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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MQF8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00078

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245523**

2.STATE VENDOR OR MEDICAID NO.
(L2) **017740700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - CLEARBROOK**
(L4) **305 3RD AVENUE SOUTHWEST**
(L5) **CLEARBROOK, MN** (L6) **56634**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/11/2012** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **43** (L18)

13.Total Certified Beds **43** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	43			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Rogers, HPR Social Work Specialist 04/13/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Susan N. Leppke, Program Specialist 04/13/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 06/29/2012 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/09/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

At the time of the standard survey completed on February 16, 2012, the facility was not in substantial compliance and the most serious deficiencies were isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On April 4, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 11, 2012 the Minnesota Department of Public Safety completed a PCR to determine that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 16, 2012, effective March 27, 2012. Therefore, remedies outlined in our letter dated March 1, 2012, will not be imposed. See attached 2567-B forms for results of the April 4, 2012 and the April 11, 2012 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

June 29, 2012 CMS Certification Number (CCN):24-5523

Ms. Angel Normandin, Administrator
Good Samaritan Society - Clearbrook
305 3rd Avenue Southwest
Clearbrook, Minnesota 56634

Dear Ms. Normandin:

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 March 27, 2012 the above facility is recommended for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Susan N. Leppke

Susan N. Leppke, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4121 Fax: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 13, 2012

Ms. Angel Normandin, Administrator
Good Samaritan Society - Clearbrook
305 3rd Avenue Southwest
Clearbrook, Minnesota 56634

RE: Project Number S5523020

Dear Ms. Normandin:

On March 1, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standardsurvey, completed on February 16, 2012. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 11, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 11, 2012 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 16, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 27, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 16, 2012, effective March 27, 2012 and therefore remedies outlined in our letter to you dated March 1, 2012, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Marge Meeker

Marge Meeker, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4121 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File 5523r12.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245523	A. Building B. Wing	4/4/2012

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - CLEARBROOK	305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0174** Reg. # **483.10(k)** LSC	Correction Completed **03/27/2012**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **03/27/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/27/2012**
ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **03/27/2012**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **03/27/2012**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/27/2012**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/27/2012**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **03/27/2012**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **03/27/2012**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/SNL	04/13/2012	29437	04/04/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/16/2012				

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245523	01 - 1953 BUILDING WITH ADDITIONS	4/11/2012

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - CLEARBROOK	305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	03/27/2012	ID Prefix Reg. # NFPA 101 LSC K0020	03/27/2012	ID Prefix Reg. # NFPA 101 LSC K0029	03/27/2012
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/SNL	04/13/2012	03006	04/11/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/14/2012			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MQF8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00078

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245523**
2.STATE VENDOR OR MEDICAID NO.
(L2) **017740700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - CLEARBROOK**
(L4) **305 3RD AVENUE SOUTHWEST**
(L5) **CLEARBROOK, MN** (L6) **56634**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/16/2012** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **43** (L18)

13.Total Certified Beds **43** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	43			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
At the time of the standard survey completed on February 16, 2012, the facility was not in substantial compliance and the most serious deficiencies were isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections are required. The facility has been givenan opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE — Date :
Virginia Meyer, HFE NE II — 03/26/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Susan N. Leppke, Program Specialist — 04/06/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 4/9/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8073 8829

March 1, 2012

Ms. Angel Normandin, Administrator
Good Samaritan Society - Clearbrook
305 3rd Avenue Southwest
Clearbrook, Minnesota 56634

RE: Project Number S5523020

Dear Ms. Normandin:

On February 16, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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>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

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

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

DEPARTMENT CONTACT

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

Marge Meeker
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301-4557

Telephone: (320) 223-7317

Fax: (320) 223-7348

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 March 27, 2012, 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 March 27, 2012 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 16, 2012 (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 16, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Marge Meeker

Marge Meeker, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7317 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File 5523s12.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245523	A. BUILDING _____ B. WING _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CLEARBROOK	305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 174 SS=D	483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure privacy was maintained for 1 of 39 residents (R42) in the sample reviewed for privacy. Findings include: R42 's family representative stated he could not use the telephone in private. R42 's diagnosis included cerebral vascular accident (CVA), dementia and Parkinson ' s disease. The annual Minimum Data Set (MDS) dated 8/22/2011, indicated R47 had adequate hearing, clear speech, and could usually understand others. On 2/14/12, at 10:08 a.m., R42 's family representative (FR-M) stated R42 was capable of speaking on the telephone, but was unable to use the telephone in private. FR-M stated when she calls R42 on the telephone, the staff brings the cordless telephone into R42 ' s room, the telephone has no reception in the room, so R47 has to go into the hallway to converse. On 2/16/12, at 9:47 a.m., the social service designee (SS-A) was interviewed and stated she was unaware that the telephone did not work in R42 ' s room. On 2/16/12, at 10:35 p.m., the licensed practical nurse (LPN-B) was interviewed and indicated that the cordless telephone would not work in many of the rooms then on R42 ' s wing.	F 174	Please see attached POC's ok'd 3/22/12 mm	

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

Administrator 3-16-12

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

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F 174	Continued From page 1 On 2/16/12, at 10:15 a.m., the cordless telephone was tried, and did not work in R42 ' s room. The facility ' s policy and procedure on telephone use revised 2/02, directed " the resident will have privacy and reasonable access to the telephone. "	F 174		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225		

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F 225	Continued From page 2 with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to investigate inappropriate sexual behavior for 1 of 1 resident (R25) in the sample to determine if it was reportable potential abuse. Findings include: R25 had 4 incidents of sexual inappropriate behavior which was not investigated. R25 had multiple diagnoses including schizophrenia and bipolar disorder. His current care plan, dated 12/20/11 identified sexually inappropriate behaviors with female residents and a goal of " will not hurt others " . Review of progress notes revealed an entry dated 12/14/11 at 7:00 p.m. identified " Off going nurse stated him and (female resident) were seen kissing and were promptly separated, him being informed inappropriate behavior. " Nursing notes on 12/5/11 at 1:00 p.m. indicated R25 was struck by the same female resident as she walked past him. No injury was noted. On 11/13/11 at 8:40 a.m. according to nursing notes, R25 " was caught rubbing hand across another female residents chest x2, when asked to stop touching resident became v. (very) angry started swearing ' We ' re just friends I hate this place. ' Told resident to go to his room if he didn ' t ' quit swearing and yelling - resident did finally propel self to room. " Progress notes on 10/14/11 at 6:30 p.m. revealed " CNA (certified nursing	F 225		

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F 225	Continued From page 3 assistant) observed (R25) pushing up pants leg of female resident (identifier) and stroking her leg. CNA stated that as soon as (R25) realized the CNA saw this, he quickly left the area in his wheelchair. " None of these incidents were investigated. Interview with the Social Service Designee on 2/16/12 at 1:15 p.m. indicated she was aware of R25 ' s inappropriate sexual behavior and which female resident he focused on with these behaviors. She was not aware of these specific incidents. Interview with the Director of Nursing on 2/16/12 at 2:25 p.m. indicated she was aware of R25 ' s behaviors but unaware of these specific incidents. She stated she had not been notified of any of the above incidents.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to operationalize their policies and procedures to ensure protection of residents from 1 of 6 residents (R25)in the sample. Findings include: Based on interview and document review the facility failed to investigate inappropriate sexual behavior for 1 of 1 resident (R25) in the sample to determine if it was reportable potential abuse. Findings include: R25 had 4 incidents of sexual inappropriate	F 226		

