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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: MPFF
Facility ID: 00303

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245455**

2. STATE VENDOR OR MEDICAID NO. (L2) **673342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - JACKSON**
(L4) **601 WEST JACKSON**
(L5) **JACKSON, MN** (L6) **56143**

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 **7/7/2016** (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 **63** (L18)

13.Total Certified Beds **63** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: A* (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	63			
(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 :
Wendy Willson, HFE NE II 08/3/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 08/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **04/01/1987** (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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245455

August 3, 2016

Mr. Daren Rife, Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, MN 56143

Dear Mr. Rife:

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 July 6, 2016 the above facility is certified for:

63 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 63 skilled nursing facility beds located in rooms.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 29, 2016

Mr. Daren Rife, Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, MN 56143

RE: Project Number S5455027 and Complaint NumberH5455013

Dear Mr. Rife:

On June 28, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective july 6, 2016. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 26, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of June 28, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 26, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on May 26, 2016, and lack of verification of substantial compliance with the Minnesota Department of Health, Office of Health Facility Complaints deficiencies at the time of our June 28, 2016 notice. The most serious deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On July 28, 2016, the Minnesota Department of Health, Office of Health Facility Complaints 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 May 26, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 26, 2016, as of July 28, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of June 28, 2016. The CMS Region V Office concurs and has authorized this Department to

notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 26, 2016, be rescinded. (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 August 26, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective August 26, 2016, is to be rescinded.

In our letter of June 28, 2016, 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 August 26, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 28, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 28, 2016

Mr. Daren Rife, Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, MN 56143

RE: Project Number H5455013 and **S5455027**

Dear Mr. Rife:

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.

On June 10, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 26, 2016. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections were required.

On June 15, 2016, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints 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 to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections are required. As a result of our finding that the facility has not achieved substantial compliance this Department is imposing the following Category 1 remedy:

- State Monitoring effective July 6, 2016. (42 CFR 488.422)

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

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 26, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January August 26, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 26, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Good Samaritan Society - Jackson is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 26, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag, from the **standard survey completed May 26, 2016**), i.e., the plan of correction should be directed to:

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag, from **the abbreviated standard survey completed June 15, 2016**), i.e., the plan of correction should be directed to:

Annette Winters, Supervisor
Office of Health Facility Complaints
Minnesota Department of Health
85 East Seventh Place, Suite 220

P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4204 Fax: (651) 281-9796

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 July 6, 2016 the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 26, 2016 (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, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health

Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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.

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
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245455 Y1	A. Building B. Wing Y2	7/7/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	601 WEST JACKSON JACKSON, MN 56143

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 06/17/2016	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 06/17/2016	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 06/17/2016
ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 06/17/2016	ID Prefix F0318 Reg. # 483.25(e)(2) LSC	Correction Completed 06/17/2016	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 06/20/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** KS/kfd	**DATE** 8/10/2016	**SIGNATURE OF SURVEYOR** 37038	**DATE** 7/7/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 5/26/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245455	A. Building 01 - MAIN BUILDING 01 B. Wing	7/12/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	601 WEST JACKSON JACKSON, MN 56143

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0011	Correction Completed 06/03/2016	ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 06/03/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 06/30/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/24/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

August 10, 2016

Mr. Daren Rife, Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, MN 56143

Re: Reinspection Results - Project Number S5455027 and Complaint NumberH5455013

Dear Mr. Rife:

On July 7, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 7, 2016, that included an investigation of complaint number H5455013. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00303 Y1	A. Building B. Wing Y2	7/7/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	601 WEST JACKSON JACKSON, MN 56143

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. 3 LSC	Correction Completed 06/17/2016	ID Prefix 20570 Reg. # MN Rule 4658.0405 Subp. 4 LSC	Correction Completed 06/17/2016	ID Prefix 20840 Reg. # MN Rule 4658.0520 Subp. 2 B LSC	Correction Completed 06/17/2016
ID Prefix 20895 Reg. # MN Rule 4658.0525 Subp. 2.B LSC	Correction Completed 06/17/2016	ID Prefix 21100 Reg. # MN Rule 4658.0650 Subp. 5 LSC	Correction Completed 07/07/2016	ID Prefix 21805 Reg. # MN St. Statute 144.651 Subd. 5 LSC	Correction Completed 06/17/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KS/kfd	DATE 8/15/2016	SIGNATURE OF SURVEYOR 37038	DATE 7/7/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 5/26/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: MPFF12

STATE FORM: REVISIT REPORT (11/06)

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: MPFF
Facility ID: 00303

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245455**

2. STATE VENDOR OR MEDICAID NO. (L2) **673342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - JACKSON**
(L4) **601 WEST JACKSON**
(L5) **JACKSON, MN** (L6) **56143**

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 **05/26/2016** (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 **63** (L18)

13.Total Certified Beds **63** (L17)

10.THE FACILITY IS CERTIFIED AS:

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
	63			
(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 :
Susan Kalis, HFE NE II 06/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 07/13/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 10, 2016

Mr. Daren Rife, Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, MN 56143

RE: Project Number S5455027

Dear Mr. Rife:

On May 26, 2016, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 5, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 5, 2016 the following remedy will be imposed:

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

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 remedies be imposed:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 26, 2016 (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 November 26, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING ______ B. WING ______	05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON JACKSON, MN 56143**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services in a dignified manner for 2 of 2 residents (R32, R38) reviewed for dignified services. Findings include: The quarterly MDS dated 5/11/16, for R32 identified a BIMS score of 14, indicating intact cognition. The MDS further identified R32 with frequent incontinence requiring extensive assistance of one staff to manage.	F 241	R32 and R38 care plans has been updated on toileting plan to reflect current level of function. All other residents who were at risk for urinary incontinence have been reviewed to assure they are receiving necessary treatment and services. Nursing staff have been reeducated on assuring dignified care. Random audits will be completed on delivery of care to ensure appropriate care and services are delivered. Audits will be done weekly times 4, then 2 times a month then as determined by QAPI	6/17/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 06/19/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 1 When questioned about dignified treatment by staff on 5/23/16, at 10:46 a.m. R32 stated, "No, sometimes I don't get the help I need. They could treat you a little better with coming and helping. I don't think they are too kind sometimes. It doesn't make me feel very good to be left without help". On 5/24/16, at 10:30 a.m. R32 was observed during morning cares lying in bed with her feet hanging over the side of the bed. R32's bed and sheets were noted to be heavily saturated with urine. R32 stated, "Can you help me I am going to fall out of bed?" The surveyor summoned staff to the room to intervene and assist R32. At the time of incident licensed practical nurse (LPN)-A entered the room and placed R32 back into bed by swinging her feet back onto the bed. LPN-A did not provide any further cares for R32, leaving her positioned low in the bed. The bed and clothing were noted to be urine saturated. R32 was interviewed at the time of the observation and stated, "I needed to toilet a long time ago and they stated they would be back (referring to nursing assistant staff) but now it is too late." On 5/24/16, at 10:41 a.m. activity aide (AA)-A entered R32's room with a wheelchair to assist R32 out of bed for activities and noted R32 was incontinent of urine. AA-A notified the nursing staff that R32 needed to be assisted with incontinence cares. The quarterly Minimum Data Set (MDS) assessment dated 5/12/16, identified R38 with a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS further identified R38 required extensive assistance of two staff with toileting, was frequently incontinent of urine with no toileting plan.	F 241	committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING ______ B. WING ______	05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 241	Continued From page 2 On 5/24/16, at 11:15 a.m. R38 and resident representative (RR)-A requested to speak to the surveyor. During interview on 5/24/16, at 11:30 a.m. R38 and RR-A stated they did not feel staff responded to needs in a timely manner. RR-A stated when visiting daily with R32, RR-A noticed staff often did not provide R38 timely urinary continence services. RR-A stated, "Two weeks ago [R38] needed assistance with toileting and he turned his light (call light) on at 2:50 p.m. Staff entered the room and turned the light off and stated they would return to assist [R38]. Staff returned to assist [R38] at 3:40 p.m. at which time he was totally saturated with urine." R38 verified the accounts of the event and stated he did not like to "wet" himself. R38 stated it was belittling to him to know he needed to toilet and when he did not receive timely assistance. When further interviewed, RR-A stated that when visiting a couple of days prior, R38 was left in bed, with pants pulled down below his knees and a urinal placed. RR-A indicated the urinal was left for 1 1/2 hrs before it was removed by staff. R38 verified the account described and indicated he felt like a "number" verses a person. When interviewed on 5/25/16, at 12:05 p.m. the director of nursing (DON) verified the described services provided by staff for R38 and R32 would be considered undignified. The DON stated staff should meet the resident needs when the need occurs versus telling the resident they will return.	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		6/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 3 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan to identify interventions that were effective based on the assessment for 1 of 1 resident (R32) reviewed for urinary status. Findings include: R32's quarterly Minimum Data Set (MDS) dated 5/11/16, identified R32 had a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition. The MDS further identified R32 with frequent incontinence requiring extensive assistance of one staff to manage. On 5/24/16, at 10:30 a.m. R32 was observed during morning cares lying in bed with her feet	F 280	R32 care plan has been updated to reflect fluctuating toileting needs. All residents who return from hospital or on admission will have 72 hour bowel and bladder assessments completed. Audits will be completed on all re-admissions and admissions monthly times 3 months then reviewed with QAPI for further recommendations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 4	F 280		

