DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MPFF PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00303 1. MEDICARE/MEDICAID PROVIDER 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) GOOD SAMARITAN SOCIETY - JACKSON 245455 NO.(L1) 1. Initial 2. Recertification (L4) 601 WEST JACKSON 4. CHOW 3. Termination 2. STATE VENDOR OR MEDICAID NO. (L6) 56143 (L5) JACKSON, MN 5. Validation 6. Complaint 673342500 (L2) 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7)8. Full Survey After Complaint (1.9)05 HHA 09 ESRD 13 PTIP 01 Hospital 22 CLIA 6. DATE OF SURVEY 02 SNF/NF/Dual 06 PRTF 10 NF 7/7/2016 (L34) 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: __ (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 12 RHC 16 HOSPICE 12/31 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: x A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): ____ 2. Technical Personnel To (b): Program Requirements Scope of Services Limit Compliance Based On: ___ 3. 24 Hour RN Medical Director 4. 7-Day RN (Rural SNF) 1. Acceptable POC 8. Patient Room Size 12. Total Facility Beds 63 (L18) ___ 5. Life Safety Code ___ 9. Beds/Room 63 (L17) 13. Total Certified Beds B. Not in Compliance with Program Requirements and/or Applied Waivers: (L12)14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18/19 SNF ICF IID (L15)18 SNF 19 SNF 1861 (e) (1) or 1861 (i) (1): 63 (L37) (L38) (L39) (L42)(L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Wendy Willson, HFE NE II 08/3/2016 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 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) RIGHTS ACT: Facility is Eligible to Participate 3. Both of the Above: Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE **VOLUNTARY** INVOLUNTARY 04/01/1987 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L24)(L41)(L25)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal A. Suspension of Admissions: 07-Provider Status Change 00-Active (L44)(L27) B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 00140 (L31) (L28)

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)

31. RO RECEIPT OF CMS-1539



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, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

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

Kamala Fiske Downing

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

Kumala Fiske Downing

Minnesota Department of Health

 $\underline{Kamala.Fiske-Downing@state.mn.us}$

Telephone: (651) 201-4112

Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building			DATE OF REVIS	SIT
	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)	Correction	Reg. # (2)	280 3.20(d)(3), 483.10(k)	Correction Completed	Reg. #	F0282 483.20(k)(3)(ii)	Correction
LSC	06/17/2016	LSC		06/17/2016	LSC		06/17/2016
ID Prefix F0315	Correction	ID Prefix F0:		Correction	ID Prefix		Correction
Reg. # 483.25(d) LSC	06/17/2016	Reg. #	3.25(e)(2)	Completed 06/17/2016	Reg. # LSC	483.35(i)	06/20/2016
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC		-	LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC		-	LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. # LSC		Completed
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) KS/kfd	DATE 8/10/2016	SIGNATURE OF	SURVEYOR	370		7/7/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE				ATE
FOLLOWUP TO SURVEY COMPLETED ON 5/26/2016			FOR ANY UNCORRECTED DEFICIENCE				□YES □ NO

Form CMS - 2567B (09/92) EF (11/06)

Page 1 of 1

EVENT ID:

MPFF12

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01			DATE OF REV	ISIT
	B. Wing		Y2	7/12/2016	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 NFPA 101 Reg. #	Correction	ID Prefix Reg. #	NFPA 101	Correction	ID Prefix Reg. #	 NFPA 101	Correction
LSC K0011	06/03/2016	LSC	K0025	06/03/2016	LSC	K0144	06/30/2016
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
			<u> </u>				- -
ID PrefixReg. #	Completed	ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #		Correction
LSC		LSC			LSC		-
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. # LSC		Completed
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		-
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATUR	E 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

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

			STAT	E FORM: RE	ISIT REPORT				
IDENTIFI	ER / SUPPLIER / CLIA / CATION NUMBER	MULTIPLE CON A. Building	ISTRUCTIC	N					OF REVISIT
00303	Y1	B. Wing					Y2	7/7/20	716 _{Y3}
_	F FACILITY SAMARITAN SOCIETY	/ - JACKSON			STREET ADDRESS		, ZIP CODE		
	JAMPAR ATTACK GOODET	0/10/10011			JACKSON, MN 561				
correctiv	ort is completed by a secompleted by a secompletion prefix code previously.	ished. Each def	iciency sho	ould be fully ident	ified using either t	ne regulation	or LSC provisio	n numb	er and the
ITE	М	DATE	ITEM	l	DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix	20565	Correction	ID Prefix	20570	Correction	ID Prefix	20840		Correction
Reg. #	MN Rule 4658.0405 Subp. 3	Completed	Reg. #	MN Rule 4658.040 Subp. 4	Completed	Reg. #	MN Rule 4658.0 Subp. 2 B	520	Completed
LSC		06/17/2016	LSC		06/17/2016	LSC			06/17/2016
ID Prefix	20895	Correction	ID Prefix	21100	Correction	ID Prefix	21805		Correction
Reg. #	MN Rule 4658.0525 Subp. 2.B	Completed	Reg. #	MN Rule 4658.065 Subp. 5	Completed	Reg. #	MN St. Statute 1 Subd. 5	44.651	Completed
LSC		06/17/2016	LSC		07/07/2016	LSC			06/17/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	I Reg. #			Completed
LSC		_	LSC			LSC			=
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	I Reg. #			Completed
LSC		_	LSC			LSC			-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	I Reg. #			Completed

	_			
REVIEWED BY STATE AGENCY	REVIEWED BY	DATE	SIGNATURE OF SURVEYOR	DATE
] (INITIALS) KS/kfd	8/15/2016	37038	7/7/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVE 5/26/2016	Y COMPLETED ON		RANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF TED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	: □YES □ NO

LSC

☐ YES ☐ NO

EVENT ID: Page 1 of 1 MPFF12

LSC

5/26/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

		TO BE COMPI						Facility ID: 00303	
MEDICARE/MEDICAID PROVIE NO.(L1)		3. NAME AND AD (L3) GOOD SAM (L4) 601 WEST J (L5) JACKSON,	IARITAN SOC IACKSON		ACKSON (L6) 5	56143	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation		
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SU 01 Hospital	IPPLIER CATEG	09 ESRD	02 (L7) 13 PTIP 22 CLIA		7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 05/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	26/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR END:	ING DATE: (L35)	
11. LTC PERIOD OF CERTIFICATIO From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF	63 (L18) 63 (L17)	Compliance1. A: X B. Not in Con	equirements e Based On: cceptable POC	gram	2. Techi 3. 24 Ho 4. 7-Day 5. Life S	nical Personnel our RN y RN (Rural SN Safety Code 3* MEETS	The Following Requirem 6. Scope of S 7. Medical D F) 8. Patient Roo 9. Beds/Roon (L12)	iervices Limit irector om Size	
(L37) (L38)	(L39)	(L42)	(L43)						
STATE SURVEY AGENCY REM SURVEYOR SIGNATURE	ARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):	18. STATE SUR	VEV A CENCY	A DDD OVAI	Date:	
Susan Kalis, HFE	NE II		6/27/2016	(L19)			th Program Represe		
PA 19. DETERMINATION OF ELIGIBIT 1. Facility is Eligible to 1 2. Facility is not Eligible	LITY Participate	20. COM	BY HCFA RE		21. 1. St 2. O	atement of Finan	rate agency cial Solvency (HCFA-25 I Interest Disclosure Stm :		
22. ORIGINAL DATE OF PARTICIPATION 04/01/1987	23. LTC AGREEN BEGINNING		4. LTC AGREEN ENDING DA		26. TERMINAT VOLUNTARY 01-Merger, Closu	00		(L30) NTARY Meet Health/Safety	
(L24) 25. LTC EXTENSION DATE: (L27)	•	VE SANCTIONS n of Admissions:	(L25) (L44) (L45)		02-Dissatisfaction 03-Risk of Involut 04-Other Reason	ntary Termination	n <u>OTHER</u>	Meet Agreement der Status Change	
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/		(L31)	30. REMARKS				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE					

(L33)

DETERMINATION APPROVAL

(L32)