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F 226	Continued From page 4	F 226		

behavior which was not investigated. R25 had multiple diagnoses including schizophrenia and bipolar disorder. His current care plan, dated 12/20/11 identified sexually inappropriate behaviors with female residents and a goal of " will not hurt others " .
Review of progress notes revealed an entry dated 12/14/11 at 7:00 p.m. identified " Off going nurse stated him and (female resident) were seen kissing and were promptly separated, him being informed inappropriate behavior. " Nursing notes on 12/5/11 at 1:00 p.m. indicated R25 was struck by the same female resident as she walked past him. No injury was noted. On 11/13/11 at 8:40 a.m. according to nursing notes, R25 " was caught rubbing hand across another female residents chest x2, when asked to stop touching resident became v. (very) angry started swearing ' We ' re just friends I hate this place. ' Told resident to go to his room if he didn ' t ' quit swearing and yelling - resident did finally propel self to room. " Progress notes on 10/14/11 at 6:30 p.m. revealed " CNA (certified nursing assistant) observed (R25) pushing up pants leg of female resident (identifier) and stroking her leg. CNA stated that as soon as (R25) realized the CNA saw this, he quickly left the area in his wheelchair. " None of these incidents were investigated.
Interview with the Social Service Designee on 2/16/12 at 1:15 p.m. indicated she was aware of R25 ' s inappropriate sexual behavior and which female resident he focused on with these behaviors. She was not aware of these specific incidents. Interview with the Director of Nursing on 2/16/12 at 2:25 p.m. indicated she was aware of R25 ' s behaviors but unaware of these specific incidents. She stated she had not been notified of

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F 226	Continued From page 5 any of the above incidents. Review of policies and procedures related to Abuse and Neglect provided by the facility as current indicated incident reports were to be filled out for all resident incidents. The policy indicated that all incident reports were to be forwarded to the investigation team for review no later than the next business day. The policy directed that the administrator be notified " immediately of any incidents of resident abuse, misappropriation of resident property, alleged or suspected abuse and injury of unknown origin, neglect, financial exploitation or involuntary seclusion. " The policy indicated the state agency would be notified by the charge nurse as appropriate or the designated person as soon as possible after reviewing the incident report. The investigation team would initiate and complete a comprehensive investigation following the review of the report. The results of the investigation would be reported to the state agency within 5 days of completion of the investigation according to the policy. The policies for abuse and neglect were not implemented for residents R25.	F 226		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide medically-related social	F 250		

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F 250	Continued From page 6 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 3 of 5 residents (R12, R21, and R7),in the sample with specific issues that required social service assessment and interventions. Findings include: Resident 12 (R12) was not assessed for, or provided with, interventions related to chemical dependency that addressed the psychosocial issues or provided support for problems associated with the legal and behavioral concerns that presented. R12 was admitted 7/2011 with diagnoses that included alcoholism, alcohol withdrawal, heart disease, social situation with homelessness and psychosocial issues. R12 was also granted a probation agreement that was in effect until 2016 that included numerous general and special conditions to continue to abide by that included a return to specialized supportive housing and CD evaluation upon completion of incarceration. The admission minimum data set (MDS) dated 8/4/12 identified R12 with cognitive independence (brief interview mental status score BIMS 14), signs and symptoms of mood disorder and the presence of behavioral symptoms. The MDS also identified discharge to the community was not feasible; however, the sections that addressed return to the community or referral to local agencies were left blank and the MDS noted there was no active discharge plan. An interdisciplinary data collection tool dated	F 250		

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F 250	Continued From page 7 7/28/11 that included social services designee input noted indicators of depression, anxiety or sad mood were [not applicable] (n/a), typical sadness to losses, orientation was [clear] and the discharge plan was [to get home.] The summary section (additional comments section) of the social history tool dated 7/28/11 was left blank and the data collected was not reviewed or summarized. The MDS care area assessment (CAA) summary dated 8/4/12 for the triggered psychosocial area identified R12 would have one to one visits 3x/week, socialize with staff and noted the probation status and the parole officer or county case worker would be contacted if needed to visit with R12. A psychiatric nurse practitioner consultation report dated 1/11/2011 identified R12 with a depressive disorder with severe stressors related to his primary support group, social environment, housing, legal and medical issues. The report noted anxiety issues and agitation and yelling out at staff and residents. The report also noted R12 would need resources to remain sober when discharged from the facility and had voiced interest in attending alcohol support group meetings and was motivated to remain sober. Antidepressant medication (Celexa) was increased from 10 to 20 mg. daily for depression and anxiety following the consultation. R12 ' s care plan dated 2/7/12 included identification of problems with alteration in mood state, behavior and psychosocial well- being related to alcohol withdrawal. Interventions were supposed to include one to one visits weekly and	F 250		

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F 250	Continued From page 8 on-going monitoring and interventions and orientation by social services (designee). Additionally, the care plan noted possible discharge home related to acute medical problems and the potential ability to care for self. The intervention and approaches identified social services(designee) was to assist in discharge planning. The facility social services designee-A (SS-A) verified during interview at 10:20 a.m. on 2/16/12 she, " Tried to check in on him 3x/weekly, " but did not conduct regularly scheduled formalized one to one visits with R12 to discuss issues related to mood or chemical dependency withdrawal. SS-A reported she was not aware of the support housing referenced in the parole agreement and had not contacted any local support groups to conduct visits with R12. SS-A reported she had made telephone contact with the parole officer but did not document any discussions or efforts to ensure R12 was provided with services he may need if discharged and did not routinely document social services notes in the interdisciplinary notes, " Unless it ' s a huge issue. " SS-A stated R12 was originally considered short term and wanted to return to his home; however, did not think it was " medically possible. " SS-A reported she did complete the screening tool for residents at admission and an actual comprehensive social services assessment was not completed by anyone in the facility. SS-A stated the MDS nurse did the documentation for social services as part of the MDS assessments and added, " I ' m just the designee. I have to do the business office work too; that takes a lot of time. "	F 250		

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F 250	Continued From page 9 The MDS nurse reported at 1:45 p.m. on 2/16/12 she, " Looked at data from the social services screening to include in the CAA's. I don ' t do a social services assessment; I think the social services designee does that and will put it at the end section (additional comments/summary section) of the social services history tool. " The MDS nurse was not aware this section of the social services history for R12 was not completed and left blank. The facility administrator reported during interview at 2:15 p.m. on 2/16/12 the MDS nurse was relatively new in the role and, " Still in the training process " to perform social services evaluations. The administrator stated corporate had a social services consultant available but they did not actually perform any direct services for specific resident issues and were more involved with quality assurance and policy reviews. The administrator also reported R12 was originally considered short term and they had worked to get placement at other locations that would not accept him and he was now transitioning into long term placement. The social services designee (SS-A) could not locate any documentation of placement attempts or discussions with the parole office or county case workers and verified at 2:30 p.m. she had not contacted the corporate social services consultant related to issues with R12. The facility faxed additional documentation from interdisciplinary summaries to review on 2/21/12. The information related to payment for nursing home room and financial assistance, private room, possible guardianship, and future	F 250		

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placement options; however, there was no discussion related to providing support and services while in the nursing home setting. Some of the information was entered by the social services designee, some by nursing.

The facility policy on how social services were provided was requested. The policy, [Social services Standards of Practice,] dated November 1999, did not include any specific procedures on how social services were provided, what services were provided, who provided them in the facility or the roles of personnel responsible. The policy was only a statement that the social services department would be in compliance with all standards and regulations.

Resident 21 (R21) had diagnoses that included history of falls, anxiety state, anemia, hypertension and depressive disorder.

The admission minimum data set (MDS) dated 11/25/11 identified R21 with moderate cognitive impairment (BIMS score 8), intermittent signs and symptoms of delirium (inattention), signs and symptoms of mood disorder and psychosis. The MDS also noted extensive assistance was required for mobility and balance was impaired during transitions. The MDS did not indicate discharge goals had been established in the assessment process but did note a discharge was determined to be feasible.