hanging over the side of the bed. R32's bed and sheets were noted to be heavily saturated with urine. R32 stated, "Can you help me I am going to fall out of bed?" The surveyor summoned staff to the room to intervene and assist R32. At the time of incident licensed practical nurse (LPN)-A entered the room and placed R32 back into bed by swinging her feet back onto the bed. LPN-A did not provide any further cares for R32, leaving her positioned low in the bed. The bed and clothing were urine saturated. R32 was interviewed at the time of the observation and stated, "I needed to toilet a long time ago and they stated they would be back (referring to nursing assistant staff) but now it is too late."

On 5/24/16, at 10:41 a.m. activity aide (AA)-A entered R32's room with a wheelchair to assist R32 out of bed for activities and noted R32 was incontinent of urine. AA-A notified the nursing staff that R32 needed to be assisted with incontinence cares.

The care plan dated 5/18/16, identified R32 with an activity of daily living (ADL) self care performance deficit related to disease process, lethargy and muscle weakness evidenced by her inability to perform all ADL's independently. R32 was identified in the care plan to require supervision and direction, related to difficulty with sequencing tasks and tiredness or drowsiness any given time of day. The care plan further identified R32 with mixed incontinence and identified she would be aware of incontinent episodes and urges. Under the personal hygiene section of the care plan, R32 was identified to require set up help with supervision/direction and assist of 1 during toilet use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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
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The Bladder Assessment dated 8/24/15, identified R32 as incontinent daily on both day and nights. The assessment also identified R32 had urinary dribbling and had small incontinent episodes R32 was identified with no scheduled toilet plan.

When interviewed on 5/25/16, at 9:16 a.m. nursing assistant (NA)-A stated R32 was frequently "wet" and did not really tell staff when she needed to toilet. NA-A stated staff try to take R32 to the toilet in the morning and before and after meals. NA-A further stated R32 was frequently wet but did have the ability to know when she needed to void.

When interviewed on 5/25/16, at 11:42 a.m. NA-B stated R32 had the ability to be continent but stated R32 did not always comply. NA-B stated on some days R32 would take herself to the toilet and other days staff had to assist her. NA-B stated she was unaware of any toilet schedule for R32 and staff just check on her occasionally.

During review of the medical record a 5/4/16, nursing dayshift note identified R32 was on a toileting schedule. The night shift form dated 5/4/16, identified R32 required extensive assistance with toileting. A nurses note dated 4/4/16, identified R32 was continent of urine.

When interviewed on 5/25/16, at 1:58 p.m. RN-C stated when R32 was alert she was able to toilet herself. RN-C verified the care plan was not revised to identify R32's fluctuating toileting needs based on her alterations in abilities day to day.

During interview on 5/25/16, at 12:05 p.m. the director of nursing (DON) verified the plan of care

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F 280	Continued From page 6 should identify the need to toilet her at times when she is less able and should specify an individualized plan for toileting.	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide restorative services in accordance with the written plan of care for 4 of 4 residents (R36, R38, R39, R11) reviewed for limited range of motion (ROM). Findings include: R36 had diagnoses identified on the care plan dated 3/29/16, which included: chronic obstructive pulmonary disease, osteoarthritis of knee, major depression, atrial fibrillation and history of fracture to left tibia. The care plan dated 3/23/16, identified R36 had limited physical mobility related to recurrent flare-ups of chronic conditions causing weakness/pain evidenced by difficulty with balance transitions. The care plan identified R36 would maintain current level of mobility in bearing weight with transfers through next review. The care plan further identified R36 had a need for restorative intervention due to activity of daily living (ADL) self-care performance deficit/limited	F 282	R36, R38 and all other residents on a restorative program care plans have been reviewed and reflect the current needs of the residents. Restorative programs have been reorganized with Activities; if there is a need to pull a restorative aide to provide personal cares programs will be switched with Activities or an RN will complete. To assure programs are sustained the Restorative Nurse will audit all residents on a restorative plan weekly X4, then monthly X2 the referred to the QAPI committee for further recommendations.	6/17/16

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F 282	Continued From page 7 physical mobility. R36's care plan goals included R36 would remain free of complications related to immobility including contractures, thrombus formation, skin breakdown, fall related injury through the next review date through restorative nursing programming which included: (1). Active range of motion seated 1# dowel bilateral upper extremity twenty-five (25) repetitions three (3) times a week; (2.) Active ROM to left/right hand on top of head for five (5) repetitions for 5 second hold three (3) times weekly; (3.) Active ROM Nu-Step at level 4 up to 15 minutes 3 times a week; and (4.) Active ROM sit to stand in parallel bars up to 5 minutes 3 times a week. During review of R36's restorative service records for April 2016 the log identified R36 received ROM 1 time in 30 days. During review of the May 2016 restorative logs, R36 received restorative services 2 days out of 31 days. R38 had diagnoses identified on the care plan dated 3/9/16, which included: Parkinson's disease, muscle weakness, diabetes, chronic kidney disease, osteoarthritis bilateral knees, and Major depression. The care plan dated 3/9/16, identified R38 with limited physical mobility related to Parkinson's disease and weakness evidenced by physical limitations. The care plan also identified R38 had a need for restorative intervention due to the ADL self-care performance deficit and limited physical mobility. The restorative interventions were identified as follows: (1). Active ROM Nu-step level 3-4 for up to 10 minutes 5 times weekly; (2.) Active ROM knee extension- hip adduction and	F 282		

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abduction 2# each leg 15 repetitions 5 times weekly; (3) Active ROM hamstring curls with red or green band 15 repetitions each leg 5 times weekly; and (4.) Active ROM standing weight shifting with walker or in parallel bars 5 times weekly.

During review of R38's April 2016 restorative service records it identified that R38 received range of motion exercises 7 times in 30 days. The May 2016 restorative records identified R38 received services 8 days out of 31 days.

R39 had diagnoses identified on the care plan dated 3/30/16, that included: Parkinson's disease, atrial fibrillation, osteoporosis, heart failure and history of falls with fractures.

The care plan for R39 identified limited physical mobility related to physical limitations and included goals for R39 to maintain current level of mobility with transfers with assistive device through next review. The care plan further identified R39 had a need for restorative intervention due to ADL self-care performance deficit and limited physical mobility. R39's restorative goal was to maintain level of ambulation by walking to/from all meals up to 200 ft each way through next review. R39's care plan identified the following restorative measures to be utilized to support maintenance: (1.) Active ROM 4 sets of 5 repetitions wrist flexion, wrist extension, forearm supination/pronation three times weekly; (2.) Active ROM Nu-step for 10 minutes at level 4 three times weekly; (3) Active ROM standing balance activities three times weekly; and (4.) Walking with stand by assist of 1 using four wheeled walker to/from all meals. During review of R39's restorative service records

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for the month of April 2016, documentation on the log identified R39 received ROM exercises 2 times in 30 days. During review of the May 2016 restorative logs, documentation indicated R39 received services 2 days out of 31 days.
R11's care plan dated 3/20/16, identified R11 with the following diagnoses: Parkinson's disease, pain, major depression, atrial fibrillation, anemia and chronic kidney disease.
R11's care plan identified R11 had limited physical mobility related to Parkinson's and arthritis evidenced by physical limitations. R11's goal identified he would maintain the ability to ambulate as some means of locomotion up to 100-200 feet (ft) at a time through next review.
The care plan further identified R11 had a need for restorative intervention due to ADL self-care performance deficit with limited physical mobility.
The restorative interventions included the following: (1.) Active ROM Nu-step level 3-4 for 10-15 min duration 3-5 times weekly; (2.) Walking with assist of 2 followed with wheelchair 50-150 ft 3 times weekly; and
(3.) Walking with assist of 2 followed by w/c outside of room 1 time daily.
During review of R11's restorative service records for April 2016 the log identified R11 received ROM exercises 6 times in 30 days. During review of the May 2016 logs for restorative services, R11 was identified to receive services 4 days out of 31 days.