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Kumalu Fiske Downing

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

PRINTED: 06/27/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245455	B. WING _		05/26/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 000	as your allegation of Department's accepenrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will	F 00	00	
F 241 SS=D	on-site revisit of you validate that substate regulations has been your verification. 483.15(a) DIGNITY INDIVIDUALITY The facility must promanner and in an elementary each resident validation.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with AND RESPECT OF omote care for residents in a environment that maintains or ident's dignity and respect in its or her individuality.	F 24	41	6/17/16
	This REQUIREMENT by: Based on observer review the facility for dignified manner for reviewed for dignified Findings include: The quarterly MDS identified a BIMS so cognition. The MDS	NT is not met as evidenced tion, interview and document alled to provide services in a r 2 of 2 residents (R32, R38) and services. dated 5/11/16, for R32 core of 14, indicating intact of further identified R32 with ce requiring extensive		R32 and R38 care plans has been updated on toileting plan to reflect colevel of function. All other residents were at risk for urinary incontinence been reviewed to assure they are receiving necessary treatment and services. Nursing staff have been reeducated on assuring dignified car Random audits will be completed on delivery of care to ensure appropriat and services are delivered. Audits we done weekly times 4, then 2 times a month then as determined by QAPI	who have
ABORATORY	L Z DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE	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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245455	B. WING			05/2	26/2016
	PROVIDER OR SUPPLIER			601 W	ET ADDRESS, CITY, STATE, ZIP CODE VEST JACKSON KSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	staff on 5/23/16, a sometimes I don't treat you a little be don't think they are make me feel very. On 5/24/16, at 10:: during morning ca hanging over the sheets were noted urine. R32 stated, to fall out of bed?" to the room to inte time of incident lice entered the room a by swinging her fedid not provide any her positioned low clothing were note was interviewed at and stated, "I need they stated they we nursing assistant so On 5/24/16, at 10:: entered R32's room R32 out of bed for incontinent of uring staff that R32 need incontinence cares. The quarterly Minimassessment dated Brief Interview for 14, indicating intactidentified R38 required.	about dignified treatment by to 10:46 a.m. R32 stated, "No, get the help I need. They could tter with coming and helping. I se too kind sometimes. It doesn't good to be left without help". 30 a.m. R32 was observed res lying in bed with her feet ide of the bed. R32's bed and to be heavily saturated with "Can you help me I am going. The surveyor summoned staff revene and assist R32. At the ensed practical nurse (LPN)-A and placed R32 back into bed et back onto the bed. LPN-A or further cares for R32, leaving in the bed. The bed and doubt do be urine saturated. R32 the time of the observation ded to toilet a long time ago and build be back (referring to staff) but now it is too late." 41 a.m. activity aide (AA)-A m with a wheelchair to assist activities and noted R32 was exactivities and noted R32 was exactivities and noted R32 was exactivities and set (MDS). 5/12/16, identified R38 with a Mental Status (BIMS) score of exactivities as assistance of ing, was frequently incontinent	F 2		ommittee.		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING			05/2	26/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON		601 W	ET ADDRESS, CITY, STATE, ZIP CODE /EST JACKSON (SON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	representative (RR) surveyor. During int a.m. R38 and RR-A responded to needs stated when visiting staff often did not p continence services ago [R38] needed a turned his light (call entered the room a stated they would returned to assist [Fine was totally saturathe accounts of the like to "wet" himself to him to know he in did not receive time interviewed, RR-A scouple of days prior pants pulled down by placed. RR-A indicative account felt like a "number"	5 a.m. R38 and resident b-A requested to speak to the derview on 5/24/16, at 11:30 a stated they did not feel staff in a timely manner. RR-A daily with R32, RR-A noticed rovide R38 timely urinary is. RR-A stated, "Two weeks assistance with toileting and he light) on at 2:50 p.m. Staff and turned the light off and eturn to assist [R38]. Staff R38] at 3:40 p.m. at which time ated with urine." R38 verified event and stated he did not is. R38 stated it was belittling at eeded to toilet and when he ely assistance. When further stated that when visiting a rated that when visiting a rated the urinal was left for 1 as removed by staff. R38 at described and indicated he verses a person.	F 2	41			
F 280 SS=D	director of nursing (services provided b be considered undig should meet the res occurs versus telling 483.20(d)(3), 483.1 PARTICIPATE PLA	NNING CARE-REVISE CP e right, unless adjudged	F 2	80			6/17/16

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245455	B. WING			05/	26/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON		60	REET ADDRESS, CITY, STATE, ZIP CODE 1 WEST JACKSON ACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 280	incapacitated under participate in plann changes in care and A comprehensive of within 7 days after comprehensive assinterdisciplinary tear physician, a register for the resident, and disciplines as determined and, to the extent put the resident, the relegal representative	r the laws of the State, to ing care and treatment or	F2	80			
	by: Based on observa review the facility fa identify interventior the assessment for reviewed for urinar. Findings include: R32's quarterly Mir 5/11/16, identified F Mental Status (BIM intact cognition. Th with frequent incon assistance of one s On 5/24/16, at 10:3	nimum Data Set (MDS) dated R32 had a Brief Interview of S) score of 14, indicating e MDS further identified R32 tinence requiring extensive			R32 care plan has been updated treflect fluctuating toileting needs. A residents who return from hospital admission will have 72 hour bowel bladder assessments completed. A will be completed on all re-admissional admissions monthly times 3 m then reviewed with QAPI for further recommendations	all or on and Audits ons onths	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245455	B. WING _		05/	/26/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 280	sheets were noted urine. R32 stated, "to fall out of bed?" to the room to intertime of incident lice entered the room a by swinging her feedid not provide any her positioned low inclothing were urine interviewed at the tistated, "I needed to they stated they wo nursing assistant storm of bed for a sincontinent of urine staff that R32 needs incontinence cares. The care plan dated an activity of daily liperformance deficit lethargy and muscle inability to perform was identified in the supervision and direst sequencing tasks a any given time of daily indentified she would episodes and urges section of the care	de of the bed. R32's bed and to be heavily saturated with Can you help me I am going The surveyor summoned staff vene and assist R32. At the nsed practical nurse (LPN)-A nd placed R32 back into bed to back onto the bed. LPN-A further cares for R32, leaving not the bed. The bed and saturated. R32 was me of the observation and to toilet a long time ago and uld be back (referring to saff) but now it is too late." 1 a.m. activity aide (AA)-A movement with a wheelchair to assist activities and noted R32 was and to be assisted with wing (ADL) self care are related to disease process, as weakness evidenced by her all ADL's independently. R32 are care plan to require ection, related to difficulty with and tiredness or drowsiness ay. The care plan further mixed incontinence and to be aware of incontinent so. Under the personal hygiene plan, R32 was identified to with supervision/direction and	F 28	30		

-	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245455	B. WING		- 05	/26/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STAT 601 WEST JACKSON JACKSON, MN 56143		, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 280	The Bladder Asses R32 as incontinent The assessment all dribbling and had swas identified with When interviewed on ursing assistant (Nerequently "wet" and she needed to toile R32 to the toilet in after meals. NA-A for frequently wet but owhen she needed to when she needed to stated R32 had the stated R32 had the stated R32 had the stated R32 and other days staff just of the stated she was unated as and staff just of the stated when R32 and staff just of the stated when R32 wherself. RN-C verificated R32 wherself. RN-C verificated R33 wherself. RN-C verificated R34 wherself. RN-C verificated R34 wherself. RN-C verificated R34 wherself. RN-C verificated R34 wherself.	sment dated 8/24/15, identified daily on both day and nights. so identified R32 had urinary mall incontinent episodes R32 no scheduled toilet plan. on 5/25/16, at 9:16 a.m. NA)-A stated R32 was did not really tell staff when t. NA-A stated staff try to take the morning and before and urther stated R32 was lid have the ability to know	F 2	80			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED				
245455			B. WING		05/26/2016		
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON	6	TREET ADDRESS, CITY, STATE, ZIP CODE 01 WEST JACKSON ACKSON, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
	should identify the r when she is less ab individualized plan f 483.20(k)(3)(ii) SEP PERSONS/PER CA The services provide must be provided b accordance with ea care. This REQUIREMEN by: Based on observat review the facility fa services in accorda care for 4 of 4 resid reviewed for limited Findings include: R36 had diagnoses dated 3/29/16, whice obstructive pulmona	need to toilet her at times and should specify an for toileting. RVICES BY QUALIFIED ARE PLAN led or arranged by the facility y qualified persons in ch resident's written plan of the resident's written plan of lied to provide restorative nee with the written plan of lents (R36, R38, R39, R11) range of motion (ROM). identified on the care plan h included: chronic lary disease, osteoarthritis of sion, atrial fibrillation and	F 282	R36, R38 and all other residents or restorative program care plans have reviewed and reflect the current neethe residents. Restorative programs have been reorganized with Activities; if there in need to pull a restorative aide to propersonal cares programs will be swewith Activities or an RN will complete To assure programs are sustained. Restorative Nurse will audit all resident and a restorative plan weekly X4, the monthly X2 the referred to the QAP	e been eds of s a covide ritched te. the dents en	6/17/16	
	The care plan dated limited physical mol flare-ups of chronic weakness/pain evic balance transitions. would maintain curr weight with transfer care plan further ide restorative intervent.	d 3/23/16, identified R36 had pility related to recurrent		committee for further recommendar			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245455	B. WING			05/	26/2016
_	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CIT 601 WEST JACKSON JACKSON, MN 561		,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE CROSS-REFERE	'S PLAN OF CORRECTIOI ECTIVE ACTION SHOULD ENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	physical mobility. R36's care plan goafree of complication including contracture breakdown, fall relareview date through programming which motion seated 1# downty-five (25) repweek; (2.) Active Richead for five (5) repthree (3) times were at level 4 up to 15 repthree (3) times were at level 4 up to 15 repthree (3) times at level 4 up to 15 repthree (3) times at level 4 up to 15 repthree (3) times were at level 4 up to 15 repthree (3) times at level 4 up to 15 repthree (3) times at level 4 up to 15 repthree (3) times at level 4 up to 15 repthree (3) times at level 2016 restorative log services 2 days out R38 had diagnoses dated 3/9/16, which disease, muscle were kidney disease, ost Major depression. The care plan datel limited physical modisease and weaknow limitations. The care need for restorating self-care performant mobility. The restor identified as follows level 3-4 for up to 1	als included R36 would remain as related to immobility res, thrombus formation, skin ated injury through the next a restorative nursing a included: (1). Active range of owel bilateral upper extremity etitions three (3) times a OM to left/right hand on top of oetitions for 5 second hold kly; (3.) Active ROM Nu-Step minutes 3 times a week; and to stand in parallel bars up to a week. 36's restorative service records a week; During review of the May gs, R36 received restorative		82			