The admission social services data collection information dated 11/18/11 identified some anxiety and wandering and the resident desired to go home but needed to be stabilized first, [looking

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F 250	Continued From page 11 like long term.] The social history section dated 11/23/11 noted R21 had been living at home the previous five years, noted contact information and previous life experience, typical sadness from loss, religion, etc. The social history did not indicate R21 had a fall history or utilized home care services five days/week prior to admission to the facility or other significant issues that would affect discharge planning activity. The summary section (additional comments section) of the social history tool dated 7/28/11 was left blank and the data collected was not reviewed or summarized. The MDS CAA (11/25/11) for the triggered area of return to community referral noted the depression, anxiety, hallucinations present, unsteady balance and assistance for cares. The family was noted to request permanent placement and the physician would reassess the discharge plan in 90 days. R21 did receive skilled therapy services until 12/9/11 and was discharged to a restorative nursing exercise program that was still being conducted. The occupational therapist noted safety concerns with walker use and decreased activity tolerance at the time of discharge. R21 ' s current care plan dated 12/5/11 identified R21 ambulated with the walker and staff supervision and/or assistance to meals and activities. The care plan identified the resident would like to return home, family was undecided and physician would reevaluate in 90 days and discharge to home was possible related to the acute nature of medical problems. Plans and approaches were for social services (designee) to assist in the	F 250		

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F 250	Continued From page 12 adjustment process and discharge planning. R21 reported during interview at 7:45 a.m. on 2/15/12 she was interested in being discharged to another setting, said she liked it at the facility but thought she would do " OK " in another setting, perhaps an assisted living facility. Review of the interdisciplinary assessments and summary review notes did not identify any specific entries by social services related to adjustment process or discharge planning. Following inquiry, the nursing director provided a late entry nursing note dated 2/16/12 that identified the discharge was discussed with the family and the family remained undecided with some wanted discharge home, others wanting continued long term care. The late entry also noted staff would readdress this with the family following the next care conference. The facility social services designee-A (SS-A) verified during interview at 10:20 a.m. on 2/16/12 she did not routinely document social services notes in the interdisciplinary notes, " Unless it ' s a huge issue " and had not documented the issues related to discharge planning and family concerns for R21. SS-A reported she did complete the screening tool for residents at admission and an actual comprehensive social services assessment was not completed by anyone in the facility. SS-A stated the MDS nurse did the documentation for social services as part of the MDS assessments and added, " I ' m just the designee. I have to do the business office work too; that takes a lot of time. " The MDS nurse reported at 1:45 p.m. on 2/16/12	F 250		

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F 250	Continued From page 13 she, " Looked at data from the social services screening to include in the CAA's. I don ' t do a social services assessment; I think the social services designee does that and will put it at the end section (additional comments/summary section) of the social services history tool. " The MDS nurse was not aware this section of the social services history for R21 was not completed and left blank. R7 lacked social service assessments and interventions related to his previous life experiences and activities. R7 had diagnosis that required specialized psychosocial needs and activities. The comprehensive minimum data set (MDS) dated 9/5/11, indicated R7 had severely impaired cognitive skills for daily living, rarely/never made decisions, had short and long term memory problems, required total staff assist with activities of daily living, and had an absence of speech. The MDS further identified R7 ' s preferences for customary routines and activity preferences were answered by staff as family/significant other were not available, and the preferences included a bed bath, reading books, newspapers or magazines and listening to music. The psychosocial care area assessment (CAA) dated 9/8/11, indicated R7 had experienced absence of daily exchanges with relatives and family over the past few years, the current living situation limited informal social interaction, R7 had no verbal communication, staff were to provide 1:1 interactions three times a week, and keep tv, music available and visit when in the room. The plan of care also directed to encourage family/friend involvement. The social history, dated 9/10/10, listed	F 250		

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	245523	A. BUILDING _____ B. WING _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 250	Continued From page 14 customary routines (a.m. routine, p.m. routine and sleep routine), education, occupations, significant experiences/achievements, travel, and hobbies as n/a (not available), and religion/spiritual denomination as unknown. The psychosocial well-being plan of care, dated 12/13/11, directs 1:1 ' s three times a week including devotions, music, reading, tv, and sports, and to keep music available, and encourage family, friend involvement. On 2/16/12, at 9:53 a.m., the social service designee (SS-A) was interviewed and stated she does not do any 1:1 visits with R7, she stops in and says hello once in a while. SS-A further stated she helps manage R7 ' s money, and does purchasing needs. When asked how R7 ' s psychosocial needs were being met, SS-A stated R7 has a lot of people involved in the care.	F 250		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272		

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F 272	Continued From page 15 Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure comprehensive assessments were completed for community discharge for 1 of 3 residents (R12), pain for 2 of 3 residents (R25, R28), and urinary incontinence for 2 of 3 residents (R28, R2) reviewed in the sample. Findings include: R25 did not receive a comprehensive assessment to assist with developing an effective individualized pain management program. R25 had multiple diagnoses including including paranoid schizophrenia, bipolar disease, and joint	F 272		

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F 272	Continued From page 16	F 272		

pain with a history of multiple traumatic fractures. The comprehensive Minimum Data Set (MDS) identified no need for a Care Area Assessment for pain. However the MDS dated 12/15/11 identified occasional, moderate pain. With the change in pain from no pain to occasional pain, a comprehensive assessment was not completed. The care plan identified no problems with pain however did identify recurrent health and anxious complaints, crying. The care plan directed staff to allow resident to vent feelings, notify nursing of health complaints, assess vitals and reassure. There was no information in an assessment or direction in the care plan to assist with determining when health complaints are valid rather than behaviorally related.

Interview with RN-B at 11:00 a.m. on 2/15/12 revealed "There should have ben something in the pain assessment for the MDS. It was hard to get anything. We usually go through what's working but if he can't tell me what's causing his pain, I can't say what's fixing it. He doesn't always verbalize where it is. The staff is very good about determining when it's valid (the health complaints including pain) and when it's not. They should assess him - but they know what his typical complaints are. He does have the tendency for attention seeking behaviors and he does have a lot of complaints so he's tough to get a gauge on."

R28 did not receive a comprehensive assessment to assist with developing an effective individualized pain management program. R28 had multiple diagnoses including arthritis and obesity. The most recent pain summary review dated 1/9/12 indicated "Resident has frequent

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F 272	Continued From page 17 complaints of pain" which included migraines and aches in legs and ankles. Review of the Minimum Data Set (MDS) dated 1/8/12 indicated R28 had no scheduled pain medications and no non-pharmacological interventions for pain. The MDS indicated R28 had as needed (PRN) pain medications. R28 indicated during the MDS assessment that she had occasional pain which was severe. Although R28 identified occasional, severe pain at the time of the MDS, there was no assessment to assist with identifying non-pharmacological and pharmacological approaches which could assist with alleviating the pain. Interview with R28 at 10:00 a.m. on 2/16/12 indicated "I get headaches every day, the spot on the back of my neck hurts and I have pain in my right knee a lot, especially when I do a lot of walking. It gets worse during the day. The pain gets up to an 8 or 10 (on a scale of 0-10) almost every day." Interview at 10:30 a.m. on 2/16/12 with RN-B indicated "She's hard because she needs weight loss. Her way to deal with it is to stay in her room and not deal with it. We're just supposed to fix her and take care of her so we're really at a loss on how to get her better. At times I think she wants the big fix. She wants the pill and the doctor." R28 failed to receive a comprehensive assessment of urinary incontinence to assist with developing interventions to minimize incontinence. R28 had multiple diagnoses including arthritis, obesity, depression, and adult failure to thrive. According to the most recent MDS (Minimum Data Set) assessment completed	F 272		