When interviewed on 5/25/16, at 9:38 a.m. the director of nursing (DON) verified the restorative aide was re-assigned to provide personal cares multiple times in the past 2 months so the plan of care could not be implemented as written.

During interview with restorative nursing aide

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F 282	Continued From page 10 (RNA)-A on 5/25/16, at 3:00 p.m. RNA-A stated supervisory staff had pulled her from restorative services multiple times in the past two months to work as a nursing assistant (NA) to provide personal cares. RNA-A stated she was unable to provide the established restorative programs when reassigned duties. During interviews with nursing assistant (NA)-A, NA-B and NA-C on 5/25/16, at 3:40 p.m. each of the NA's stated they did not have time to perform the restorative program duties when a restorative aide was not specifically assigned those duties.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure 1 of 1 resident (R32) in the sample identified as frequently incontinent of urine, was assessed to assure appropriate treatment and services were implemented to minimize urinary incontinence. Findings include:	F 315	R32 care plan has been updated on toileting plan to reflect her current level of function. All other residents who were at risk for urinary incontinence have been reviewed to assure they are receiving necessary treatment and services. Random audits will be completed on delivery of care to ensure appropriate care	6/17/16

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F 315	Continued From page 11	F 315	and services are delivered. Audits will be done weekly times 4, then 2 times a month then as determined by QAPI committee.	

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R32's quarterly Minimum Data Set (MDS) dated 5/11/16, identified R32 had a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition. The MDS further identified R32 with frequent incontinence requiring extensive assistance of one staff to manage.

On 5/24/16, at 10:30 a.m. R32 was observed during morning cares lying in bed with her feet hanging over the side of the bed. R32's bed and sheets were noted to be heavily saturated with urine. R32 stated, "Can you help me I am going to fall out of bed?" The surveyor summoned staff to the room to intervene and assist R32. At the time of incident licensed practical nurse (LPN)-A entered the room and placed R32 back into bed by swinging her feet back onto the bed. LPN-A did not provide any further cares for R32, leaving her positioned low in the bed. The bed and clothing were urine saturated. R32 was interviewed at the time of the observation and stated, "I needed to toilet a long time ago and they stated they would be back (referring to nursing assistant staff) but now it is too late."

On 5/24/16, at 10:41 a.m. activity aide (AA)-A entered R32's room with a wheelchair to assist R32 out of bed for activities and noted R32 was incontinent of urine. AA-A notified the nursing staff that R32 needed to be assisted with incontinence cares.

The care plan dated 5/18/16, identified R32 with an activity of daily living (ADL) self care performance deficit related to disease process, lethargy and muscle weakness evidenced by her inability to perform all ADL's independently. R32 was identified in the care plan to require

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supervision and direction, related to difficulty with sequencing tasks and tiredness or drowsiness any given time of day. The care plan further identified R32 with mixed incontinence and identified she would be aware of incontinent episodes and urges. Under the personal hygiene section of the care plan, R32 was identified to require set up help with supervision/direction and assist of 1 during toilet use.

The Bladder Assessment dated 8/24/15, identified R32 as incontinent daily on both day and nights. The assessment also identified R32 had urinary dribbling and had small incontinent episodes R32 was identified with no scheduled toilet plan.

When interviewed on 5/25/16, at 9:16 a.m. nursing assistant (NA)-A stated R32 was frequently "wet" and did not really tell staff when she needed to toilet. NA-A stated staff try to take R32 to the toilet in the morning and before and after meals. NA-A further stated R32 was frequently wet but did have the ability to know when she needed to void.

When interviewed on 5/25/16, at 11:42 a.m. NA-B stated R32 had the ability to be continent but stated R32 did not always comply. NA-B stated on some days R32 would take herself to the toilet and other days staff had to assist her. NA-B stated she was unaware of any toilet schedule for R32 and staff just check on her occasionally.

During review of the medical record a 5/4/16, nursing dayshift note identified R32 was on a toileting schedule. The night shift form dated 5/4/16, identified R32 required extensive assistance with toileting. A nurses note dated 4/4/16, identified R32 was continent of urine.

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F 315	Continued From page 13 During interview with registered nurse (RN)-A on 5/25/16, at 1:37 p.m. RN-A stated she was unsure how staff determined her toileting needs. RN-A stated she thought a three day bladder tracking assessment was conducted to determine toileting needs but was unable to verify and/or identify a completed diary in R32's medical record. When interviewed on 5/25/16, at 1:58 p.m. RN-C stated when R32 was alert she was able to toilet herself. RN-C verified the care plan was not revised to identify R32's fluctuating toileting needs based on her alterations in abilities day to day. During interview on 5/25/16, at 12:05 p.m. the director of nursing (DON) verified R32's care plan should specifically identify the need to toilet her at times when she is less able and should specify an individualized plan for toileting. Although the plan of care identified R32 was incontinent, it lacked individualized interventions based on a comprehensive bladder assessment to provide the necessary services for R32 to maintain her urinary status.	F 315		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		6/17/16

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F 318	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the assessed treatment and services for 4 of 4 residents (R36, R38, R39, R11) reviewed with limited range of motion (ROM). Findings include: R36 had diagnoses identified on the care plan dated 3/29/16, which included: chronic obstructive pulmonary disease, osteoarthritis of knee, major depression, atrial fibrillation and history of fracture to left tibia. The quarterly Minimum Data Set (MDS) assessment dated 3/9/16, identified R36 required extensive assist of 1-2 staff with all ADLs except eating and had limited functional ROM in one lower extremity. The care plan dated 3/23/16, identified R36 had limited physical mobility related to recurrent flare-ups of chronic conditions causing weakness/pain evidenced by difficulty with balance transitions. The care plan identified R36 would maintain current level of mobility in bearing weight with transfers through next review. The care plan further identified R36 had a need for restorative intervention due to activity of daily living (ADL) self-care performance deficit/limited physical mobility. R36's care plan goals included R36 would remain free of complications related to immobility including contractures, thrombus formation, skin	F 318	R36, R38, R39,R11 and all other residents on a restorative program care plans have been reviewed and reflect the current needs of the residents. Restorative programs have been reorganized with Activities; if there is a need to pull a restorative aide to provide personal cares programs will be switched with Activities or an RN will complete. To assure programs are appropriate and sustained Restorative Nurse will audit all residents on a restorative plan weekly X4, the monthly X2 the referred to the QAPI committee for further recommendations.	

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breakdown, fall related injury through the next review date through restorative nursing programming which included: (1). Active range of motion seated 1# dowel bilateral upper extremity twenty-five (25) repetitions three (3) times a week; (2.) Active ROM to left/right hand on top of head for five (5) repetitions for 5 second hold three (3) times weekly; (3.) Active ROM Nu-Step at level 4 up to 15 minutes 3 times a week; and (4.) Active ROM sit to stand in parallel bars up to 5 minutes 3 times a week.

During review of R36's restorative service records for April 2016 the log identified R36 received ROM 1 time in 30 days. During review of the May 2016 restorative logs, R36 received restorative services 2 days out of 31 days.

R38 had diagnoses identified on the care plan dated 3/9/16, which included: Parkinson's disease, muscle weakness, diabetes, chronic kidney disease, osteoarthritis bilateral knees, and Major depression.