-	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245455	B. WING			05/2	26/2016	
	PROVIDER OR SUPPLIER			601	REET ADDRESS, CITY, STATE, ZIP CODE WEST JACKSON CKSON, MN 56143	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 282	abduction 2# each weekly; (3) Active or green band 15 r weekly; and (4.) As shifting with walked weekly. During review of R service records it is range of motion ex The May 2016 rest received services 8 R39 had diagnose dated 3/30/16, that atrial fibrillation, os history of falls with The care plan for F mobility related to included goals for mobility related to included goals for mobility with transf through next review identified R39 had intervention due to deficit and limited prestorative goal was ambulation by walk ft each way throug identified the follow utilized to support 4 sets of 5 repetition extension, forearm times weekly; (2.) minutes at level 4 the ROM standing bala weekly; and (4.) Wusing four wheeled	leg 15 repetitions 5 times ROM hamstring curls with red epetitions each leg 5 times ctive ROM standing weight or in parallel bars 5 times 38's April 2016 restorative dentified that R38 received ercises 7 times in 30 days. corative records identified R38 3 days out of 31 days. s identified on the care plan included: Parkinson's disease, teoporosis, heart failure and	F 2	282				

_	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING _		05	/26/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP C 601 WEST JACKSON JACKSON, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 282	for the month of Ap log identified R39 rutimes in 30 days. Durestorative logs, do received services 2 R11's care plan dat the following diagnopain, major depresand chronic kidney R11's care plan ide physical mobility rearthritis evidenced goal identified he wambulate as some 100-200 feet (ft) at The care plan furth for restorative interperformance deficit The res	ril 2016, documentation on the eceived ROM exercises 2 uring review of the May 2016 cumentation indicated R39 days out of 31 days. ed 3/20/16, identified R11 with oses: Parkinson's disease, sion, atrial fibrillation, anemia disease. Intified R11 had limited lated to Parkinson's and by physical limitations. R11's ould maintain the ability to means of locomotion up to a time through next review. er identified R11 had a need wention due to ADL self-care with limited physical mobility. Inventions included the re ROM Nu-step level 3-4 for 3-5 times weekly; (2.) Walking owed with wheelchair 50-150 ft dissist of 2 followed by w/c	F 28	32			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245455	B. WING			05/26/2016	
	ROVIDER OR SUPPLIER	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282	supervisory staff has ervices multiple tirwork as a nursing apersonal cares. RN provide the establis when reassigned do During interviews w NA-B and NA-C on the NA's stated the the restorative progaide was not specif	s, at 3:00 p.m. RNA-A stated and pulled her from restorative the sin the past two months to assistant (NA) to provide NA-A stated she was unable to hed restorative programs	F 28			6/17/16	
SS=D	Based on the reside assessment, the far resident who enters indwelling catheter resident's clinical or catheterization was who is incontinent of treatment and servi	ent's comprehensive cility must ensure that a the facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder					
	by: Based on observat review, the facility for (R32) in the sample incontinent of urine appropriate treatment	ion, staff interview and record ailed to ensure 1 of 1 resident identified as frequently was assessed to assure and services were aimize urinary incontinence.		R32 care plan has been updated of toileting plan to reflect her current lefunction. All other residents who we risk for urinary incontinence have be reviewed to assure they are receivinecessary treatment and services. Random audits will be completed of delivery of care to ensure appropria	evel of ere at een ng		

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING			05/2	26/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - JACKSON				6	TREET ADDRESS, CITY, STATE, ZIP CODE 01 WEST JACKSON ACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	5/11/16, identified F Mental Status (BIM intact cognition. The with frequent incomassistance of one s. On 5/24/16, at 10:3 during morning care hanging over the sisheets were noted urine. R32 stated, "to fall out of bed?" to the room to intertime of incident lice entered the room a by swinging her feed did not provide any her positioned low is clothing were urine interviewed at the tistated, "I needed to they stated they wo nursing assistant stone of the state of the st	imum Data Set (MDS) dated R32 had a Brief Interview of S) score of 14, indicating e MDS further identified R32 tinence requiring extensive taff to manage. O a.m. R32 was observed es lying in bed with her feet de of the bed. R32's bed and to be heavily saturated with Can you help me I am going The surveyor summoned staff vene and assist R32. At the nsed practical nurse (LPN)-A and placed R32 back into bed t back onto the bed. LPN-A further cares for R32, leaving in the bed. The bed and saturated. R32 was me of the observation and toilet a long time ago and uld be back (referring to aff) but now it is too late." 1 a.m. activity aide (AA)-A with a wheelchair to assist activities and noted R32 was AA-A notified the nursing ded to be assisted with	F3	315	and services are delivered. Audits done weekly times 4, then 2 times month then as determined by QAP committee.	а	

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING		- 05	5/26/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT 601 WEST JACKSON JACKSON, MN 56143	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 315	sequencing tasks a any given time of cidentified R32 with identified she woul episodes and urge section of the care require set up help assist of 1 during to the Bladder Asses R32 as incontinent The assessment adribbling and had swas identified with When interviewed nursing assistant (frequently "wet" and she needed to toile R32 to the toilet in after meals. NA-A frequently wet but when she needed When interviewed stated R32 had the stated R32 did not on some days R32 and other days stated she was una R32 and staff just of the buring review of the nursing dayshift not toileting schedule. 5/4/16, identified Rassistance with toileting schedule.	rection, related to difficulty with and tiredness or drowsiness lay. The care plan further mixed incontinence and d be aware of incontinent s. Under the personal hygiene plan, R32 was identified to with supervision/direction and oilet use. Sement dated 8/24/15, identified a daily on both day and nights. Iso identified R32 had urinary small incontinent episodes R32 no scheduled toilet plan. On 5/25/16, at 9:16 a.m. NA)-A stated R32 was d did not really tell staff when et. NA-A stated staff try to take the morning and before and further stated R32 was did have the ability to know	F3	115			

