill pitchers every shift, but that it didn't always happen and stated they could offer water to residents if they requested it. No policy regarding offering of fluids/water was provided. R48's admission MDS, dated 1/22/18, identified	F 692		

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F 692	Continued From page 20	F 692		

a BIMS score of 7 indicating severe cognitive impairment, supervision with eating, diagnosis including renal failure and dialysis.
R48's nutritional status CAA, dated 1/22/18, identified R48 had ESRD (end stage renal disease) with dialysis 3 times weekly, is on a renal diet and appetite is poor. The renal dietitian was contacted regarding liberalizing the diet due to poor intake, due to a history of weight loss will pursue a nutritional supplement order. No fluid restriction was identified in the CAA.
R48's care plan, dated 1/29/18, identified R48 had nutritional problem related to ESRD with dialysis, and GERD (gastroesophageal reflux disease) evidenced by therapeutic diet order and poor appetite. Interventions included: pursue liberalization, explain and reinforce to resident the importance of maintaining the diet ordered including any fluid restrictions, fluid restriction as ordered by health care provider, total 1200 cc with 600 cc from dietary and 600 cc from nursing, see charge nurse before giving any fluids between meals and document all fluids provided.
R48's nursing assistant bedside kardex, dated 3/1/18, did not identify R48's fluid restriction.
The order summary report, dated 1/29/18, identified regular fluid consistency, renal diet with 1200 milliliter (ml) fluid restriction, 5 - 8 oz glasses / 24 hours (1,200 cubic centimeter (cc)/day) 600 for nursing and 600 per dietary.
The dietitian assessment and planning note, dated 1/20/18, identified R48 had stage 5 renal disease, required dialysis 3 times weekly, fed self, tolerated thin liquids and was on a 1200 cc fluid restriction.
Review of R48's fluid intake from February 1st to March 1st identified intakes documented fluid intake at mealtimes only. On 2/1, 2/4, 2/12, 2/13, 2/15, 2/20, 2/23, 2/24, 2/25, 2/27 and 3/1 R48

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F 692	Continued From page 21 received over the intake of 600 cc allotted for dietary. During observation on 2/26/18, at 4:44 p.m. R48 was noted to have a 1/2 full water pitcher as well as a small can of soda on bedside table. R48's wife stated, "I don't think they are restricting his fluids here." During observation 2/27/18, at 11:30 a.m., R48 had a full water pitcher in room. During observation on 2/28/18, at 9:13 a.m. R48 had a water pitcher approximately a quarter full in the room on a table. At 11:30 a.m., R48 had fresh water delivered, and received a full pitcher of ice water. During interview on 3/02/18, at 10:14 a.m. NA-B stated R48 was on a fluid restriction but she was not sure how much the restriction was for. She stated it's on his diet slip and the nurses know too. During interview on 3/1/18, at 1:31 p.m. NM-A stated we don't keep track of how much water we give with medication passes, however, the NAs document it in the kiosk they used for charting. NM-A stated, "I don't know why he would have a water pitcher in his room, he shouldn't have." During interview on 3/2/18, at 9:53 a.m. the certified dietary manager (CDM) stated R48 was on a 1200 cc fluid restriction that is split between dietary and nursing. She stated the NA's serve the fluids at meals and give 200 cc per meal. She stated if R48 desired more drinks, smaller ounce glasses are used. She stated nursing should be documenting what they are giving him with medication passes as well as any fluids given between medication passes. She stated R48 should not have a water pitcher in room. She stated she was not aware nursing was not documenting/watching fluid intakes. The CDM reviewed R48's intakes for February and stated,	F 692		

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F 692	Continued From page 22 "I am going to tell you they are not ideal, a lot are over the allotted amount for dietary alone." During interview with the director of nursing on 3/2/18, at 10:45 a.m., the DON stated nursing should be keeping track of intakes per the care plan. She stated R48 should not have a water pitcher in his room. The facility procedure entitled Residents at Risk for Dehydration/Fluid Maintenance, revised 1/16/17, included, Fluid Restriction - If the physician ordered a specific amount of fluid or a fluid restriction for the resident, the DFN (director of food and nutrition) will interview the resident and/or family about the resident's fluid preferences and habits. c. Employees will check with the charge nurse before providing any fluid to the resident between meals. d. Employees will document fluid intake with meals and between meals in PCC/POC (electronic medical record). Fluids provided at medication pass will be documented on the eMAR (electronic medication administration record). e. Employees will monitor the record to determine if fluid goals or calculated fluid needs are being met consistently and document in the electronic progress notes (PN - Nutritional Status).	F 692		

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

(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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division on February 27, 2018. At the time of this survey, Good Samaritan Society Albert Lea was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Good Samaritan Society - Albert Lea, is a 1-story building. The building was constructed at 6 different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1968, an addition was constructed and was determined to be of Type II(111) construction. In 1975, an addition was constructed and was determined to be of Type II (111) construction. In 1980, an addition was constructed and was determined to be of Type II(111) construction. In 1997, an addition was constructed and was determined to be of Type II(111) construction In 1998, an addition was constructed and was determined to be of Type II(111) construction Because the original building and the 5 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 95 beds and had a census of 87 at the time of the survey.	K 000		

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING **01 - ALBERT LEA GOOD SAMARITAN CENTER** B. WING _____	**02/27/2018**

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K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		