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F 272	Continued From page 18 1/8/12, R28 had behavioral symptoms not directed at others but had no rejection of cares and was totally dependent on two staff for toileting assistance. The MDS also identified R28 was on a toileting program and was frequently incontinent of urine. The Care Area Assessment (CAA) dated 4/16/11 indicated R28 had functional incontinence. However the Bladder Assessment reviewed as current on 1/6/12 noted R28 to have mixed incontinence. Although the Bladder Assessment identified multiple risk factors including "leaking" urine, medications, diagnoses, toileting abilities and behaviors there was no assessment to determine if any of the identified risk factors could be modified to improve the incontinence. In addition, the assessment indicated inconsistencies with incontinence, post-void residual (PVR) had not been checked, and R28 was not referred to a practitioner for further evaluation. Further review of the record failed to review a comprehensive, individualized bladder assessment to assist with maximizing continence, including a review of medical history and risk factors and a bladder diary to assist with identifying any patterns of incontinence. Facility staff indicated the incontinence was related to behaviors, however there was no assessment supporting this belief. Interview at 10:15 a.m. on 2/16/12 "I was wet when I first got here but it's gotten worse. I can't control it and I can't get no help straightening it out. I wish I could do better with it. They tell me I can control it that I can hold it but I can't." RN-B indicated at 10:40 a.m. on 2/16/12 "She has no s/s of UTI's so I'm not concerned about that, we wonder if it's a behavioral thing. We	F 272		

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F 272	Continued From page 19 know she can make it. We wonder if it's just more behavioral." At 1:00 p.m. on 2/16/12 RN-A indicated "I have documentation of her behaviors related to toileting. She will say she doesn't need to go to the bathroom and then void on the floor." RN-A also identified that staff believe R28's incontinence to be related to behaviors, however acknowledged there had not been an assessment completed to determine the cause of incontinence. Resident (R2) lacked a comprehensive bladder assessment that accurately depicted bladder function, as well as interventions to reduce incontinent episodes. The admission minimum data set (MDS) indicated moderately impaired cognition (brief interview mental status score BIMS 7), and with noted occasional urinary incontinence, no urinary toileting program to prompt voiding or train the bladder. The quarterly MDS dated 1/8/12 R2 was on a toileting program. The facility bladder assessment dated 10/7/11 indicated R2 was continent of urine upon admission. The following bladder assessment dated 1/6/12 noted, "no change current", however the care plan updated 1/17/12 included urinary incontinence as a concern. The assessment lacked a summary of factors that contributed to incontinence, such as memory loss. The assessment failed to include whether the resident verbalized the need to void, or whether the resident was able to successfully void using the toilet.	F 272		

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F 272	Continued From page 20 R2's admission care plan, dated 10/5/11 indicated R2 was continent and did not include incontinence as a concern, therefore, there were no interventions to direct staff to help the resident to maintain or improve bladder function. At 1:00 p.m. on 2/16/12 the MDS nurse stated R2 was incontinent upon admission, which conflicted with the admission assessment indicating no incontinence. The MDS nurse stated R2 had increased times of urinary incontinence, self toilets and used incontinent products at times, although the assessment dated 1/6/12 indicated, "no change current"which referenced R2 was continent. Resident 12 was not comprehensively assessed for issues related to psychosocial concerns related to chemical dependency and withdrawal and other factors that affected resident well-being and barriers to community discharge. R12 was admitted 7/2011 with diagnoses that included alcoholism, alcohol withdrawal, heart disease, social situation with homelessness and psychosocial issues. R12 was also granted a probation agreement that was in effect until 2016 that included numerous general and special conditions to continue to abide by that included a return to specialized supportive housing and CD evaluation upon completion of incarceration. The admission minimum data set (MDS) dated	F 272		

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F 272	Continued From page 21 8/4/12 identified R12 with cognitive independence (brief interview mental status score BIMS 14), signs and symptoms of mood disorder and the presence of behavioral symptoms. The MDS also identified discharge to the community was not feasible; however, the sections that addressed return to the community or referral to local agencies were left blank and the MDS noted there was no active discharge plan. An interdisciplinary data collection tool dated 7/28/11 that included social services designee input noted indicators of depression, anxiety or sad mood were [not applicable] (n/a), typical sadness to losses, orientation was [clear] and the discharge plan was [to get home.] The summary section (additional comments section) of the social history tool dated 7/28/11 was left blank and the data collected was not reviewed or summarized. The facility social services designee-A (SS-A) verified during interview at 10:20 a.m. on 2/16/12 she, " Tried to check in on him 3x/weekly, " but did not conduct regularly scheduled formalized one to one visits with R12 to discuss issues related to mood or chemical dependency withdrawal. SS-A reported she was not aware of the support housing referenced in the parole agreement and had not contacted any local support groups to conduct visits with R12. SS-A reported she had made telephone contact with the parole officer but did not document any discussions or efforts to ensure R12 was provided with services he may need if discharged and did not routinely document social services notes in the interdisciplinary notes, " Unless it ' s a huge issue. " SS-A stated R12 was originally considered short term and wanted to return to his	F 272		

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F 272	Continued From page 22 home; however, did not think it was " medically possible. " SS-A reported she did complete the screening tool for residents at admission and an actual comprehensive social services assessment was not completed by anyone in the facility. SS-A stated the MDS nurse did the documentation for social services as part of the MDS assessments and added, " I ' m just the designee. I have to do the business office work too; that takes a lot of time. " The MDS nurse reported at 1:45 p.m. on 2/16/12 she, " Looked at data from the social services screening to include in the CAAs. I don ' t do a social services assessment; I think the social services designee does that and will put it at the end section (additional comments/summary section) of the social services history tool. " The MDS nurse was not aware this section of the social services history for R12 was not completed and left blank. The facility administrator reported during interview at 2:15 p.m. on 2/16/12 the MDS nurse was relatively new in the role and, " Still in the training process " to perform social services evaluations. The administrator stated corporate had a social services consultant available but they did not actually perform any direct services for specific resident issues and were more involved with quality assurance and policy reviews. The facility policy on how social services were provided was requested. The policy, [Social services Standards of Practice,] dated November 1999, did not include any specific procedures or details on how social services were provided or	F 272		

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F 272	Continued From page 23 comprehensive assessments were completed. Resident 21 was not comprehensively assessed for issues related to psychosocial concerns related to long term care placement and other relevant factors that affected resident well-being and barriers to community discharge. Resident 21 (R21) had diagnoses that included history of falls, anxiety state, anemia, hypertension and depressive disorder. The admission minimum data set (MDS) dated 11/25/11 identified R21 with moderate cognitive impairment (BIMS score 8), intermittent signs and symptoms of delirium (inattention), signs and symptoms of mood disorder and psychosis. The MDS also noted extensive assistance was required for mobility and balance was impaired during transitions. The MDS did not indicate discharge goals had been established in the assessment process but did note a discharge was determined to be feasible. The admission social services data collection information dated 11/18/11 identified some anxiety and wandering and the resident desired to go home but needed to be stabilized first, [looking like long term.] The social history section dated 11/23/11 noted R21 had been living at home the previous five years, noted contact information and previous life experience, typical sadness from loss, religion, etc. The social history did not indicate R21 had a fall history or utilized home care services five days/week prior to admission to the facility or other significant issues that would affect	F 272		

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F 272	Continued From page 24 discharge planning activity. The summary section (additional comments section) of the social history tool dated 7/28/11 was left blank and the data collected was not reviewed or summarized. The MDS CAA (11/25/11) for the triggered area of return to community referral noted the depression, anxiety, hallucinations present, unsteady balance and assistance for cares. The family was noted to request permanent placement and the physician would reassess the discharge plan in 90 days. Review of the interdisciplinary assessments and summary review notes did not identify any specific entries by social services related to adjustment process or discharge planning. Following inquiry, the nursing director provided a late entry nursing note dated 2/16/12 that identified the discharge was discussed with the family and the family remained undecided with some wanted discharge home, others wanting continued long term care. The late entry also noted staff would readdress this with the family following the next care conference. The facility social services designee-A (SS-A) verified during interview at 10:20 a.m. on 2/16/12 she did not routinely document social services notes in the interdisciplinary notes, " Unless it ' s a huge issue " and had not documented the issues related to discharge planning and family concerns for R21. SS-A reported she did complete the screening tool for residents at admission and an actual comprehensive social services assessment was not completed by anyone in the facility. SS-A stated the MDS nurse did the documentation for	F 272		