-	DI AN OF CORRECTION IN IMPER		A. BUILDING			COMPLETED	
		245455	B. WING	B. WING		/26/2016	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - JACKSON				STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 315	5/25/16, at 1:37 p.m unsure how staff de RN-A stated she the tracking assessment oileting needs but videntify a completed record.	ge 13 th registered nurse (RN)-A on n. RN-A stated she was etermined her toileting needs. ought a three day bladder nt was conducted to determine was unable to verify and/or d diary in R32's medical on 5/25/16, at 1:58 p.m. RN-C as alert she was able to toilet	F 3	15			
	herself. RN-C verification revised to identify Fineeds based on he day. During interview on director of nursing (should specifically itimes when she is lean individualized plane.	ed the care plan was not R32's fluctuating toileting r alterations in abilities day to 5/25/16, at 12:05 p.m. the DON) verified R32's care plan dentify the need to toilet her at ess able and should specify					
	incontinent, it lacked based on a compreto provide the necessariation her urinary 483.25(e)(2) INCRETIN RANGE OF MORESTANDED Based on the compresident, the facility with a limited range appropriate treatments.	d individualized interventions hensive bladder assessment ssary services for R32 to y status. EASE/PREVENT DECREASE TION Trehensive assessment of a must ensure that a resident of motion receives ent and services to increase d/or to prevent further	F3	18		6/17/16	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY PLETED
		245455	B. WING			05/2	26/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON		60	TREET ADDRESS, CITY, STATE, ZIP CODE 01 WEST JACKSON ACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 318 Continued From page 14		ge 14	F3	18			
	by: Based on observat review the facility fa treatment and servi R38, R39, R11) rev motion (ROM). Findings include: R36 had diagnoses dated 3/29/16, whice obstructive pulmons knee, major depres history of fracture to The quarterly Minimassessment dated sextensive assist of eating and had limit lower extremity. The care plan dated limited physical modifiare-ups of chronic weakness/pain evic balance transitions would maintain curr weight with transfer care plan further ide restorative interven living (ADL) self-car physical mobility. R36's care plan gos free of complication	ary disease, osteoarthritis of sion, atrial fibrillation and o left tibia. num Data Set (MDS) 3/9/16, identified R36 required 1-2 staff with all ADLs except red functional ROM in one d 3/23/16, identified R36 had billity related to recurrent			R36, R38, R39,R11 and all other residents on a restorative program plans have been reviewed and reflecurrent needs of the residents. Restorative programs have been reorganized with Activities; if there need to pull a restorative aide to propersonal cares programs will be swith Activities or an RN will complet a sasure programs are appropriat sustained Restorative Nurse will auresidents on a restorative plan weethe monthly X2 the referred to the committee for further recommendations.	is a ovide vitched te. e and lidit all kly X4, QAPI	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY IPLETED
		245455	B. WING			05/	26/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON		601	REET ADDRESS, CITY, STATE, ZIP CODE WEST JACKSON CKSON, MN 56143	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	breakdown, fall relareview date through programming which motion seated 1# d twenty-five (25) rep week; (2.) Active Rohead for five (5) rep three (3) times wee at level 4 up to 15 m (4.) Active ROM sit 5 minutes 3 times at During review of R3 for April 2016 the lo ROM 1 time in 30 d 2016 restorative log services 2 days out R38 had diagnoses dated 3/9/16, which disease, muscle we kidney disease, ost Major depression. The quarterly MDS with a Brief Intervie (BIMS) of 14, indicated that R38 m 1-2 staff with all AD identified the activit The MDS also iden problem when ambidentified he had lin bilateral lower extremation.	atted injury through the next in restorative nursing included: (1). Active range of owel bilateral upper extremity etitions three (3) times a OM to left/right hand on top of petitions for 5 second hold kly; (3.) Active ROM Nu-Step innutes 3 times a week; and to stand in parallel bars up to a week. Be's restorative service records g identified R36 received lays. During review of the May gs, R36 received restorative of 31 days. Identified on the care plant included: Parkinson's eakness, diabetes, chronic eoarthritis bilateral knees, and dated 5/12/16, identified R38 w for Mental Status Score ating intact cognition. It also required extensive assist of L's except ambulating and y of ambulating did not occur. It ified R38 with a balance ulating or transferring and intation in functional ROM in emities.	F3	18			
	disease and weakn	bility related to Parkinson's ess evidenced by physical e plan further identified R38					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
		245455	B. WING		05	/26/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP C 601 WEST JACKSON JACKSON, MN 56143	•	, , ,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 318	had an ADL self can to health conditions evidenced by physisupport fluctuations and ambulating. Ramaintain his curren mobility, transfers, personal hygiene the plan also identified intervention due to deficit and limited prestorative intervention follows: (1). Active to 10 minutes 5 tim knee extension-hip each leg 15 repetiti ROM hamstring currepetitions each leg Active ROM standing or in parallel bars 5. During review of Raservice records it in range of motion exercited services 8. Ray had diagnoses dated 3/30/16, that atrial fibrillation, ost history of falls with a Brief Interviee (BIMS) of 15, indicational fibrillation and the requisited Ray requisited	re performance deficit related with secondary complications cal limitations and ADL anoted specific to transfers 88's goals identified R38 would to level of function in bed dressing, toilet use and arough next review. The care R38 had a need for restorative the ADL self-care performance thysical mobility. The tions were identified as ROM Nu-step level 3-4 for up es weekly; (2.) Active ROM adduction and abduction 2# ons 5 times weekly; (3) Active rls with red or green band 15 to 5 times weekly; and (4.) and weight shifting with walker times weekly. 88's April 2016 restorative lentified that R38 received ercises 7 times in 30 days. For a control of the care plan included: Parkinson's disease, eoporosis, heart failure and	F 3	18		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		` '	E SURVEY PLETED
		245455	B. WING			05/2	26/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP C 601 WEST JACKSON JACKSON, MN 56143	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD	BE	(X5) COMPLETION DATE
F 318	mobility related to pincluded goals for pincluded goals for probable through next review identified R39 had a intervention due to deficit and limited prestorative goal was ambulation by walk ft each way through R39's care plan ide measures to be util (1.) Active ROM 4 s flexion, wrist extens supination/pronation Active ROM Nu-ste three times weekly; balance activities the (4.) Walking with st wheeled walker to/f During review of R3 for the month of Aplog identified R39 retimes in 30 days. Does to received services 2 R11's care plan dat the following diagnor pain, major depress and chronic kidney R11 with a Brief Inte (BIMS) of 12, indicated identified R11 r 1-2 staff with all AD indicated he only residentified R11 r	ferring. 39 identified limited physical hysical limitations and and any to maintain current level of ers with assistive device of the care plan further a need for restorative and self-care performance hysical mobility. R39's at to maintain level of ing to/from all meals up to 200 an next review. Intified the following restorative ized to support maintenance: sets of 5 repetitions wrist sion, forearm in three times weekly; (2.) profor 10 minutes at level 4 (3) Active ROM standing aree times weekly; and and by assist of 1 using four rom all meals. By's restorative service records and by a service records and by a service of the May 2016 cumentation indicated R39 days out of 31 days. ed 3/20/16, identified R11 with oses: Parkinson's disease, sion, atrial fibrillation, anemia	F3	18			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		COMPLETED		
		245455	B. WING _		05	/26/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CO 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 318	R11's care plan ide physical mobility re arthritis evidenced goal identified he wambulate as some 100-200 feet (ft) at The care plan furth for restorative interperformance defici The restorative interfollowing: (1.) Activ 10-15 min duration with assist of 2 following with assist of 2 following with asoutside of room 1 to During review of R for April 2016 the log ROM exercises 6 to for the May 2016 log	sferring between surfaces. Intified R11 had limited lated to Parkinson's and by physical limitations. R11's vould maintain the ability to means of locomotion up to a time through next review. It is interested to the limited physical mobility. It is reventions included the version R0M Nu-step level 3-4 for 3-5 times weekly; (2.) Walking bowed with wheelchair 50-150 ft dessist of 2 followed by w/c		8		
	director of nursing aide was re-assign provide personal ca show up for work to the restorative aide	on 5/25/16, at 9:38 a.m. the (DON) verified the restorative ed to work on the floor (to ares) due to a NA who failed to oday. The DON further verified was re-assigned to provide Itiple times in the past 2				
	(RNA)-A on 5/25/16 supervisory staff has ervices multiple till work as a nursing a	th restorative nursing aide 5, at 3:00 p.m. RNA-A stated ad pulled her from restorative mes in the past two months to assistant (NA) to provide NA-A stated she was unable to				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245455	B. WING		05/26/2016	
	PROVIDER OR SUPPLIER	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 318	when reassigned dithe facility had been she was reassigned help with general carenough NA staff. During interviews w NA-B and NA-C on the NA's stated the the restorative progaide was not specif. The NA's stated the perform all the restoralled in sick and/o 483.35(i) FOOD PF STORE/PREPARE. The facility must - (1) Procure food froconsidered satisfact authorities; and	hed restorative programs uties. RNA-A further stated in short of NA help recently and diffrom restorative duties to ares when there was not with nursing assistant (NA)-A, 5/25/16, at 3:40 p.m. each of y did not have time to perform uram duties when a restorative ically assigned those duties. Here was not enough staff to prative programs when staff in finot showing up to work. ROCURE, SERVE - SANITARY	F 3			6/20/16
	by: Based on observatifailed to ensure that prevent potential cowere thawed in a nacross-contamination	NT is not met as evidenced cion and interview the facility to food was properly stored to entamination and raw meats nanner that prevents of other food in the ad the potential to affect all 44 on the facility.		Education was given to the Dietar Manager on rules and regulations perishable food. Upon delivery from supplier items will be properly stor All Dietary staff will receive educate thawing of meat. Audits will be completed on food states.	of n food ed. ion on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING _		05/	26/2016
_	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP C 601 WEST JACKSON JACKSON, MN 56143	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 371	5/23/16, at 6:45 a.r. noted to have 3 star food stored on the of one box of mixed peas. The second stox of fruit cups. The second stox of fruit cups. The food second stox of fruit cups. The food directly comprised of 2 box second stack consiculations of the box of eggs who refrigerator. The ration a tray nor in a put the meat from dripp beneath, resulting it contamination of food when interviewed dietary manager (Edelivers food items and placed the box refrigerator and frest the noted stacked if food delivery on The and were stored in confirmed the grout top of the box of egway we store meat	ar of the facility kitchen on in. the walk in freezer was cks of boxes containing frozen floor. The first stack comprised divegetables and one box of stack was comprised of one the third stack was comprised in burgers, vegetables, and a box of pork patties. of the walk-in refrigerator it acks of food boxes were tly on the floor. The first stack is es of egg blend; and the sted of one box creamy ggs, and a 10 pound tube of the ground beef was placed on ille it was thawing in the wigner ground beef was not placed an while it thawed to prevent bing into the box of eggs in potential cross	F 37	delivery day weekly X1 mor randomly as determined by committee. Audits will be converted by the QAPI meeting for further recommendations.	QAPI ompleted	

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING		_	05/26/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STA 601 WEST JACKSON JACKSON, MN 56143	TE, ZIP CODE	2. 2. 2. 2	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCEI	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)		
F 371	meat juices. During a follow up a.m. the DM confir time and indicated education related to	ing rack to prevent dripping of interview on 5/26/15, at 11:33 rmed the above findings at this the staff would need further to the safety of storage to tion. Although requested, no	F3	571			

Electronically Signed

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

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245455 B. WING 05/24/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **601 WEST JACKSON GOOD SAMARITAN SOCIETY - JACKSON** JACKSON, MN 56143 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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: (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.