The quarterly MDS dated 5/12/16, identified R38 with a Brief Interview for Mental Status Score (BIMS) of 14, indicating intact cognition. It also identified that R38 required extensive assist of 1-2 staff with all ADL's except ambulating and identified the activity of ambulating did not occur. The MDS also identified R38 with a balance problem when ambulating or transferring and identified he had limitation in functional ROM in bilateral lower extremities.

The care plan dated 3/9/16, identified R38 with limited physical mobility related to Parkinson's disease and weakness evidenced by physical limitations. The care plan further identified R38

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had an ADL self care performance deficit related to health conditions with secondary complications evidenced by physical limitations and ADL support fluctuations noted specific to transfers and ambulating. R38's goals identified R38 would maintain his current level of function in bed mobility, transfers, dressing, toilet use and personal hygiene through next review. The care plan also identified R38 had a need for restorative intervention due to the ADL self-care performance deficit and limited physical mobility. The restorative interventions were identified as follows: (1). Active ROM Nu-step level 3-4 for up to 10 minutes 5 times weekly; (2.) Active ROM knee extension- hip adduction and abduction 2# each leg 15 repetitions 5 times weekly; (3) Active ROM hamstring curls with red or green band 15 repetitions each leg 5 times weekly; and (4.) Active ROM standing weight shifting with walker or in parallel bars 5 times weekly.

During review of R38's April 2016 restorative service records it identified that R38 received range of motion exercises 7 times in 30 days. The May 2016 restorative records identified R38 received services 8 days out of 31 days.

R39 had diagnoses identified on the care plan dated 3/30/16, that included: Parkinson's disease, atrial fibrillation, osteoporosis, heart failure and history of falls with fractures.

R39's annual MDS dated 3/16/16, identified R39 with a Brief Interview for Mental Status Score (BIMS) of 15, indicating intact cognition and identified R39 required extensive assist of 1-2 staff with all ADL's except eating and indicated she only required supervision. The MDS also identified R39 with a balance problem when

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F 318	Continued From page 17 ambulating or transferring. The care plan for R39 identified limited physical mobility related to physical limitations and included goals for R39 to maintain current level of mobility with transfers with assistive device through next review. The care plan further identified R39 had a need for restorative intervention due to ADL self-care performance deficit and limited physical mobility. R39's restorative goal was to maintain level of ambulation by walking to/from all meals up to 200 ft each way through next review. R39's care plan identified the following restorative measures to be utilized to support maintenance: (1.) Active ROM 4 sets of 5 repetitions wrist flexion, wrist extension, forearm supination/pronation three times weekly; (2.) Active ROM Nu-step for 10 minutes at level 4 three times weekly; (3) Active ROM standing balance activities three times weekly; and (4.) Walking with stand by assist of 1 using four wheeled walker to/from all meals. During review of R39's restorative service records for the month of April 2016, documentation on the log identified R39 received ROM exercises 2 times in 30 days. During review of the May 2016 restorative logs, documentation indicated R39 received services 2 days out of 31 days. R11's care plan dated 3/20/16, identified R11 with the following diagnoses: Parkinson's disease, pain, major depression, atrial fibrillation, anemia and chronic kidney disease. R11's quarterly MDS dated 3/16/16,11 identified R11 with a Brief Interview for Mental Status Score (BIMS) of 12, indicating mildly impaired cognition and identified R11 required extensive assist of 1-2 staff with all ADL's except eating and indicated he only required supervision. The MDS also identified R11 with a balance problem when	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING ______ B. WING ______	05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON JACKSON, MN 56143**

(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 318	Continued From page 18	F 318		

ambulating or transferring between surfaces. R11's care plan identified R11 had limited physical mobility related to Parkinson's and arthritis evidenced by physical limitations. R11's goal identified he would maintain the ability to ambulate as some means of locomotion up to 100-200 feet (ft) at a time through next review. The care plan further identified R11 had a need for restorative intervention due to ADL self-care performance deficit with limited physical mobility. The restorative interventions included the following: (1.) Active ROM Nu-step level 3-4 for 10-15 min duration 3-5 times weekly; (2.) Walking with assist of 2 followed with wheelchair 50-150 ft 3 times weekly; and
(3.) Walking with assist of 2 followed by w/c outside of room 1 time daily.
During review of R11's restorative service records for April 2016 the log identified R11 received ROM exercises 6 times in 30 days. During review of the May 2016 logs for restorative services, R11 was identified to receive services 4 days out of 31 days.

When interviewed on 5/25/16, at 9:38 a.m. the director of nursing (DON) verified the restorative aide was re-assigned to work on the floor (to provide personal cares) due to a NA who failed to show up for work today. The DON further verified the restorative aide was re-assigned to provide personal cares multiple times in the past 2 months.

During interview with restorative nursing aide (RNA)-A on 5/25/16, at 3:00 p.m. RNA-A stated supervisory staff had pulled her from restorative services multiple times in the past two months to work as a nursing assistant (NA) to provide personal cares. RNA-A stated she was unable to

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F 318	Continued From page 19 provide the established restorative programs when reassigned duties. RNA-A further stated the facility had been short of NA help recently and she was reassigned from restorative duties to help with general cares when there was not enough NA staff. During interviews with nursing assistant (NA)-A, NA-B and NA-C on 5/25/16, at 3:40 p.m. each of the NA's stated they did not have time to perform the restorative program duties when a restorative aide was not specifically assigned those duties. The NA's stated there was not enough staff to perform all the restorative programs when staff called in sick and/or if not showing up to work.	F 318		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that food was properly stored to prevent potential contamination and raw meats were thawed in a manner that prevents cross-contamination of other food in the refrigerator. This had the potential to affect all 44 residents residing in the facility.	F 371	Education was given to the Dietary Manager on rules and regulations of perishable food. Upon delivery from food supplier items will be properly stored. All Dietary staff will receive education on thawing of meat. Audits will be completed on food supply	6/20/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON JACKSON, MN 56143**

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F 371	Continued From page 20 Findings include: During an initial tour of the facility kitchen on 5/23/16, at 6:45 a.m. the walk in freezer was noted to have 3 stacks of boxes containing frozen food stored on the floor. The first stack comprised of one box of mixed vegetables and one box of peas. The second stack was comprised of one box of fruit cups. The third stack was comprised of one box of frozen burgers, vegetables, Brussels sprouts and a box of pork patties. During observation of the walk-in refrigerator it was noted that 2 stacks of food boxes were stored/placed directly on the floor. The first stack comprised of 2 boxes of egg blend; and the second stack consisted of one box creamy coleslaw, shelled eggs, and a 10 pound tube of raw ground beef. The ground beef was placed on the box of eggs while it was thawing in the refrigerator. The raw ground beef was not placed on a tray nor in a pan while it thawed to prevent the meat from dripping into the box of eggs beneath, resulting in potential cross contamination of food. When interviewed on 5/23/16, at 7:58 a.m., the dietary manager (DM) indicated the food supplier delivers food items on Mondays and Thursdays and placed the boxes of food directly on the refrigerator and freezer floors. The DM confirmed the noted stacked boxes of food were from the food delivery on Thursday 5/19/16, 4 days prior and were stored in this manner since. The DM confirmed the ground beef had been placed on top of the box of eggs, stating, that was "not the way we store meat". The DM further indicated the ground beef should be kept in the freezer and/or	F 371	delivery day weekly X1 month then randomly as determined by QAPI committee. Audits will be completed weekly X 4, monthly X2 then reviewed at QAPI meeting for further recommendations.	