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F 272	Continued From page 25 social services as part of the MDS assessments and added, " I ' m just the designee. I have to do the business office work too; that takes a lot of time. " The MDS nurse reported at 1:45 p.m. on 2/16/12 she, " Looked at data from the social services screening to include in the CAAs. I don ' t do a social services assessment; I think the social services designee does that and will put it at the end section (additional comments/summary section) of the social services history tool. " The MDS nurse was not aware this section of the social services history for R21 was not completed and left blank.	F 272		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently follow the care plan for interventions related to fall prevention for 1 of 3 residents (R24) and behavior management for 1 of 1 residents (R25) reviewed in the sample. Findings include: Resident 24 (R24), who had a multiple fall history, did not receive the regular 15 minute checks by staff to reduce the risk of additional falls as	F 282		

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F 282	Continued From page 26 directed by the care plan. R24 had diagnoses that included heart failure, chronic airway obstruction, anxiety state, osteoporosis, chronic pain syndrome, and fall history. The most recent quarterly minimum data set (MDS) dated 1/12/12 identified R24 with cognitive independence, signs/symptoms of mood disorder, presence of verbal behaviors, independence/supervision with mobility, one person physical assistance for toilet use, some balance loss during transitions and impaired upper extremity range of motion that affected one side. The MDS also noted two or more falls had occurred since the most recent assessment. R24 was assessed by a comprehensive fall assessment to be at high risk of falls and the current care plan dated 1/24/12 identified fall history problem with generalized weakness and independence to extensive assistance with transfers and bed mobility and ambulation. Plans and approaches included independence to extensive assistance using the walker and transfers, encouragement to use the call light and conduct every 15 minute safety checks. During continuous observations of R24 ' s room from 8:50 a.m. to 10:10 a.m. on 2/15/12, R24 was noted to transfer herself from the toilet to the bed without assistance and was sitting sideways, fallen back against the wall while in the bed. Breakfast tray at bedside. During the one hour period, R24 had the door to the room completely closed and she could not be observed. Several staff were noted to walk by the room and not	F 282		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 27 attempt to perform a check on R24 or open the door to determine safety concerns. At 9:43 a.m. an activity aide opened the door to peer inside looking for another staff. R24 remained back against the wall until putting the call light on at 10:05 a.m. and it was answered by nursing assistant-A (NA-A) at 10:10 am. The time elapsed without a safety check was 53 minutes and 27 minutes. Nursing assistant-A (NA-A), who was assigned to the unit with R24 reported during interview at 10:20 a.m. R24 should be on every 15 minute checks because of a fall history, but reported, she was, " Not always able to do it because of breakfast and when cares have to be done for other residents. " NA-A reported, " I kind of know the resident ' s routines and when they are in bed or on the toilet and what they are doing. " R24 ' s room was also observed continually from 8:25 a.m. to 9:15 a.m. on 2/16/12. During the 50 minute period elapsed, no staff were observed to perform 15 minute checks on R24. Again, several staff including NA-F were observed to pass R24 ' s room with a closed door such that R24 could not be observed or checked on unless the door was opened. R24 could be heard coughing loudly during this time and was noted to be sitting on the bed eating breakfast, partly dressed. At 9:15 a.m. the director of nursing (DON) verified during interview that R24 should have 15 minute checks completed as was indicated in the current care plan, but she had not actually watched to see if they were done and aides should observe or " poke their head in " the room to perform the check. NA-F verified during interview at 9:30 a.m. she	F 282		

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F 282	Continued From page 28 did not perform the 15 minute checks and said she was not sure who did, but " somebody must be. " R25 did not have his plan of care followed related to behaviors. R25 had multiple diagnoses including paranoid schizophrenia and bipolar disorder. His care plan most recently dated 12/20/11 directed staff to notify the director of nursing (DON) of all issues with inappropriate sexual behaviors. R25 had documented incidents of inappropriate sexual behaviors on 12/14/11, 12/5/11, 11/13/11, and 10/14/11. Record review revealed no documentation that the DON had been notified. Interview with the DON on 2/16/12 at 2:25 p.m. revealed she had not been notified that any of these incidents had occurred.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure comprehensive pain management programs were in effect for 2 of 3 residents (R25, R28) reviewed in the sample with pain. This resulted in actual harm for R25. Findings include:	F 309		

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F 309	Continued From page 29 R25 failed to receive an effective pain management program. This resulted in R25 having "bad, so bad" pain which was actual harm. R25 had multiple diagnoses including paranoid schizophrenia, bipolar disease, and joint pain with a history of multiple traumatic fractures. The comprehensive Minimum Data Set (MDS) dated 9/16/11 identified no need for a Care Area Assessment for pain. However the MDS dated 12/15/11 identified occasional, moderate pain. The care plan dated 12/20/11 identified no problems with pain however did identify recurrent health and anxious complaints, crying. The care plan directed staff to allow resident to vent feelings, notify nursing of health complaints, assess vitals and reassure. There was no information in an assessment or direction in the care plan to assist with determining when health complaints are valid rather than behaviorally related. R25 was observed at 4:30 p.m. and 6:30 p.m. complaining of pain in his right foot. Staff was observed to be at the nursing station during both observations and were present to hear R25's concern. Staff were observed to not provide any interventions or redirection at that time. R25 remained restless in his wheelchair continuing to complain of foot pain. When interviewed at 10:20 a.m. on 2/14/12 R25 indicated he recently had podiatry services and his feet have bothered him ever since. "What can I do? It just hurts me so. I try to be happy and look forward to a new day but it hurts." Review of the medical record verified R25 had podiatry services on 12/14/11 in which he had 4	F 309		

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F 309	Continued From page 30 toe nails sharply debrided and was identified with capsulitis and bursitis. The podiatry referral directed staff to regularly monitor shoewear or pressure reducing devices, and transfer devices such as wheelchairs for increased pressure to bony prominence's. The facility could consider accommodative shoewear, or pressure relieving devices for digital/pedal deformities. At 1:00 p.m. on 2/14/12 R28 was observed at the nursing station tearful and crying indicating he had pain in his right foot. "It's just so horrible, my foot is so horrible. Oh it hurts." RN-A and TMA-A were present at the time of the observation. Both staff members were observed to acknowledge R28's pain stating "I know, I know. I know that foot hurts." However, no treatment or intervention was provided to R25 to assist with relieving pain. Review of the progress notes and Medication Administration Records (MAR's) on 2/15/12 at 8:00 a.m. identified no entries were made regarding the pain on 2/14/12. At 7:00 a.m. on 2/15/12 R25 was observed to be up in his wheelchair with a gown on, wearing his shoes and a brace to his lower right foot without socks on his feet. His legs were in the dependent position. R25 stated the pain is usually better in the morning and worse after he's been up awhile. R25 was unable to rate his pain but identified it as "bad" and "horrible". R25 was observed to be transferred back to bed and complained of pain in the right foot. At 7:50 a.m. nursing assistant -G (NA-G) removed R25's shoes after transferring him to bed. Observed on the bottom of R25's right foot was an area on the ball of his foot, approximately 4 cm in diameter and deep red and purple in color. According to NA-G this area was	F 309		

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F 309	Continued From page 31 "new" and had not been there when she cared for R25 on 2/13/12. At 8:15 a.m. while providing cares, NA-G further stated the area on the bottom of the right foot "came on really fast. I don't think they know about that one." R25 then stated "They don't believe me, nobody looks at my foot and they won't give me anything for pain. Nothing works and it hurts so bad - I think I'm going to cry and I hate to cry." NA-G reminded R25 that he can't take codeine as it makes him too sleepy. On 2/15/12 at 9:00 a.m. NA-G indicated R25 has "been saying for a week that his foot hurt and nobody believed it, nobody would look at it." Interview with LPN-A and LPN-C on 2/15/12 at 12:20 p.m. and 12:15 p.m. respectively revealed they had not been informed of R25's pain or the area of concern on the bottom of his right foot. Record review indicated R25 had physician orders for Baclofen orally for muscle spasms, 10 mg twice a day and 20 mg at bedtime; Neurontin orally 600 mg three times a day, and ibuprofen 400 mg every 4-6 hours as needed for pain. Pain was not addressed in the Physician progress notes from 12/14/11. However on 9/6/11, physician progress notes identified left foot pain and directed staff to obtain an x-ray as was "likely to be soft tissue problem." The x-ray was negative for any fractures. Review of progress notes revealed a late entry dated 2/15/12 for 2/13/12 which indicated "Res (Resident) c/o (complaining of) right great toe, reddened nail and placed small amount of cotton lower corner resident stated this helped with discomfort." There had been no other progress notes since 2/7/12 and no entries related to foot or toe pain since 1/9/12.	F 309		