Facility ID: 00303

06/19/2016

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245455	B. WING			05/	24/2016
	PROVIDER OR SUPPLIER			60	TREET ADDRESS, CITY, STATE, ZIP CODE 01 WEST JACKSON ACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Angela.Kappenma <mailto:angela.ka 1.="" 1st="" 2.="" 2nd="" 3nd="" a="" actual,="" add<="" addition="" and="" as="" cc="" constructed="" construction.="" corprevent="" correct="" defice="" deficiency="" description="" followed="" following="" for="" good="" has="" i(332)="" info="" lower="" mus="" no="" of="" or="" plan="" possible="" reoccurr="" samaritan="" sconstructed="" td="" the="" to="" was="" wone-story="" wone-story,=""><td>state.mn.us nitney@state.mn.us> and n@state.mn.us ppenman@state.mn.us> PRRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. rociety Jackson was ows: ng was constructed in 1956, is pasement, is fully fire sprinkler determined to be of Type rection; ras constructed in 1976, is pasement, is fully fire sprinkler determined to be of Type rection; ras constructed in 1976, is partial basement, is fully fire ted and was determined to be estruction; ras constructed in 1996, is pasement, is fully fire sprinkler determined to be of Type determined to be of Type rection; ras constructed in 1996, is pasement, is fully fire sprinkler determined to be of Type</td><td>K</td><td>0000</td><td></td><td></td><td></td></mailto:angela.ka>	state.mn.us nitney@state.mn.us> and n@state.mn.us ppenman@state.mn.us> PRRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. rociety Jackson was ows: ng was constructed in 1956, is pasement, is fully fire sprinkler determined to be of Type rection; ras constructed in 1976, is pasement, is fully fire sprinkler determined to be of Type rection; ras constructed in 1976, is partial basement, is fully fire ted and was determined to be estruction; ras constructed in 1996, is pasement, is fully fire sprinkler determined to be of Type determined to be of Type rection; ras constructed in 1996, is pasement, is fully fire sprinkler determined to be of Type	K	0000			
	detection in the co	rridors and spaces open to the monitored for automatic fire					

TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG 01 - Main Building 01	(X3) DATE SURVEY COMPLETED	
		245455	B. WING		05/	24/2016
	OVIDER OR SUPPLIER	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP C 601 WEST JACKSON JACKSON, MN 56143	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
t:	capacity of 63 beds ime of the survey. The requirement at NOT MET as evide	tion. The facility has a and had a census of 43 at 42 CFR, Subpart 483.70(a) is need by:	K 00			6/3/16
SS=D I record to the second se	f the building has a nonconforming build parrier having at least addition. Communications and shall self-closing fire documents of the building has nonconforming build parrier having at least ating constructed of addition. Communications and shall self-closing fire documents are self-closing fire documents and shall self-closing fire	l.2, 18.2.3.2, 19.1.1.4.1,	KO	The penetration above the entrance around the electric the southwest end of our bufilled with fire caulk to seal to penetration. This was comparated and the comparation of the comparat	cal conduit on uilding was the eleted by the	0/3/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' ′	(2) MULTIPLE CONSTRUCTION . BUILDING 01 - MAIN BUILDING 01		E SURVEY PLETED
		245455	B. WING		05/	24/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CO 601 WEST JACKSON JACKSON, MN 56143	DDE	
(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 025 SS=D			КО	- 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	between the hours observation reveals electrical conduits a smoke barrier in the to the Housekeepir This deficient pract Maintenance Super NFPA 101 LIFE SA Generators inspect under load for 30 m in accordance with 3-4.4.1 and 8-4.2 (I 110) This STANDARD i	pection on May 24, 2016, of 10:30 AM and 12:30 PM, ed penetrations around five above the lay in ceiling at the e North Central Hallway nexting Room.	K 1	44	t work on	6/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ') DATE SURVEY COMPLETED	
		245455	B. WING		05/2	24/2016
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		<u> </u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE '
K 144	in accordance with 3-4.4.1 and 8-4.2 (110) FINDINGS INCLU During documentate between the hours the following was (1.) During documentate that the transfer tirpower and cool do on the Monthly EmReport. 2.) During documentation indicate that the Was conducted du to 1/9/16, 1/19/16 and 2/2/16 to 2/6/2	minutes per month and shall be a NFPA 99 and NFPA 110. (NFPA 99), Chapter 6 (NFPA DE: ation review on May 24, 2016, of 10:30 AM and 12:30 PM, discovered: entation review, it was revealed me from normal to emergency own time was not documented hergency Generator Test entation review, it was revealed ne could not be provided to leekly Generator Inspection ring the following weeks: 1/5/16 to 1/23/16, 1/26/16 to 1/30/16 lee.	K 144	generators will come and instate and/or program it so that we we document the transfer and contimes. These times will be document the maintenance department responsible for filling out. This scheduled to take place on June	ill be able to ol down umented on on report ent is is	



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

Good Samaritan Society - Jackson June 10, 2016 Page 2

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

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health Kamala. Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 07/25/2016 FORM APPROVED

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___

		00303	B. WING		05/26/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON 601 WES	DDRESS, CITY, S ST JACKSON DN, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETE
	Initial Comments *****ATTE! NH LICENSING In accordance with 144A.10, this corrected shall with a schedule of fithe Minnesota Departments of the Minnesota Departments of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected. You may request a that may result from orders provided that the Department with	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation or assessed in accordance ines promulgated by rule of artment of Health. The ther a violation has been compliance with all rule provided at the tag alle number indicated below. In the items will be considered be ack of compliance upon any item of multi-part rule will ment of a fine even if the items uring the initial inspection was the aring on any assessments in non-compliance with these that a written request is made to non 15 days of receipt of a not for non-compliance.	2 000		THATE DATE
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	in 14-01, available at ate.mn.us/divs/fpc/profinfo/inf e licensing orders are			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

06/19/16

TITLE

Electronically Signed

(X6) DATE

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00303	B. WING		05/2	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	JACKSON I, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	you electronically. is necessary for State enter the word "cortext. You must then State licensure procompletion date, th	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent 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.					
	column entitled "ID statute/rule out of co "Summary Stateme and replaces the "T correction order. The findings which are in after the statement evidence by." Follow	umber appears in the far left Prefix Tag." The state compliance is listed in the ent of Deficiencies" column Co Comply" portion of the his column also includes the n violation of the state statute n, "This Rule is not met as wing the surveyors findings Method of Correction and crection.				
	FOURTH COLUMN "PROVIDER'S PLA	ARD THE HEADING OF THE N WHICH STATES, NN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

Minnesota Department of Health

STATE FORM 6899 MPFF11 If continuation sheet 2 of 26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						DATE SURVEY COMPLETED	
		00303		B. WING		05/2	26/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- JACKSON		「JACKSON I, MN 56143	.		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2		2 000			
	THIS WILL APPEA	R ON EACH PA	AGE.				
	THERE IS NO REC PLAN OF CORREC MINNESOTA STAT	CTION FOR VI	OLATIONS OF				
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Com	prehensive	2 565			6/17/16
	Subp. 3. Use. A comust be used by all care of the resident	personnel invo					
	This MN Requirements by: Based on observation review the facility farservices in accordate care for 4 of 4 residences reviewed for limited	on, interview and to provide to provide to provide the writh the writh the writh (R36, R38).	nd document restorative ritten plan of 3, R39, R11)		Corrected		
	Findings include:						
	R36 had diagnoses dated 3/29/16, whice obstructive pulmona knee, major depres history of fracture to	ch included: chr ary disease, os sion, atrial fibri	onic teoarthritis of				
	The care plan dated limited physical mol flare-ups of chronic weakness/pain evic balance transitions. would maintain curr weight with transfer	bility related to conditions cau lenced by diffic The care plan rent level of mo	recurrent using ulty with identified R36 bility in bearing				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00303	B. WING		05/2	26/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	T JACKSON N, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	care plan further id restorative interven living (ADL) self-ca physical mobility. R36's care plan go free of complication including contractul breakdown, fall relareview date through programming which motion seated 1# d twenty-five (25) repweek; (2.) Active R head for five (5) repthree (3) times were at level 4 up to 15 r (4.) Active ROM sit 5 minutes 3 times at During review of R3 for April 2016 the logony and the ROM 1 time in 30 c 2016 restorative log services 2 days out R38 had diagnoses dated 3/9/16, which disease, muscle we kidney disease, ost Major depression.	entified R36 had a need for tion due to activity of daily re performance deficit/limited als included R36 would remain as related to immobility res, thrombus formation, skin ated injury through the next a restorative nursing a included: (1). Active range of lowel bilateral upper extremity retitions three (3) times a OM to left/right hand on top of petitions for 5 second hold rekly; (3.) Active ROM Nu-Step minutes 3 times a week; and to stand in parallel bars up to a week. 36's restorative service records a week. 36's restorative service records a gidentified R36 received days. During review of the May respect to 131 days. 36 identified on the care plan included: Parkinson's reakness, diabetes, chronic recoarthritis bilateral knees, and		DEFICIENCY)		
	limited physical mo disease and weakn limitations. The car a need for restorati self-care performan mobility. The restor	d 3/9/16, identified R38 with bility related to Parkinson's less evidenced by physical e plan also identified R38 had we intervention due to the ADL nce deficit and limited physical rative interventions were s: (1). Active ROM Nu-step				

Minnesota Department of Health

STATE FORM 6899 MPFF11 If continuation sheet 4 of 26

PRINTED: 07/25/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00303	B. WING		05/2	6/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	N, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 4	2 565			
	Active ROM knee e abduction 2# each weekly; (3) Active or green band 15 re weekly; and (4.) Ac shifting with walker weekly. During review of R3	0 minutes 5 times weekly; (2.) extension- hip adduction and leg 15 repetitions 5 times ROM hamstring curls with redepetitions each leg 5 times tive ROM standing weight or in parallel bars 5 times				
	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.					
	mobility related to pincluded goals for Fincluded goals for Fincluded goals for Fincluded problem intervention due to deficit and limited prestorative goal was ambulation by walk fit each way through identified the follow utilized to support of 4 sets of 5 repetition extension, forearm times weekly; (2.) A minutes at level 4 th ROM standing bala weekly; and (4.) W	39 identified limited physical physical limitations and 39 to maintain current level of ers with assistive device 7. The care plan further a need for restorative ADL self-care performance physical mobility. R39's so to maintain level of ing to/from all meals up to 200 in next review. R39's care plan ing restorative measures to be maintenance: (1.) Active ROM nos wrist flexion, wrist supination/pronation three active ROM Nu-step for 10 pree times weekly; (3) Active noce activities three times alking with stand by assist of 1 walker to/from all meals.				