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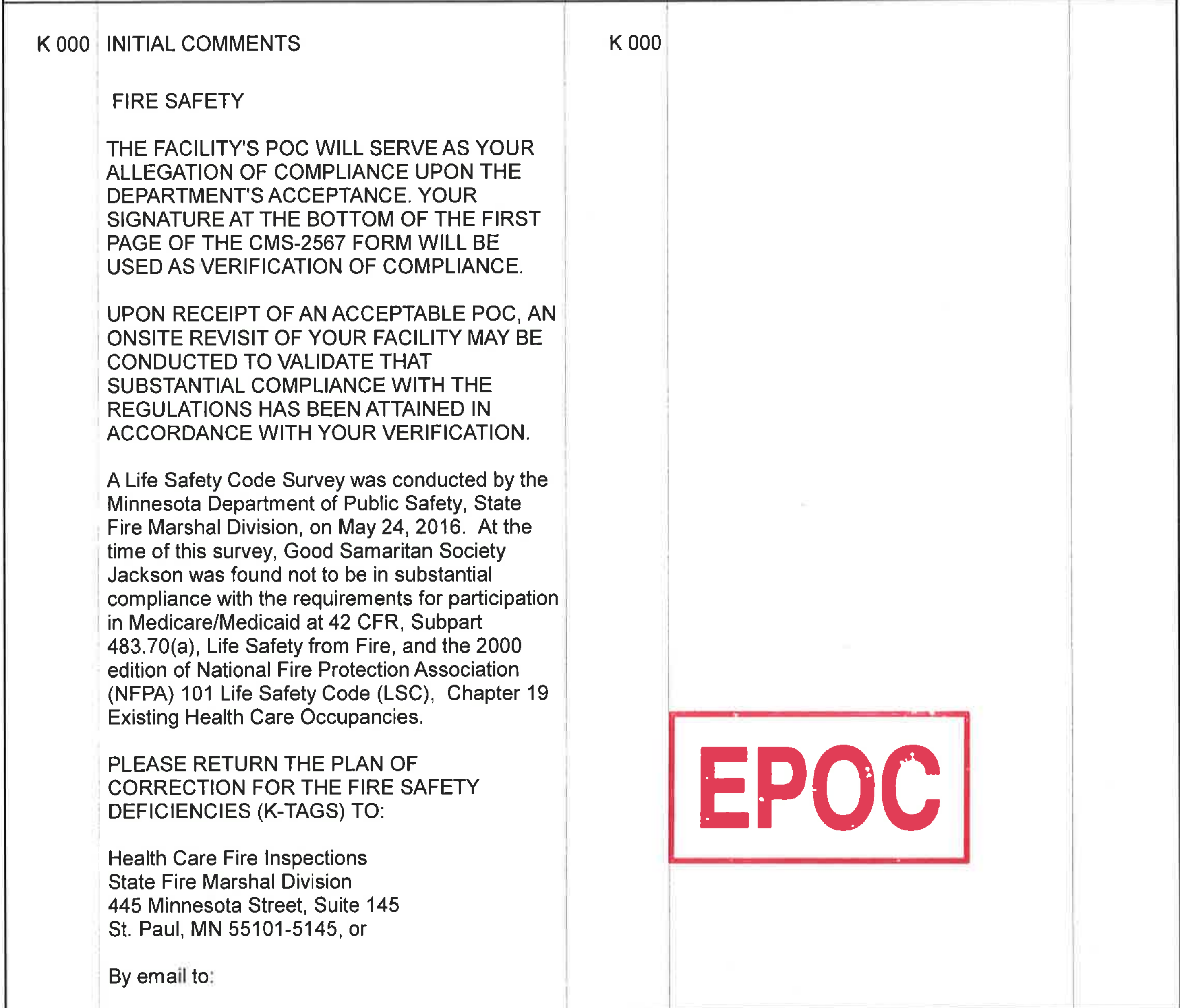
F 371	Continued From page 21 placed on the thawing rack to prevent dripping of meat juices. During a follow up interview on 5/26/15, at 11:33 a.m. the DM confirmed the above findings at this time and indicated the staff would need further education related to the safety of storage to prevent contamination. Although requested, no policy was submitted.	F 371		

F5455024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	601 WEST JACKSON JACKSON, MN 56143

(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	K 000		



FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on May 24, 2016. At the time of this survey, Good Samaritan Society Jackson was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145, or

By email to:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/19/2016

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

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K 000	Continued From page 1	K 000		

Marian.Whitney@state.mn.us
<mailto:Marian.Whitney@state.mn.us> and
Angela.Kappenman@state.mn.us
<mailto:Angela.Kappenman@state.mn.us>

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Good Samaritan Society Jackson was constructed as follows:
The original building was constructed in 1956, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type I(332) construction;
The 1st Addition was constructed in 1965, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type I(332) construction;
The 2nd Addition was constructed in 1976, is one-story, has a partial basement, is fully fire sprinklered protected and was determined to be of Type I(332) construction;
The 3rd Addition was constructed in 1996, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type I(332) construction.

The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire

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

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	245455	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/24/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON** **JACKSON, MN 56143**

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K 000	Continued From page 2 department notification. The facility has a capacity of 63 beds and had a census of 43 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 FINDINGS INCLUDE: On 05/24/2016 between 10:30 AM and 12:30 PM, during the inspection a penetration was observed around an electrical conduit above the lay in ceiling at the 2 hour fire separation wall at the Physical Therapy Entrance. This deficient practice was verfied by the Maintenance Supervisor.	K 011	The penetration above the therapy wing entrance around the electrical conduit on the southwest end of our building was filled with fire caulk to seal the penetration. This was completed by the maintenance director by June 3rd of	6/3/16

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K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 FINDINGS INCLUDE: During Facility Inspection on May 24, 2016, between the hours of 10:30 AM and 12:30 PM, observation revealed penetrations around five electrical conduits above the lay in ceiling at the smoke barrier in the North Central Hallway next to the Housekeeping Room. This deficient practice was verfied by the Maintenance Supervisor.	K 025	- The penetration above the north central hallway around the 5 electrical conduits was filled with fire caulk to seal the penetration. This was completed by the maintenance director by June 3rd of 2016.	6/3/16
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised	K 144	Approved technicians that work on	6/30/16

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K 144	Continued From page 4 under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) FINDINGS INCLUDE: During documentation review on May 24, 2016, between the hours of 10:30 AM and 12:30 PM, the following was discovered: 1.) During documentation review, it was revealed that the transfer time from normal to emergency power and cool down time was not documented on the Monthly Emergency Generator Test Report. 2.) During documentation review, it was revealed that documentation could not be provided to indicate that the Weekly Generator Inspection was conducted during the following weeks: 1/5/16 to 1/9/16, 1/19/16 to 1/23/16, 1/26/16 to 1/30/16 and 2/2/16 to 2/6/16. This deficient practice was verfied by the Maintenance Supervisor.	K 144	generators will come and install a meter and/or program it so that we will be able to document the transfer and cool down times. These times will be documented on the weekly generator inspection report that the maintenance department is responsible for filling out. This is scheduled to take place on June 30, 2016	

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
June 10, 2016

Mr. Daren Rife, Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, MN 56143

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5455027

Dear Mr. Rife:

The above facility was surveyed on May 23, 2016 through May 26, 2016 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, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the

correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Kathryn Serie, Unit Supervisor at (507) 476-4233.

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

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

Please feel free to call me with any questions.

Sincerely,

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00303	A. BUILDING: ______ B. WING ______	05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON JACKSON, MN 56143**

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2 000	Initial Comments	2 000		

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On May 23rd, 24th, 25th and 26th 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide restorative services in accordance with the written plan of care for 4 of 4 residents (R36, R38, R39, R11) reviewed for limited range of motion (ROM). Findings include: R36 had diagnoses identified on the care plan dated 3/29/16, which included: chronic obstructive pulmonary disease, osteoarthritis of knee, major depression, atrial fibrillation and history of fracture to left tibia. The care plan dated 3/23/16, identified R36 had limited physical mobility related to recurrent flare-ups of chronic conditions causing weakness/pain evidenced by difficulty with balance transitions. The care plan identified R36 would maintain current level of mobility in bearing weight with transfers through next review. The	2 565	Corrected	6/17/16

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2 565	Continued From page 3	2 565		

care plan further identified R36 had a need for restorative intervention due to activity of daily living (ADL) self-care performance deficit/limited physical mobility.

R36's care plan goals included R36 would remain free of complications related to immobility including contractures, thrombus formation, skin breakdown, fall related injury through the next review date through restorative nursing programming which included: (1). Active range of motion seated 1# dowel bilateral upper extremity twenty-five (25) repetitions three (3) times a week; (2.) Active ROM to left/right hand on top of head for five (5) repetitions for 5 second hold three (3) times weekly; (3.) Active ROM Nu-Step at level 4 up to 15 minutes 3 times a week; and (4.) Active ROM sit to stand in parallel bars up to 5 minutes 3 times a week.