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F 309	Continued From page 32 Interview with LPN-C at 12:15 p.m. on 2/15/12 identified "I haven't had any report about (R25) and his right foot today. He got Tylenol yesterday but I haven't heard anything about it today." LPN-C further indicated that if PRN (as needed) pain medications are given, it is to be documented on the back of the MAR including why you gave it and its effectiveness. Review of the MAR on 2/15/12 at 4:00 p.m. indicated no PRN Tylenol had been given on 2/14/12. Review of progress notes on 2/16/12 identified a late entry dated 2/16/12 for 2/14/12 indicating that Tylenol had been given for right foot pain. The note further indicated that R25's right foot and toes were inspected and no injuries were noted. LPN-A at 12:20 p.m. on 2/15/12 stated "I looked at his toe Monday and put the cotton under it. It looked like he was getting an ingrown nail again. He said it helped. I haven't heard anything today. He wants codeine but he can't have it - it snows him." The director of nursing (DON) confirmed this stating "Yeah, he can't have the codeine he just gets snowed." When asked if anything else has been tried to manage R25's pain, they both said I don't know. When informed R25 stated the Tylenol and ibuprofen weren't working, they stated "He just wants the codeine." On 2/15/12 at 12:00 p.m. R25 reported that the staff was telling him that he didn't have pain yesterday, "like I don't know what I'm talking about." At 1:00 p.m. on 2/15/12 R25's right foot was observed with the DON and LPN-A. At that time the area was no longer purple and much less red.	F 309		

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F 309	Continued From page 33 The DON stated "its just a callous. We'll call podiatry." When asked if the area had been measured, the DON stated it had not and measured the area at surveyor request. The area measured 3 cm x 4 cm and was pink in color and had a 1.5 cm x 2 cm callous like area in the center. At that time, R25 shouted "you aren't treating my pain, I'll call the county! It feels like fire, why won't you listen to me?" At 2:00 p.m. on 2/15/12 the DON reported R25 was now also on Ultram 50 mg by mouth every 4 hours as needed for pain and was seeing podiatry in the morning at 9:00 a.m. On 2/15/12 at 11:00 a.m. RN-B stated "The staff is very good about determining when it's valid (the health complaints, such as pain) and when it's not. They should assess him. He does have the tendency for attention seeking behaviors and he does have a lot of complaints so he's tough to get a gauge on." When RN-A was asked about the observed incident of R25 crying in pain on 2/14/12 she stated "I don't remember that incident, I don't remember that. I thought he was getting medicated for it." Review of the podiatry referral upon return 2/16/12 identified "Pain under right first MTP (metatarsophalengeal) joint-needs padding between brace and foot." Review of the facility policy for "Pain Data Collection and Management" dated as revised on 11/09 and provided by the facility as current noted "The analysis should help determine what other methods or alternatives of pain control/relief may be implemented prior to contacting a physician.	F 309		

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F 309	Continued From page 34 The Care Team and nurses must continually monitor and evaluate the pain management program." The "Non-Pharmacological Pain Intervention" policy dated as revised on 2/05 and provided by the facility as current indicated "Pain can destroy the quality of life, erode the will to live, impair sleep and decrease appetite while also impeding recovery." The policy identified a variety of interventions noting "non-pharmacological interventions should be attempted first; however, in the event they are not completed successfully, they may be combined with a pharmacological regime." R28 had complaints of pain which were not relieved with the current pain management plan. R28 had multiple diagnoses including arthritis and obesity. Most recent pain summary review dated 1/9/12 indicated "Resident has frequent complaints of pain" which included migraines and aches in legs and ankles. Review of the Minimum Data Set (MDS) dated 1/8/12 indicated R28 had no scheduled pain medications and no non-pharmacological interventions for pain. The MDS indicated R28 had as needed (PRN) pain medications. R28 indicated during the MDS assessment that she had occasional pain which was severe. The care plan dated 1/17/12 identified a problem of pain related to chronic arthritis, migraines and low activity level. R28's goal was to have the pain controlled with PRN medications. Interventions included PRN medications per MD orders, observe for signs and symptoms of pain and report any changes, exacerbations, or new pain. The plan of care further indicated R28 had frequent complaints of pain and to encourage activity and to complete cares independently.	F 309		

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F 309	Continued From page 35 Interview with R28 at 7:00 p.m. on 2/13/12 indicated she gets "pain in my right leg and low back. I get pain medicine like Excedrin for my bad headaches but it doesn't always help." At 10:00 a.m. on 2/16/12 R28 stated "I get headaches every day, the spot on the back of my neck hurts and I have pain in my right knee a lot, especially when I do a lot of walking. It gets worse during the day. The pain gets up to an 8 or 10 (on a scale of 0-10) almost every day. They give me pills that work sometimes but it doesn't work right away - and it has to get bad before it gets better. I don't know what to ask for - they ask me if I want Tylenol or Motrin but I don't know what to ask for. I don't know the difference. I've never been told. It sometimes gets worse with activity. I don't do anything for the pain besides the pills - no one's ever said anything about doing anything else." At 10:30 a.m. on 2/16/12 RN-B stated "She's hard because she needs weight loss. Her way to deal with it is to stay in her room and not deal with it. Her goals are to be independent - and that's ours. But there's the psychological aspect. We're just supposed to fix her and take care of her so we're really at a loss on how to get her better. She wants the pill and the doctor. I know they will do little things to alleviate pain like positioning, back rubs. A lot of times she'll tell one person one thing and she'll tell another person another thing." RN-A stated at 2:50 p.m. on 2/16/12 "(R28) has complaints nearly every day - it's always something different. It's the umbilical area - we send her out and they never find anything or they do and they fix it and then it's something else. She's always got some complaint."	F 309		

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide the necessary care and services to reduce urinary incontinence episodes for 2 of 3 residents (R28, R2) in the sample reviewed with urinary incontinence. Findings include: R28 did not receive an individualized urinary incontinence plan to assist with managing her incontinence. R28 had multiple diagnoses including arthritis, obesity, depression, and adult failure to thrive. According to the most recent MDS (Minimum Data Set) assessment completed 1/8/12, R28 had behavioral symptoms not directed at others but had no rejection of cares and was totally dependent on two staff for toileting assistance. The MDS also identified R28 was on a toileting program and was frequently incontinent of urine. The Care Area Assessment (CAA) dated 4/16/11 indicated R28 had functional incontinence. However the Bladder Assessment	F 315		

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F 315	Continued From page 37	F 315		

reviewed as current on 1/6/12 noted R28 to have mixed incontinence. The care plan dated 1/17/12 identified behaviors which included a refusal to toilet as well as urinary incontinence. The care plan directed staff to provide R28 with the risk/benefit of her behaviors, assist with toileting, encourage to toilet hourly while awake and three times at night. Further review of the record failed to review a comprehensive, individualized bladder assessment to assist with maximizing continence, including a review of medical history and risk factors and a bladder diary to assist with identifying any patterns of incontinence.

Interview with R28 at 10:15 a.m. on 2/16/12 indicated "I was wet when I got here but it's gotten worse. I can't control it and I can't get no help straightening it out. I've had 3 kids. Maybe I can fix it. I wish I could do better with it. They tell me I can control it, that I can hold it, but I can't. There has to be some way to help me with it."