Minnesota Department of Health

STATE FORM 6899 MPFF11 If continuation sheet 5 of 26

PRINTED: 07/25/2016 FORM APPROVED

Minnesota Department of Health

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00303	B. WING		05/2	6/2016
NAME OF PRO	VIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD SAM	ARITAN SOCIETY	- JACKSON	JACKSON I, MN 56143	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
Difo log time recently the part of the par	or the month of Aprig identified R39 remes in 30 days. Do estorative logs, doo exceived services 2 11's care plan date in following diagnoral, major depressed chronic kidney of 11's care plan identified he would be a care plan further thritis evidenced by the care plan further restorative interversorative inter	eg's restorative service records ril 2016, documentation on the eceived ROM exercises 2 puring review of the May 2016 cumentation indicated R39 days out of 31 days. Red 3/20/16, identified R11 with eses: Parkinson's disease, sion, atrial fibrillation, anemia disease. The rest and exercise to Parkinson's and e	2 565			

Minnesota Department of Health

STATE FORM 6899 MPFF11 If continuation sheet 6 of 26

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00303		B. WING		05/2	26/2016
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON		T JACKSON N, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN / MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 6		2 565			
	(RNA)-A on 5/25/16 supervisory staff has services multiple tir work as a nursing a personal cares. RN provide the establis when reassigned dispersoned control of the stable of the stab	ad pulled her from mes in the past tw assistant (NA) to p NA-A stated she w shed restorative p	restorative o months to provide vas unable to				
	During interviews w NA-B and NA-C on the NA's stated the the restorative prog aide was not specif	5/25/16, at 3:40 p y did not have tim yram duties when	o.m. each of e to perform a restorative				
	SUGGESTED MET The director of nurs review and revise p to ensuring the care resident is followed designee could dev and develop a mon are providing care a of care.	sing (DON) or destrollicies and proced plan for each independent of the controlling system to distribute the controlling system to destruct the controlling system the controlling system the controlling system.	ignee could dures related dividual nursing or educate staff ensure staff				
	TIME PERIOD FOR (21) days.	R CORRECTION:	Twenty-one				
2 570	MN Rule 4658.0409 Plan of Care; Revis		ehensive	2 570			6/17/16
	Subp. 4. Revision care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen	wed and revised by methat includes the red nurse with rest of other appropriate imined by the resionacticable, with the resident, the resident,	by an all the attending sponsibility e staff in dent's needs, ne dent's legal				

Minnesota Department of Health

STATE FORM 6899 MPFF11 If continuation sheet 7 of 26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00303	B. WING		05/2	6/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	JACKSON I, MN 56143	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 7	2 570			
		seven days of the revision of resident assessment required subpart 3, item B.				
	by: Based on observati review the facility fa identify intervention	ent is not met as evidenced on, interview and document illed to revise the care plan to s that were effective based on 1 of 1 resident (R32) y status.		Corrected		
	Findings include:					
	5/11/16, identified F Mental Status (BIM intact cognition. The	imum Data Set (MDS) dated R32 had a Brief Interview of S) score of 14, indicating a MDS further identified R32 inence requiring extensive taff to manage.				
	during morning care hanging over the sis sheets were noted urine. R32 stated, "to fall out of bed?" to the room to intertime of incident lice entered the room a by swinging her feedid not provide any her positioned low is clothing were urine interviewed at the tistated, "I needed to they stated they wo	0 a.m. R32 was observed es lying in bed with her feet de of the bed. R32's bed and to be heavily saturated with Can you help me I am going The surveyor summoned staff wene and assist R32. At the nsed practical nurse (LPN)-And placed R32 back into bed t back onto the bed. LPN-A further cares for R32, leaving in the bed. The bed and saturated. R32 was me of the observation and toilet a long time ago and uld be back (referring to aff) but now it is too late."				