During review of R36's restorative service records for April 2016 the log identified R36 received ROM 1 time in 30 days. During review of the May 2016 restorative logs, R36 received restorative services 2 days out of 31 days.

R38 had diagnoses identified on the care plan dated 3/9/16, which included: Parkinson's disease, muscle weakness, diabetes, chronic kidney disease, osteoarthritis bilateral knees, and Major depression.

The care plan dated 3/9/16, identified R38 with limited physical mobility related to Parkinson's disease and weakness evidenced by physical limitations. The care plan also identified R38 had a need for restorative intervention due to the ADL self-care performance deficit and limited physical mobility. The restorative interventions were identified as follows: (1). Active ROM Nu-step

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level 3-4 for up to 10 minutes 5 times weekly; (2.) Active ROM knee extension- hip adduction and abduction 2# each leg 15 repetitions 5 times weekly; (3) Active ROM hamstring curls with red or green band 15 repetitions each leg 5 times weekly; and (4.) Active ROM standing weight shifting with walker or in parallel bars 5 times weekly.

During review of R38's April 2016 restorative service records it identified that R38 received range of motion exercises 7 times in 30 days. The May 2016 restorative records identified R38 received services 8 days out of 31 days.

R39 had diagnoses identified on the care plan dated 3/30/16, that included: Parkinson's disease, atrial fibrillation, osteoporosis, heart failure and history of falls with fractures.

The care plan for R39 identified limited physical mobility related to physical limitations and included goals for R39 to maintain current level of mobility with transfers with assistive device through next review. The care plan further identified R39 had a need for restorative intervention due to ADL self-care performance deficit and limited physical mobility. R39's restorative goal was to maintain level of ambulation by walking to/from all meals up to 200 ft each way through next review. R39's care plan identified the following restorative measures to be utilized to support maintenance: (1.) Active ROM 4 sets of 5 repetitions wrist flexion, wrist extension, forearm supination/pronation three times weekly; (2.) Active ROM Nu-step for 10 minutes at level 4 three times weekly; (3) Active ROM standing balance activities three times weekly; and (4.) Walking with stand by assist of 1 using four wheeled walker to/from all meals.

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2 565	Continued From page 5	2 565		

During review of R39's restorative service records for the month of April 2016, documentation on the log identified R39 received ROM exercises 2 times in 30 days. During review of the May 2016 restorative logs, documentation indicated R39 received services 2 days out of 31 days.
R11's care plan dated 3/20/16, identified R11 with the following diagnoses: Parkinson's disease, pain, major depression, atrial fibrillation, anemia and chronic kidney disease.
R11's care plan identified R11 had limited physical mobility related to Parkinson's and arthritis evidenced by physical limitations. R11's goal identified he would maintain the ability to ambulate as some means of locomotion up to 100-200 feet (ft) at a time through next review. The care plan further identified R11 had a need for restorative intervention due to ADL self-care performance deficit with limited physical mobility. The restorative interventions included the following: (1.) Active ROM Nu-step level 3-4 for 10-15 min duration 3-5 times weekly; (2.) Walking with assist of 2 followed with wheelchair 50-150 ft 3 times weekly; and
(3.) Walking with assist of 2 followed by w/c outside of room 1 time daily.
During review of R11's restorative service records for April 2016 the log identified R11 received ROM exercises 6 times in 30 days. During review of the May 2016 logs for restorative services, R11 was identified to receive services 4 days out of 31 days.

When interviewed on 5/25/16, at 9:38 a.m. the director of nursing (DON) verified the restorative aide was re-assigned to provide personal cares multiple times in the past 2 months so the plan of care could not be implemented as written.

During interview with restorative nursing aide

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2 565	Continued From page 6 (RNA)-A on 5/25/16, at 3:00 p.m. RNA-A stated supervisory staff had pulled her from restorative services multiple times in the past two months to work as a nursing assistant (NA) to provide personal cares. RNA-A stated she was unable to provide the established restorative programs when reassigned duties. During interviews with nursing assistant (NA)-A, NA-B and NA-C on 5/25/16, at 3:40 p.m. each of the NA's stated they did not have time to perform the restorative program duties when a restorative aide was not specifically assigned those duties. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least	2 570		6/17/16

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2 570	Continued From page 7 quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan to identify interventions that were effective based on the assessment for 1 of 1 resident (R32) reviewed for urinary status. Findings include: R32's quarterly Minimum Data Set (MDS) dated 5/11/16, identified R32 had a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition. The MDS further identified R32 with frequent incontinence requiring extensive assistance of one staff to manage. On 5/24/16, at 10:30 a.m. R32 was observed during morning cares lying in bed with her feet hanging over the side of the bed. R32's bed and sheets were noted to be heavily saturated with urine. R32 stated, "Can you help me I am going to fall out of bed?" The surveyor summoned staff to the room to intervene and assist R32. At the time of incident licensed practical nurse (LPN)-A entered the room and placed R32 back into bed by swinging her feet back onto the bed. LPN-A did not provide any further cares for R32, leaving her positioned low in the bed. The bed and clothing were urine saturated. R32 was interviewed at the time of the observation and stated, "I needed to toilet a long time ago and they stated they would be back (referring to nursing assistant staff) but now it is too late."	2 570	Corrected	

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2 570	Continued From page 8	2 570		

On 5/24/16, at 10:41 a.m. activity aide (AA)-A entered R32's room with a wheelchair to assist R32 out of bed for activities and noted R32 was incontinent of urine. AA-A notified the nursing staff that R32 needed to be assisted with incontinence cares.

The care plan dated 5/18/16, identified R32 with an activity of daily living (ADL) self care performance deficit related to disease process, lethargy and muscle weakness evidenced by her inability to perform all ADL's independently. R32 was identified in the care plan to require supervision and direction, related to difficulty with sequencing tasks and tiredness or drowsiness any given time of day. The care plan further identified R32 with mixed incontinence and identified she would be aware of incontinent episodes and urges. Under the personal hygiene section of the care plan, R32 was identified to require set up help with supervision/direction and assist of 1 during toilet use.

The Bladder Assessment dated 8/24/15, identified R32 as incontinent daily on both day and nights. The assessment also identified R32 had urinary dribbling and had small incontinent episodes R32 was identified with no scheduled toilet plan.

When interviewed on 5/25/16, at 9:16 a.m. nursing assistant (NA)-A stated R32 was frequently "wet" and did not really tell staff when she needed to toilet. NA-A stated staff try to take R32 to the toilet in the morning and before and after meals. NA-A further stated R32 was frequently wet but did have the ability to know when she needed to void.

When interviewed on 5/25/16, at 11:42 a.m. NA-B stated R32 had the ability to be continent but

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2 570	Continued From page 9 stated R32 did not always comply. NA-B stated on some days R32 would take herself to the toilet and other days staff had to assist her. NA-B stated she was unaware of any toilet schedule for R32 and staff just check on her occasionally. During review of the medical record a 5/4/16, nursing dayshift note identified R32 was on a toileting schedule. The night shift form dated 5/4/16, identified R32 required extensive assistance with toileting. A nurses note dated 4/4/16, identified R32 was continent of urine. When interviewed on 5/25/16, at 1:58 p.m. RN-C stated when R32 was alert she was able to toilet herself. RN-C verified the care plan was not revised to identify R32's fluctuating toileting needs based on her alterations in abilities day to day. During interview on 5/25/16, at 12:05 p.m. the director of nursing (DON) verified the plan of care should identify the need to toilet her at times when she is less able and should specify an individualized plan for toileting. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could provide training for all nursing staff and review current policy related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin	2 840		6/17/16

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Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:

B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence.

[144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.]

Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and

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2 840	Continued From page 11	2 840		

clothing must be removed immediately from resident areas to prevent odors.

This MN Requirement is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to ensure 1 of 1 resident (R32) in the sample identified as frequently incontinent of urine, was assessed to assure appropriate treatment and services were implemented to minimize urinary incontinence.

Corrected

Findings include:

R32's quarterly Minimum Data Set (MDS) dated 5/11/16, identified R32 had a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition. The MDS further identified R32 with frequent incontinence requiring extensive assistance of one staff to manage.