Interview with RN- B at 10:40 a.m. on 2/16/12 revealed "She (R28) says she's continent but she's not continent. She tells her family and her guardian that she's continent. She has no signs or symptoms of urinary tract infections (UTI's) so I'm not concerned about that. We wonder if it's a behavioral thing. We know she can make it (to the toilet). A lot of times she'll get out of bed and pees on the floor but other times she makes it and it goes just fine." When interviewed at 1:00 p.m. on 2/16/12 the director of nursing (DON) indicated there was documentation in the record related to behaviors with toileting. However, when asked neither RN-B or the DON were able to provide any additional information or evidence that potential physiological causes contributing to

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F 315	Continued From page 38 the incontinence had been ruled out. In addition, the urinary incontinence assessment failed to contain any information related to R28's medically complex urinary incontinence. Resident (R2) lacked a comprehensive bladder assessment that accurately depicted bladder function, as well as interventions to reduce incontinent episodes. R2 had diagnoses that included diabetes mellitus and atrial fibrillation. The admission minimum data set (MDS) indicated moderately impaired cognition with a (BIMS) score of 7 and with noted occasional urinary incontinence, no urinary toileting program to prompt voiding or train the bladder. The care area assessment (CAA) summary dated 10/13/11 for the triggered area of urinary incontinence noted urinary incontinence ranges from occasionally to always, dribbling between voids, stress incontinence with coughing, sneezing and functional incontinence with physical disability or problems with thinking or communicating. On the following quarterly MDS dated 1/8/12 R2 was on a toileting program. A bladder assessment dated 10/7/11 indicated R2 was continent of urine upon admission. The following bladder assessment dated 1/6/12 noted, "no change current", however the care plan updated 1/17/12 included urinary incontinence as a concern. R2's admission care plan, dated 10/5/11 indicated R2 was continent and did not include incontinence as a concern, therefore, there were	F 315		

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F 315	Continued From page 39 no interventions to direct staff to help the resident to maintain or improve bladder function. At 1:00 p.m. on 2/16/12 the MDS nurse stated R2 had increased times of urinary incontinence, self toilets and used incontinent products at times. At 1:13 p.m. on 2/17/12 the MDS nurse was unable to state the reason for incontinence and would review the record for a causative diagnosis.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents related to falls for 1 of 3 residents (R24) reviewed in the sample. Findings include: Resident 24 (R24), who had a history of repeated falls, was not provided with interventions and on-going supervision (15 minute checks), as determined by a comprehensive assessment, to reduce the risk of additional falls and injury. R24 had diagnoses that included heart failure, chronic airway obstruction, anxiety state,	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245523	A. BUILDING _____ B. WING _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CLEARBROOK	305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 40 osteoporosis, chronic pain syndrome, and fall history. The most recent quarterly minimum data set (MDS) dated 1/12/12 identified R24 with cognitive independence, signs/symptoms of mood disorder, presence of verbal behaviors, independence/supervision with mobility, one person physical assistance for toilet use, some balance loss during transitions and impaired upper extremity range of motion that affected one side. The MDS also noted two or more falls had occurred since the most recent assessment. The fall risk assessment data collection tool dated 2/6/12 identified R24 with high risk of falls(score 16-21 with high risk >12.) Tinetti balance assessment tool completed 3/24/10 also identified R24 at high risk of falling (score 14 with <19 at high risk.) R24 ' s current care plan dated 1/24/12 identified fall history problem with generalized weakness and independence to extensive assistance with transfers and bed mobility and ambulation. Plans and approaches included independence to extensive assistance using the walker and transfers, encouragement to use the call light and conduct every 15 minute safety checks. Fall incident reviews noted R24 had fallen at least 7 times during the previous year. Fall incidents reports were dated 2/15/12, 2/1/12,12/20/11, 11/30/11, 11/16/11, 11/1/11 and 4/8/11. Several of the falls occurred during transfers, ambulation and toilet/bathroom activity. No significant injuries had occurred; however, there were skin tears and bruises from some falls.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245523	A. BUILDING _____ B. WING _____	02/16/2012

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F 323	Continued From page 41 During continuous observations of R24 ' s room from 8:50 a.m. to 10:10 a.m. on 2/15/12, R24 was noted to transfer herself from the toilet to the bed without assistance and was sitting sideways, fallen back against the wall while in the bed. Breakfast tray at bedside. During the one hour period, R24 had the door to the room completely closed and she could not be observed. Several staff were noted to walk by the room and not attempt to perform a check on R24 or open the door to determine safety concerns. At 9:43 a.m. an activity aide opened the door to peer inside looking for another staff. R24 remained back against the wall until putting the call light on at 10:05 a.m. and it was answered by nursing assistant-A (NA-A) at 10:10 am. The times elapsed without a safety check was 53 minutes and 27 minutes. Nursing assistant-A (NA-A), who was assigned to the unit with R24 reported during interview at 10:20 a.m. R24 should be on every 15 minute checks because of a fall history, but reported, she was, " Not always able to do it because of breakfast and when cares have to be done for other residents. " NA-A reported, " I kind of know the resident ' s routines and when they are in bed or on the toilet and what they are doing. " R24 ' s room was also observed continually from 8:25 a.m. to 9:15 a.m. on 2/16/12. During the 50 minute period elapsed, no staff were observed to perform 15 minute checks on R24. Again, several staff including NA-F were observed to pass R24 ' s room with a closed door such that R24 could not be observed or checked on unless the door was opened. R24 could be heard coughing loudly during this time and was noted to be sitting on the bed eating breakfast.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245523	A. BUILDING _____ B. WING _____	02/16/2012

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F 323	Continued From page 42 At 9:15 a.m. the director of nursing (DON) verified during interview that R24 should have 15 minute checks completed, but she had not actually watched to see if they were done and aides should observe or " poke their head in " the room to perform the check. NA-F verified during interview at 9:30 a.m. she did not perform the 15 minute checks and said she was not sure who did, but, " somebody must be. "	F 323		

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General Disclaimer

Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.

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F174
Telephone Privacy

1. Resident # 42 and spouse notified of areas they may complete private phone calls including therapy room, staff offices, and small dining room. They were also notified of plan to purchase new phone system for facility to increase availability to make private calls from own residents rooms. Local Phone Company contacted regarding purchase of new commercial phone system for facilities cordless needs.

2. All residents were reviewed and updated on privacy accommodations via letter sent out per administrator.

3. All residents will be informed upon admission of the right to have individual telephones in their room at their own cost or the availability of special areas to Meet privacy needs for communication via telephone. Also, staff will review at Resident Council Meetings quarterly. Resident Rights regarding privacy reviewed with nursing staff and staff educated on the residents need to make private phone calls, educated on areas available including staff offices, private dining room, or use of newly purchased cordless telephone that may be brought to residents' rooms.

4. DNS will complete observation audits weekly to ensure that residents are using the private area accommodations within the facility for their calls. This will be completed weekly x 1month with results to QA for further recommendations

5. Corrective Action will be completed 3-27-12.

OK
3/22/12

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F225
Investigate/Report Allegations/Individuals

1. R25 Behaviors have been investigated, addressed and Plan of Care updated. Incidents noted and results of investigation have been reported to OHFC and local point of contact per facility Policy and Procedure. Nursing staff educated on mandated reporting, Abuse and Neglect Policy and Procedures and the requirement to complete incident reports and notify Administrator immediately

2. All current residents have been identified as being vulnerable adults. All alleged violations including but not limited to mistreatment, neglect, or abuse including injuries of unknown sources and misappropriation of resident property are reported immediately according to facility Policy and Procedure. All alleged violations are investigated by Director of Nursing Services, Social Service Designee and Administrator.