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00303	B. WING		05/2	6/2016
	PROVIDER OR SUPPLIER	- JACKSON 601 WEST	DRESS, CITY, S F JACKSON N, MN 56143	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 570	On 5/24/16, at 10:4 entered R32's room R32 out of bed for a incontinent of urine staff that R32 need incontinence cares. The care plan date an activity of daily liperformance deficit lethargy and musclinability to perform was identified in the supervision and directions are given time of didentified R32 with identified she would episodes and urges section of the care require set up help assist of 1 during to the Bladder Asses R32 as incontinent. The Bladder Asses R32 as incontinent. The assessment all dribbling and had signified with the When interviewed on the care require set up help assist of 1 during to the Bladder Asses R32 as incontinent. The assessment all dribbling and had signified with the was identified with the was identified with the was identified with the requently wet but the staff of the requently wet but the when she needed to when interviewed to when int	e1 a.m. activity aide (AA)-A with a wheelchair to assist activities and noted R32 was. AA-A notified the nursing ded to be assisted with ded to be assisted with a related to disease process, e weakness evidenced by her all ADL's independently. R32 exace plan to require ection, related to difficulty with and tiredness or drowsiness ay. The care plan further mixed incontinence and disease be aware of incontinent and disease of incontinent and disease process, exace plan to require ection, related to difficulty with and tiredness or drowsiness ay. The care plan further mixed incontinence and disease aware of incontinent and disease aware of incontinent and disease aware of incontinent and be aware of incontinent and bilet use. Sment dated 8/24/15, identified daily on both day and nights, so identified R32 had urinary mall incontinent episodes R32 no scheduled toilet plan. Don 5/25/16, at 9:16 a.m. NA)-A stated R32 was did not really tell staff when the NA-A stated staff try to take the morning and before and urther stated R32 was did have the ability to know	2 570			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00303	B. WING		05/2	6/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	T JACKSON N, MN 56143	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	on some days R32 and other days staff stated she was una R32 and staff just of During review of the nursing dayshift not toileting schedule. To 5/4/16, identified R3 assistance with toile 4/4/16, identified R3 When interviewed of stated when R32 wherself. RN-C verificated when R32 wherself. RN-C verificated based on he day. During interview on director of nursing (should identify the rowhen she is less abindividualized plan for current policy related plan revisions. The assurance committated in the rowhen she is less abindividualized plan for current policy related plan revisions. The assurance committated in the rowhen she is less abindividualized plan for current policy related plan revisions. The assurance committated in the rowhen she is less abindividualized plan for current policy related plan revisions. The assurance committated in the rowhen she is less abindividualized plan for current policy related plan revisions. The assurance committated in the rowhen she is less abindividualized plan for current policy related plan revisions. The assurance committated in the rowhen she is less abindividualized plan for current policy related plan revisions. The assurance committated in the rowhen she is less abindividualized plan for current policy related plan revisions.	always comply. NA-B stated would take herself to the toiler of had to assist her. NA-B aware of any toilet schedule for theck on her occasionally. The medical record a 5/4/16, the identified R32 was on a The night shift form dated 32 required extensive eting. A nurses note dated 32 was continent of urine. The night shift form dated 32 was continent of urine. The night shift form dated 32 required extensive eting. A nurses note dated 32 was continent of urine. The salert she was able to toilet ed the care plan was not reason all the care plan was not as a lert she was able to toilet ed the care plan was not reason as a lert she was able to toilet ed the care plan was not as a lert she was able to toilet ed the care plan was not reason as a lert she was able to toilet ed the care plan was not as a lert she was able to toilet ed the care plan was not reason as a lert she was able to toilet ed the care plan was not reason as a lert she was able to toilet ed the care plan was not as a lert she was able to toilet ed the care plan was not reason as a lert she was able to toilet ed the care plan was not reason as a lert she was able to toilet ed the care plan was not reason as a lert she was able to toilet ed the care plan was not reason as a lert she was able to toilet ed the care plan was not reason as a lert she was able to toilet ed the care plan was not reason as a lert she was able to toilet ed the care plan was not reason as a lert she was able to toilet ed the care plan was not reason as a lert she was able to toilet ed the care plan was not reason as a lert she was able to toilet ed the care plan was not reason as a lert she was able to toilet ed the care plan was not reason as a lert she was able to toilet ed the care plan was not reason as a lert she was able to toilet ed the care plan was not reason as a lert she was able to the lert she was able to toilet ed the care plan was not reason as a lert she was able to toilet ed the care plan was not reason as a lert she was able to the lert she was able to t				
	(21) days.	R CORRECTION: Twenty-one				
2 840	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 2 B Adequate and re; Clean skin	2 840			6/17/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
		00303	B. WING		05/2	6/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	T JACKSON N, MN 56143	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 840	Continued From pa	ge 10	2 840			
	B. Clean skin a odors. A bathing pl resident's plan of ca condition requires the must be given a condition other day and more incontinent resident every two hours, and	or determining adequate and criteria for determining er care include: and freedom from offensive an must be part of each are. A resident whose hat the resident remain in bed implete bath at least every e often as indicated. An at must be checked at least and must receive perineal care ode of incontinence.				
	Notwithstanding Mir 4658.0520, an inco checked according written in the reside attending physician interval longer than if competent, or a fa appointed conserva agent of a resident in writing to waive p determining this into	Incontinent residents. Innesota Rules, part Intinent resident must be Ito a specific time interval Intis care plan. The resident's Intis care plan. The resident's Intis care plan writing any Itwo hours unless the resident, Intis maily member or legally Itor, guardian, or health care Intis who is not competent, agrees Intis hysician involvement in Interval, and this waiver is Interval, and this waiver is Interval writing and writing an				
	promptly each time Perineal care include the perineal area. It to keep the bed dry comfort. Special at skin to prevent irritatypes of protectors completely covered	hing must be provided the bed or clothing is soiled. des the washing and drying of Pads or diapers must be used and for the resident's tention must be given to the ation. Rubber, plastic, or other must be kept clean, be and not come in direct ident. Soiled linen and				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION :		(X3) DATE SURVEY COMPLETED	
		00303	B. WING		05/	26/2016
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY.	STATE, ZIP CODE		
		601 WI	EST JACKSON			
GOOD S	AMARITAN SOCIETY	- JACKSON JACKS	ON, MN 5614	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 840	Continued From pa		2 840	DEI IOIEIOT)		
2010	·	moved immediately from	20.0			
	by: Based on observati review, the facility fa (R32) in the sample incontinent of urine appropriate treatme	ent is not met as evidenced on, staff interview and recordailed to ensure 1 of 1 resider e identified as frequently , was assessed to assure ent and services were nimize urinary incontinence.		Corrected		
	Findings include:					
	5/11/16, identified F Mental Status (BIM- intact cognition. The	imum Data Set (MDS) dated 32 had a Brief Interview of S) score of 14, indicating e MDS further identified R32 tinence requiring extensive taff to manage.				
	during morning care hanging over the side sheets were noted to urine. R32 stated, "to fall out of bed?" to the room to intentime of incident lice entered the room a by swinging her feed id not provide any her positioned low inclothing were urine interviewed at the tistated, "I needed to they stated they wo	0 a.m. R32 was observed es lying in bed with her feet de of the bed. R32's bed an to be heavily saturated with Can you help me I am going The surveyor summoned stavene and assist R32. At the nsed practical nurse (LPN)-And placed R32 back into bed to back onto the bed. LPN-A further cares for R32, leaving the bed. The bed and saturated. R32 was me of the observation and to toilet a long time ago and ald be back (referring to saff) but now it is too late."	aff A			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00303		B. WING		05/	26/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON	601 WES	DRESS, CITY, S F JACKSON N, MN 56143	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 840	On 5/24/16, at 10:4 entered R32's room R32 out of bed for a incontinent of urine staff that R32 need incontinence cares. The care plan dated an activity of daily liperformance deficit lethargy and muscle inability to perform a was identified in the supervision and diresequencing tasks a any given time of daidentified SA2 with identified she would episodes and urges section of the care require set up help assist of 1 during to The Bladder Assess R23 as incontinent. The assessment all dribbling and had si was identified with in When interviewed on ursing assistant (Norequently "wet" and she needed to toilet R32 to the toilet in tafter meals. NA-A for frequently wet but of when she needed to when interviewed to when she needed to when interviewed to when int	1 a.m. activity aid with a wheelchar activities and note. AA-A notified the ded to be assisted at 5/18/16, identified to be assisted at 5/18/16, identified to be assisted at 5/18/16, identified to detect on the care plan to request on the care plan to request on the care plan to request on the care plan at the care plan mixed incontinent of the aware of incomplete as a complete to a care plan and the care plan and the care plan at the care plan and the care plan at the care plan at the care plan at the care plan at the care plan and the care plan	ir to assist d R32 was e nursing with ed R32 with are e process, need by her dently. R32 uire difficulty with rowsiness further and intinent onal hygiene entified to direction and was staff when ff try to take before and was to know				

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STATE FORM 6899 MPFF11 If continuation sheet 13 of 26

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
				,			
		00303		B. WING		05/2	26/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON		「JACKSON I, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FI SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 840	stated R32 did not a on some days R32 and other days staff stated she was una R32 and staff just of During review of the nursing dayshift not toileting schedule. 5/4/16, identified R3 assistance with toile 4/4/16, identified R3 During interview wit 5/25/16, at 1:37 p.n. unsure how staff de RN-A stated she the tracking assessment toileting needs but identify a completed record. When interviewed of stated when R32 wherself. RN-C verificated when R32 wherself. RN-C verificated based on he day. During interview on director of nursing of should specifically it times when she is I an individualized plan. Although the plan of	ability to be continent always comply. NA-B s would take herself to the final to assist her. NAtware of any toilet scheck on her occasionate identified R32 was of the night shift form da a required extensive eting. A nurses note da a required extensive eting. A nurses note da a required extensive eting. A nurses note da a registered nurse (RIn. RN-A stated she was etermined her toileting ought a three day bladent was conducted to de was unable to verify and diary in R32's medical of the care plan was radiated and the care plan was radiated and should sign for toileting.	stated the toilet the toilet the Bedule for ally. /16, on a ted lated ine. N)-A on s needs. Ider etermine nd/or al n. RN-C to toilet not ng s day to . the eare plan et her at pecify vas	2 840			
	based on a bladder	d individualized interver assessment to provide for R32 to maintain he	le the				

Minnesota Department of Health

STATE FORM 6899 MPFF11 If continuation sheet 14 of 26

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				A. BOILDING.			
		00303		B. WING		05/2	26/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- JACKSON		「JACKSON I, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 840	urinary status. SUGGESTED MET The director of nurs review all residents incontinence to ass necessary treatmen of nursing or design conduct random au ensure appropriate implemented.	THOD OF CORRECTI	ee, could the director ystem to care to	2 840			
2 895	Subp. 2. Range of that is directed town through positioning implemented and not comprehensive rest of nursing services development of a not provides that: B. a resident with receives appropriate increase range of not decrease in range of the transport of the t	motion. A supportive ard prevention of defo and range of motion in naintained. Based on ident assessment, the must coordinate the tursing care plan which a limited range of motion and to prevent for motion. ent is not met as evidualled to provide the assessment and doctailed to provide the assessment and service to the service of motion.	program rmities must be the e director n otion ces to further	2 895	Corrected		6/17/16

Minnesota Department of Health STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00303	B. WING		05/2	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	T JACKSON N, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 15	2 895			
	R38, R39, R11) rev motion (ROM).	iewed with limited range of				
	Findings include:					
	dated 3/29/16, whice obstructive pulmon	s identified on the care plan ch included: chronic ary disease, osteoarthritis of esion, atrial fibrillation and o 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.					
	limited physical mo flare-ups of chronic weakness/pain evid balance transitions would maintain curr weight with transfer care plan further id- restorative interven	d 3/23/16, identified R36 had bility related to recurrent conditions causing denced by difficulty with The care plan identified R36 rent level of mobility in bearing through next review. The entified R36 had a need for tion due to activity of daily re performance deficit/limited				
	free of complication including contractul breakdown, fall relative review date through programming which motion seated 1# dtwenty-five (25) repweek; (2.) Active Rhead for five (5) reg	als included R36 would remain as related to immobility res, thrombus formation, skin ated injury through the next a restorative nursing a included: (1). Active range of lowel bilateral upper extremity etitions three (3) times a OM to left/right hand on top of petitions for 5 second hold lokly; (3.) Active ROM Nu-Step				

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STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLI IDENTIFICATION N			E CONSTRUCTION		SURVEY PLETED
				A. BUILDING.			
		00303		B. WING		05/2	26/2016
NAME OF PROV	IDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD SAMA	RITAN SOCIETY	- JACKSON		TJACKSON N, MN 56143	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
at le (4.) 5 m Dur for A RO 201 service dise kidre Maj The with (BII idea 1-2 idea The proidea bila The limit dise limit had to he evice suppande mai molecular molecular mai molecula	Active ROM sith aninutes 3 times a string review of R3 April 2016 the load of	ninutes 3 times a we to stand in parallel I a week. 36's restorative serving identified R36 reclays. During review of 31 days. 36 identified on the cast included: Parkinson eakness, diabetes, of eoarthritis bilateral identified R38 with a ball ulating or transferring intation in functional	ice records eived of the May storative are plan in schronic knees, and attified R38 Score in It also assist of ang and anot occur. ance ang and ROM in R38 with inson's hysical fied R38 cit related in plications and another school in the related i	2 895	DEFICIENCY		