On 5/24/16, at 10:30 a.m. R32 was observed during morning cares lying in bed with her feet hanging over the side of the bed. R32's bed and sheets were noted to be heavily saturated with urine. R32 stated, "Can you help me I am going to fall out of bed?" The surveyor summoned staff to the room to intervene and assist R32. At the time of incident licensed practical nurse (LPN)-A entered the room and placed R32 back into bed by swinging her feet back onto the bed. LPN-A did not provide any further cares for R32, leaving her positioned low in the bed. The bed and clothing were urine saturated. R32 was interviewed at the time of the observation and stated, "I needed to toilet a long time ago and they stated they would be back (referring to nursing assistant staff) but now it is too late."

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2 840	Continued From page 12	2 840		

On 5/24/16, at 10:41 a.m. activity aide (AA)-A entered R32's room with a wheelchair to assist R32 out of bed for activities and noted R32 was incontinent of urine. AA-A notified the nursing staff that R32 needed to be assisted with incontinence cares.

The care plan dated 5/18/16, identified R32 with an activity of daily living (ADL) self care performance deficit related to disease process, lethargy and muscle weakness evidenced by her inability to perform all ADL's independently. R32 was identified in the care plan to require supervision and direction, related to difficulty with sequencing tasks and tiredness or drowsiness any given time of day. The care plan further identified R32 with mixed incontinence and identified she would be aware of incontinent episodes and urges. Under the personal hygiene section of the care plan, R32 was identified to require set up help with supervision/direction and assist of 1 during toilet use.

The Bladder Assessment dated 8/24/15, identified R23 as incontinent daily on both day and nights. The assessment also identified R23 had urinary dribbling and had small incontinent episodes R32 was identified with no scheduled toilet plan.

When interviewed on 5/25/16, at 9:16 a.m. nursing assistant (NA)-A stated R32 was frequently "wet" and did not really tell staff when she needed to toilet. NA-A stated staff try to take R32 to the toilet in the morning and before and after meals. NA-A further stated R32 was frequently wet but did have the ability to know when she needed to void.

When interviewed on 5/25/16, at 11:42 a.m. NA-B

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2 840	Continued From page 13	2 840		

stated R32 had the ability to be continent but stated R32 did not always comply. NA-B stated on some days R32 would take herself to the toilet and other days staff had to assist her. NA-B stated she was unaware of any toilet schedule for R32 and staff just check on her occasionally.

During review of the medical record a 5/4/16, nursing dayshift note identified R32 was on a toileting schedule. The night shift form dated 5/4/16, identified R32 required extensive assistance with toileting. A nurses note dated 4/4/16, identified R32 was continent of urine.

During interview with registered nurse (RN)-A on 5/25/16, at 1:37 p.m. RN-A stated she was unsure how staff determined her toileting needs. RN-A stated she thought a three day bladder tracking assessment was conducted to determine toileting needs but was unable to verify and/or identify a completed diary in R32's medical record.

When interviewed on 5/25/16, at 1:58 p.m. RN-C stated when R32 was alert she was able to toilet herself. RN-C verified the care plan was not revised to identify R32's fluctuating toileting needs based on her alterations in abilities day to day.

During interview on 5/25/16, at 12:05 p.m. the director of nursing (DON) verified R32's care plan should specifically identify the need to toilet her at times when she is less able and should specify an individualized plan for toileting.

Although the plan of care identified R32 was incontinent, it lacked individualized interventions based on a bladder assessment to provide the necessary services for R32 to maintain her

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 840	Continued From page 14 urinary status. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents at risk for urinary incontinence to assure they are receiving the necessary treatment and services. The director of nursing or designee could develop a system to conduct random audits of the delivery of care to ensure appropriate care and serves are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the assessed treatment and services for 4 of 4 residents (R36,	2 895	Corrected	6/17/16

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2 895	Continued From page 15 R38, R39, R11) reviewed with limited range of motion (ROM). Findings include: R36 had diagnoses identified on the care plan dated 3/29/16, which included: chronic obstructive pulmonary disease, osteoarthritis of knee, major depression, atrial fibrillation and history of fracture to left tibia. The quarterly Minimum Data Set (MDS) assessment dated 3/9/16, identified R36 required extensive assist of 1-2 staff with all ADLs except eating and had limited functional ROM in one lower extremity. The care plan dated 3/23/16, identified R36 had limited physical mobility related to recurrent flare-ups of chronic conditions causing weakness/pain evidenced by difficulty with balance transitions. The care plan identified R36 would maintain current level of mobility in bearing weight with transfers through next review. The care plan further identified R36 had a need for restorative intervention due to activity of daily living (ADL) self-care performance deficit/limited physical mobility. R36's care plan goals included R36 would remain free of complications related to immobility including contractures, thrombus formation, skin breakdown, fall related injury through the next review date through restorative nursing programming which included: (1). Active range of motion seated 1# dowel bilateral upper extremity twenty-five (25) repetitions three (3) times a week; (2.) Active ROM to left/right hand on top of head for five (5) repetitions for 5 second hold three (3) times weekly; (3.) Active ROM Nu-Step	2 895		

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2 895	Continued From page 16	2 895		

at level 4 up to 15 minutes 3 times a week; and (4.) Active ROM sit to stand in parallel bars up to 5 minutes 3 times a week.

During review of R36's restorative service records for April 2016 the log identified R36 received ROM 1 time in 30 days. During review of the May 2016 restorative logs, R36 received restorative services 2 days out of 31 days.

R38 had diagnoses identified on the care plan dated 3/9/16, which included: Parkinson's disease, muscle weakness, diabetes, chronic kidney disease, osteoarthritis bilateral knees, and Major depression.

The quarterly MDS dated 5/12/16, identified R38 with a Brief Interview for Mental Status Score (BIMS) of 14, indicating intact cognition. It also identified that R38 required extensive assist of 1-2 staff with all ADL's except ambulating and identified the activity of ambulating did not occur. The MDS also identified R38 with a balance problem when ambulating or transferring and identified he had limitation in functional ROM in bilateral lower extremities.

The care plan dated 3/9/16, identified R38 with limited physical mobility related to Parkinson's disease and weakness evidenced by physical limitations. The care plan further identified R38 had an ADL self care performance deficit related to health conditions with secondary complications evidenced by physical limitations and ADL support fluctuations noted specific to transfers and ambulating. R38's goals identified R38 would maintain his current level of function in bed mobility, transfers, dressing, toilet use and personal hygiene through next review. The care plan also identified R38 had a need for restorative

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2 895	Continued From page 17 intervention due to the ADL self-care performance deficit and limited physical mobility. The restorative interventions were identified as follows: (1). Active ROM Nu-step level 3-4 for up to 10 minutes 5 times weekly; (2.) Active ROM knee extension- hip adduction and abduction 2# each leg 15 repetitions 5 times weekly; (3) Active ROM hamstring curls with red or green band 15 repetitions each leg 5 times weekly; and (4.) Active ROM standing weight shifting with walker or in parallel bars 5 times weekly. During review of R38's April 2016 restorative service records it identified that R38 received range of motion exercises 7 times in 30 days. The May 2016 restorative records identified R38 received services 8 days out of 31 days. R39 had diagnoses identified on the care plan dated 3/30/16, that included: Parkinson's disease, atrial fibrillation, osteoporosis, heart failure and history of falls with fractures. R39's annual MDS dated 3/16/16, identified R39 with a Brief Interview for Mental Status Score (BIMS) of 15, indicating intact cognition and identified R39 required extensive assist of 1-2 staff with all ADL's except eating and indicated she only required supervision. The MDS also identified R39 with a balance problem when ambulating or transferring. The care plan for R39 identified limited physical mobility related to physical limitations and included goals for R39 to maintain current level of mobility with transfers with assistive device through next review. The care plan further identified R39 had a need for restorative intervention due to ADL self-care performance deficit and limited physical mobility. R39's restorative goal was to maintain level of	2 895		