Minnesota Department of Health

STATE FORM 6899 MPFF11 If continuation sheet 17 of 26

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:	·		
		00303	B. WING		05/2	26/2016
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	ST JACKSON ON, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	intervention due to deficit and limited prestorative interven follows: (1). Active to 10 minutes 5 tim knee extension- hip each leg 15 repetiti ROM hamstring curepetitions each leg Active ROM standin or in parallel bars 5. During review of R3 service records it is range of motion extended to receive did services 8. R39 had diagnoses dated 3/30/16, that atrial fibrillation, ost history of falls with R39's annual MDS with a Brief Intervie (BIMS) of 15, indicated the received services identified R39 requistaff with all ADL's she only required sidentified R39 with ambulating or trans. The care plan for R mobility related to pincluded goals for R mobility related to pincluded goals for R mobility with transfet through next review identified R39 had a intervention due to deficit and limited p	the ADL self-care performance obysical mobility. The tions were identified as ROM Nu-step level 3-4 for upes weekly; (2.) Active ROM adduction and abduction 2# ons 5 times weekly; (3) Actively suith red or green band 15 g 5 times weekly; and (4.) and weight shifting with walker times weekly. 38's April 2016 restorative dentified that R38 received ercises 7 times in 30 days. For a time and second of a days out of 31 days. 38 identified on the care plan included: Parkinson's disease teoporosis, heart failure and fractures. 39 dated 3/16/16, identified R39 w for Mental Status Score ating intact cognition and ired extensive assist of 1-2 except eating and indicated upervision. The MDS also a balance problem when	e e , , , , , , , , , , , , , , , , , ,			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00303	B. WING		05/2	26/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOODS	SAMARITAN SOCIETY	- JACKSON	ΓJACKSON I, MN 56143	.		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	ambulation by walk ft each way through R39's care plan ide measures to be util (1.) Active ROM 4 steps flexion, wrist extension supination/pronation Active ROM Nu-steps three times weekly balance activities the (4.) Walking with steps wheeled walker to for the month of Aplog identified R39 restorative logs, do received services and chronic kidney R11's care plan data the following diagnopain, major depress and chronic kidney R11's quarterly MD R11 with a Brief Int (BIMS) of 12, indicated the only realso identified R11 ambulating or trans R11's care plan ide physical mobility rearthritis evidenced goal identified he wambulate as some 100-200 feet (ft) at The care plan furth for restorative inter	ing to/from all meals up to 200 in next review. Intified the following restorative ized to support maintenance: sets of 5 repetitions wrist sion, forearm in three times weekly; (2.) is por 10 minutes at level 4 is (3) Active ROM standing ince times weekly; and and by assist of 1 using four from all meals. 39's restorative service records in 2016, documentation on the eccived ROM exercises 2 uring review of the May 2016 cumentation indicated R39 is days out of 31 days. Ited 3/20/16, identified R11 with incess: Parkinson's disease, is sion, atrial fibrillation, anemial disease. S dated 3/16/16,11 identified erview for Mental Status Score ating mildly impaired cognition required extensive assist of of the problem when were supported to the problem when were at the problem when in the problem when i	2 895			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00303	B. WING		05/2	6/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- JACKSON	TJACKSON I, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 19	2 895			
	10-15 min duration with assist of 2 follo 3 times weekly; and (3.) Walking with as outside of room 1 ti During review of R for April 2016 the lo ROM exercises 6 ti of the May 2016 log was identified to redays.	ssist of 2 followed by w/c me daily. 11's restorative service records g identified R11 received mes in 30 days. During review as for restorative services, R11 beive services 4 days out of 31 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.					
	(RNA)-A on 5/25/16 supervisory staff has services multiple tirwork as a nursing apersonal cares. RN provide the establis when reassigned dithe facility had been she was reassigned	th restorative nursing aide is, at 3:00 p.m. RNA-A stated and pulled her from restorative mes in the past two months to assistant (NA) to provide IA-A stated she was unable to the restorative programs uties. RNA-A further stated in short of NA help recently and diffrom restorative duties to ares when there was not				
	NA-B and NA-C on the NA's stated the	oith nursing assistant (NA)-A, 5/25/16, at 3:40 p.m. each of y did not have time to perform tram duties when a restorative				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00303	B. WING		05/26/2016	
NAME OF	PROVIDER OR SUPPLIER		L	STATE, ZIP CODE	05/2	.0/2010
GOOD S	AMARITAN SOCIETY	- JACKSON	T JACKSON N, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	aide was not specif The NA's stated the perform all the rest called in sick and/o SUGGESTED MET The director of nurs all residents at risk assure they are rec treatment/services range of motion. The designee, could could delivery of care; to services are implent	rically assigned those duties. Fre was not enough staff to orative programs when staff r if not showing up to work. THOD OF CORRECTION: Sing or designee, could review for limited range of motion to reiving the necessary to prevent further limitation in the director of nursing or nduct random audits of the ensure appropriate care and	2 895			
21100	Storage of Perishal Subp. 5. Storage of perishable food mu washable, corrosion sanitary conditions, will protect against. This MN Requirements by: Based on observatification of the prevent potential converted were thawed in a macross-contamination.	of perishable food. All list be stored off the floor on in-resistant shelving under and at temperatures which spoilage. ent is not met as evidenced ion and interview the facility at food was properly stored to iontamination and raw meats manner that prevents in of other food in the ad the potential to affect all 44	21100	Corrected		6/20/16

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00303	B. WING		05/	26/2016
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	EST JACKSON SON, MN 56143	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21100	During an initial tou 5/23/16, at 6:45 a.m noted to have 3 star food stored on the form of one box of mixed peas. The second stox of fruit cups. The of one box of frozer Brussels sprouts are During observation was noted that 2 star stored/placed direct comprised of 2 box second stack consist coleslaw, shelled expray ground beef. The box of eggs white refrigerator. The ray on a tray nor in a pathe meat from dripp beneath, resulting in contamination of for When interviewed of dietary manager (D) delivers food items and placed the box refrigerator and free the noted stacked by food delivery on The and were stored in a confirmed the ground top of the box of egway we store meat ground beef should placed on the thawit meat juices.	r of the facility kitchen on the walk in freezer was cks of boxes containing froz floor. The first stack comprise vegetables and one box of stack was comprised of one third stack was comprised burgers, vegetables, and a box of pork patties. of the walk-in refrigerator it tacks of food boxes were tally on the floor. The first states of egg blend; and the sted of one box creamy ggs, and a 10 pound tube of the ground beef was placed alle it was thawing in the w ground beef was not place an while it thawed to preven bing into the box of eggs in potential cross	d ck f on ed t eethe			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00202			05/0	06/0016
NAME OF F	PROVIDER OR SUPPLIER	00303		STATE, ZIP CODE	05/2	26/2016
	AMARITAN SOCIETY	- JACKSON 601 WEST	JACKSON			
		JACKSON	I, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21100	Continued From pa	ge 22	21100			
	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 staf and monitor for continued compliance.					
	TIME PERIOD FOR CORRECTION: Twenty one (21) days					
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			6/17/16
	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.					
	by: Based on observati review the facility fa	ent is not met as evidenced ion, interview and document alled to provide services in a r 2 of 2 residents (R32, R38) ed services.		Corrected		
	Findings include:					
	identified a BIMS so cognition. The MDS	dated 5/11/16, for R32 core of 14, indicating intact 6 further identified R32 with ce requiring extensive staff to manage.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00303		B. WING		05/	26/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- JACKSON	601 WEST	DRESS, CITY, S JACKSON I, MN 56143	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE ' MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21805	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			21805			
	and stated, "I needed they stated they wo nursing assistant st	uld be back (referrir	ig to				
	On 5/24/16, at 10:4 entered R32's room R32 out of bed for a incontinent of urine staff that R32 need incontinence cares.	n with a wheelchair to activities and noted look. AA-A notified the rolled to be assisted w	o assist R32 was nursing				
	Brief Interview for M	5/12/16, identified R Mental Status (BIMS cognition. The MDS red extensive assist ng, was frequently ir	38 with a) score of S further ance of				

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00303 B. WING 05/26/2016	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			00303	B. WING		05/2	96/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	NAME OF PR	PROVIDER OR SUPPLIER		DRESS CITY S	STATE ZIP CODE	1 03/2	.0/2010
GOOD SAMARITAN SOCIETY - JACKSON 601 WEST JACKSON JACKSON, MN 56143							
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	PRÉFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	(X5) COMPLETE DATE	
DEFICIENCY) 21805 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	Orsars scattes rhtlitcii or f Vosts scattes f	SAMARITAN SOCIETY - JACKSON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 24 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		21805	DEFICIENCY)		

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		00303	B. WING		05/2	6/2016					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
GOOD SAMARITAN SOCIETY - JACKSON JACKSON, MN 56143											
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE					
21805	Continued From pa	age 25	21805								
	compliance.										
		R CORRECTION: Twenty-one									

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