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2 895	Continued From page 18	2 895		

ambulation by walking to/from all meals up to 200 ft each way through next review.
R39's care plan identified the following restorative measures to be utilized to support maintenance: (1.) Active ROM 4 sets of 5 repetitions wrist flexion, wrist extension, forearm supination/pronation three times weekly; (2.) Active ROM Nu-step for 10 minutes at level 4 three times weekly; (3) Active ROM standing balance activities three times weekly; and (4.) Walking with stand by assist of 1 using four wheeled walker to/from all meals.
During review of R39's restorative service records for the month of April 2016, documentation on the log identified R39 received ROM exercises 2 times in 30 days. During review of the May 2016 restorative logs, documentation indicated R39 received services 2 days out of 31 days.
R11's care plan dated 3/20/16, identified R11 with the following diagnoses: Parkinson's disease, pain, major depression, atrial fibrillation, anemia and chronic kidney disease.
R11's quarterly MDS dated 3/16/16,11 identified R11 with a Brief Interview for Mental Status Score (BIMS) of 12, indicating mildly impaired cognition and identified R11 required extensive assist of 1-2 staff with all ADL's except eating and indicated he only required supervision. The MDS also identified R11 with a balance problem when ambulating or transferring.
R11's care plan identified R11 had limited physical mobility related to Parkinson's and arthritis evidenced by physical limitations. R11's goal identified he would maintain the ability to ambulate as some means of locomotion up to 100-200 feet (ft) at a time through next review.
The care plan further identified R11 had a need for restorative intervention due to ADL self-care performance deficit with limited physical mobility.
The restorative interventions included the

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2 895	Continued From page 19	2 895		

following: (1.) Active ROM Nu-step level 3-4 for 10-15 min duration 3-5 times weekly; (2.) Walking with assist of 2 followed with wheelchair 50-150 ft 3 times weekly; and
(3.) Walking with assist of 2 followed by w/c outside of room 1 time daily.

During review of R11's restorative service records for April 2016 the log identified R11 received ROM exercises 6 times in 30 days. During review of the May 2016 logs for restorative services, R11 was identified to receive services 4 days out of 31 days.

When interviewed on 5/25/16, at 9:38 a.m. the director of nursing (DON) verified the restorative aide was re-assigned to work on the floor (to provide personal cares) due to a NA who failed to show up for work today. The DON further verified the restorative aide was re-assigned to provide personal cares multiple times in the past 2 months.

During interview with restorative nursing aide (RNA)-A on 5/25/16, at 3:00 p.m. RNA-A stated supervisory staff had pulled her from restorative services multiple times in the past two months to work as a nursing assistant (NA) to provide personal cares. RNA-A stated she was unable to provide the established restorative programs when reassigned duties. RNA-A further stated the facility had been short of NA help recently and she was reassigned from restorative duties to help with general cares when there was not enough NA staff.

During interviews with nursing assistant (NA)-A, NA-B and NA-C on 5/25/16, at 3:40 p.m. each of the NA's stated they did not have time to perform the restorative program duties when a restorative

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2 895	Continued From page 20 aide was not specifically assigned those duties. The NA's stated there was not enough staff to perform all the restorative programs when staff called in sick and/or if not showing up to work. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure that food was properly stored to prevent potential contamination and raw meats were thawed in a manner that prevents cross-contamination of other food in the refrigerator. This had the potential to affect all 44 residents residing in the facility. Findings include:	21100	Corrected	6/20/16

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During an initial tour of the facility kitchen on 5/23/16, at 6:45 a.m. the walk in freezer was noted to have 3 stacks of boxes containing frozen food stored on the floor. The first stack comprised of one box of mixed vegetables and one box of peas. The second stack was comprised of one box of fruit cups. The third stack was comprised of one box of frozen burgers, vegetables, Brussels sprouts and a box of pork patties.

During observation of the walk-in refrigerator it was noted that 2 stacks of food boxes were stored/placed directly on the floor. The first stack comprised of 2 boxes of egg blend; and the second stack consisted of one box creamy coleslaw, shelled eggs, and a 10 pound tube of raw ground beef. The ground beef was placed on the box of eggs while it was thawing in the refrigerator. The raw ground beef was not placed on a tray nor in a pan while it thawed to prevent the meat from dripping into the box of eggs beneath, resulting in potential cross contamination of food.

When interviewed on 5/23/16, at 7:58 a.m., the dietary manager (DM) indicated the food supplier delivers food items on Mondays and Thursdays and placed the boxes of food directly on the refrigerator and freezer floors. The DM confirmed the noted stacked boxes of food were from the food delivery on Thursday 5/19/16, 4 days prior and were stored in this manner since. The DM confirmed the ground beef had been placed on top of the box of eggs, stating, that was "not the way we store meat". The DM further indicated the ground beef should kept in the freezer and/or placed on the thawing rack to prevent dripping of meat juices.

During a follow up interview on 5/26/15, at 11:33

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21100	Continued From page 22 a.m. the DM confirmed the above findings at this time and indicated the staff would need further education related to the safety of storage to prevent potential contamination. SUGGESTED METHOD FOR CORRECTION: The dietary director could review and revise policies related to storage and thawing of food in areas of potential contamination. The dietary director could provide education to all dietary staff and monitor for continued compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21100		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services in a dignified manner for 2 of 2 residents (R32, R38) reviewed for dignified services. Findings include: The quarterly MDS dated 5/11/16, for R32 identified a BIMS score of 14, indicating intact cognition. The MDS further identified R32 with frequent incontinence requiring extensive assistance of one staff to manage.	21805	Corrected	6/17/16

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When questioned about dignified treatment by staff on 5/23/16, at 10:46 a.m. R32 stated, "No, sometimes I don't get the help I need. They could treat you a little better with coming and helping. I don't think they are too kind sometimes. It doesn't make me feel very good to be left without help".

On 5/24/16, at 10:30 a.m. R32 was observed during morning cares lying in bed with her feet hanging over the side of the bed. R32's bed and sheets were noted to be heavily saturated with urine. R32 stated, "Can you help me I am going to fall out of bed?" The surveyor summoned staff to the room to intervene and assist R32. At the time of incident licensed practical nurse (LPN)-A entered the room and placed R32 back into bed by swinging her feet back onto the bed. LPN-A did not provide any further cares for R32, leaving her positioned low in the bed. The bed and clothing were noted to be urine saturated. R32 was interviewed at the time of the observation and stated, "I needed to toilet a long time ago and they stated they would be back (referring to nursing assistant staff) but now it is too late."

On 5/24/16, at 10:41 a.m. activity aide (AA)-A entered R32's room with a wheelchair to assist R32 out of bed for activities and noted R32 was incontinent of urine. AA-A notified the nursing staff that R32 needed to be assisted with incontinence cares.

The quarterly Minimum Data Set (MDS) assessment dated 5/12/16, identified R38 with a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS further identified R38 required extensive assistance of two staff with toileting, was frequently incontinent of urine with no toileting plan.

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On 5/24/16, at 11:15 a.m. R38 and resident representative (RR)-A requested to speak to the surveyor. During interview on 5/24/16, at 11:30 a.m. R38 and RR-A stated they did not feel staff responded to needs in a timely manner. RR-A stated when visiting daily with R32, RR-A noticed staff often did not provide R38 timely urinary continence services. RR-A stated, "Two weeks ago [R38] needed assistance with toileting and he turned his light (call light) on at 2:50 p.m. Staff entered the room and turned the light off and stated they would return to assist [R38]. Staff returned to assist [R38] at 3:40 p.m. at which time he was totally saturated with urine." R38 verified the accounts of the event and stated he did not like to "wet" himself. R38 stated it was belittling to him to know he needed to toilet and when he did not receive timely assistance. When further interviewed, RR-A stated that when visiting a couple of days prior, R38 was left in bed, with pants pulled down below his knees and a urinal placed. RR-A indicated the urinal was left for 1 1/2 hrs before it was removed by staff. R38 verified the account described and indicated he felt like a "number" verses a person.

When interviewed on 5/25/16, at 12:05 p.m. the director of nursing (DON) verified the described services provided by staff for R38 and R32 would be considered undignified. The DON stated staff should meet the resident needs when the need occurs versus telling the resident they will return.

SUGGESTED METHOD OF CORRECTION: The facility could review their education and training in providing dignified care of vulnerable adults and review/implement policies and procedures for assuring dignified care. The facility could provide ongoing education and training and monitor for

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21805	Continued From page 25 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		