3. Education provided to nursing staff on Abuse and Neglect Policy and Procedures and Incident Reporting on 2-22-12 and 2-23-12. All were also educated regarding being mandated reporters. Incident reports reviewed and investigated per DON and Interdisciplinary Team. Staff educated on appropriate and timely notification of personnel for incidents reported per Policy and Procedure. Administrator is to be notified immediately

4. Audits will be completed on all incident reports to ensure that all allegations of abuse neglect are reported immediately to the Administrator. Audit results will be reviewed by the Quality Assurance Committee for further recommendation.

5. Corrective Action will be completed by 3-27-12.

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F226 Develop Implement Abuse Neglect Policies

1. R25 Incident of sexual behaviors have been addressed and updated on Plan of Care. Incidents noted have been reported on 3-9-12 to OHFC and Common Entry Point as per Policy and Procedure. Resident involved was evaluated to ensure her safety. CP updated to include- resident to be kept away from affected resident as able, not to be alone in room or anywhere private with female residents. Notify LN of any and all sexual advances to be investigated.

2. All incidents of past 6 weeks were reviewed to ensure prompt reporting of allegations of abuse/neglect was reported timely.

3. Education provided to nursing staff on Abuse and Neglect Policy and Procedures and Incident Reporting on 2-22-12 and 2-23-12. Prompt reporting of alleged incidents was reviewed with staff. Staff was also educated regarding being mandated reporters. Incident reports reviewed and investigated per DON and Interdisciplinary Team. Staff educated on appropriate and timely notification of personnel for incidents reported per Policy and Procedure. DON/Administrator will be notified of incidents and investigating per Policy and Procedure as on ongoing process.

4. Audits will be completed randomly per staff interview on Policy and Procedure for Abuse and Neglect and Incident Reporting. Follow up on incidents and trends at Quality Assurance Committee.

5. Corrective Action will be completed by 3-27-12.

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F 250
Provisions of Medically Related Social Service

1) R12 was assessed for and provided with interventions related to chemical dependency. Social Data summarized SW-Designee has met with resident regarding chemical dependency and resources outside of facility. He has been referred and set up with The Most Excellent Way classes for chemical dependency starting 3-15-12 and is scheduled for every Thursday. Psychiatric Nurse Consult has been scheduled for 3-14-12. MDS note dated 8-29-11 notes coordination with County case worker and White Earth Tribe on discharge placement, would reevaluate as resident was not ready to discharge, resident said he wasn't ready to go. Follow up on 9-15-11 regarding County was contacted and they were working on finding placement. 10-5-11 IDP note stated that SW was contacted and continued to work on alternative placement but was not able to find d/t history of not paying his bills. On 11-22-11 resident spoke with a female who was sending him an application for residency but she stated he had been denied prior. Late entry on 2-20-12 stated that resident's home was uninhabitable per County SW. To date every placement attempt has been denied due to history. Per County Case worker he would like to see resident stay in this facility however we will continue to coordinate on placement out of the facility. R12 Plan of Care has been revised to reflect changes. Facility will continue to work towards discharge and will have monthly contact with local Social Services.

   R21 has been determined to be a Long Term resident; this was addressed at her Care Conference on 2-28-12 per family interview which was her 90 day follow-up review. Plan of Care has been updated to reflect LTC with no possible discharge to home. Social Data has been updated to reflect summary of social history on 3-12-12. Resident's primary physician has also addressed the need for long term placement.

   R7 has had a social history completed by the court appointed guardian in which information has been provided on customary routines, education, occupations, significant experiences/achievements, travel, religious preference hobbies and activity preferences. Family/Friends are encouraged to visit R7 on a regular basis. The Plan of Care has been updated to reflect changes.

2) All current resident charts have been reviewed to ensure that social service assessments and interventions are complete and accurate to meet the individual needs of each resident. Plans of Care have been updated to reflect necessary changes.

3) All residents will have a social history completed accurately upon admission and reviewed quarterly, annually and with significant changes to ensure that data is current. Psychosocial plan of care will be developed upon admission and reviewed

quarterly, annually and with significant changes to ensure that all residents' individual psychosocial needs are.
Education has been provided to the social service designee and MDS coordinator in ' regards to the proper process to gather data and assist in meeting the psychosocial wellbeing for all residents, the proper process in the development of a discharge plan, and the appropriate process for completion of the social history.

4) Audits will be completed by Director of Nursing Service or MDS Coordinator on all new admission to ensure that completion of social history, a current discharge plan is documented and plans of care for psychosocial wellbeing are implemented and executed appropriately 1x week for 2 months. Audit results will be reviewed and recommendations made by Quality Assurance Committee.

5) Corrective Action will be completed by 3-27-12

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F272
Comprehensive Assessments

1. R25

   Has had a new comprehensive Pain Assessment completed on 3-8-12 and Care Plan (CP) updated to reflect current changes.

   R28

   A new comprehensive Pain assessment completed 2-21-12 and Bladder Assessments 3-8-12, including bladder diary and type of incontinence defined have been completed CP has been updated to reflect changes.
   Follow up was completed with past hospital that treated resident to determine any further workup that was completed and treatment interventions.
   Urology consult has been scheduled for May 2012 to complete physiological workup of resident's condition.

   R2

   Has had a new comprehensive Bladder assessment completed 3-8-12 along with bladder diary. Updates to CP to reflect current changes.

   R21

   Has been determined to be a Long Term resident; this was addressed at her Care Conference on 2-28-12 per family interview which was her 90 day follow-up review.
   CP has been updated to reflect LTC with no possible discharge to home.
   Social Data has been updated to reflect summary of social history on 3-12-12.

   R12

   Social Data updated 3-12-12. Social Data summarized..
   SW-Designee has met with resident regarding chemical dependency and resources outside of facility. He has been referred and set up with The Most Excellent Way classes for chemical dependency starting 3-15-12 and is scheduled for every Thursday.
   Psychiatric Nurse Consult has been scheduled for 3-14-12.
   MDS note dated 8-29-11 notes coordination with County case worker and White Earth Tribe on discharge placement, would reevaluate as resident was not ready to discharge, resident said he wasn't ready to go. Follow up on 9-15-11 regarding County was contacted and they were working on finding placement. 10-5-11 IDP note stated that SW was contacted and continued to work on alternative placement but was not able to find d/t history of not paying his bills. On 11-22-11 resident spoke with a female who was sending him an application for residency but she stated he had been denied prior. Late entry on 2-20-12 stated that resident's home was uninhabitable per County SW. To date every placement attempt has been denied due to history. Per County Case worker he would like to see resident stay

in this facility however we will continue to coordinate on placement out of the facility.

2. All current residents reviewed to ensure that assessments for accuracy of bowel/bladder, pain and discharge assessments are current and reassessed if indicated and Care Plans updated as needed to reflect current plan of care

3. All residents having pain on admission and with any new pain will be assessed and reassessed quarterly. All residents having any incontinence will have a bladder assessment done on admission and with change in continence. All residents will have an individualized discharge plan in place. Any and all active Behaviors will also be care planned to assist staff in dealing with and treating. Education will be held for licensed staff on pain assessments and bladder assessments including bladder diary and inclusion of type of incontinence. This training will be done on 3-21-12.

4. DON/MDS Coordinator will complete audits of Pain, Bowel and Bladder, and Discharge Assessments for new admissions or residents with new pain or change in continence x 3 months to ensure appropriate completion and care planning. Audit results will be reviewed and recommendations made by Quality Assurance Committee.

5. Corrective Action will be completed by 3-27-12.

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F 282
Services by Qualified Persons/Per Care Plan

1. R24:
   Care Plan was amended. Resident interviewed and informed staff that she did not want staff poking there heads in to check on her, she wanted her privacy and not be bothered so often. Every 30 minute safety checks were preferred. Care Plan was changed to reflect this. Resident given risk vs benefit of this choice. She verbalized understanding. CP is being followed.
   R25:
   Care Plan was reviewed and updated. Nursing staff educated on Policy and Procedure for following plan of care and timely notification of incidents to DON/Administrator.

2. All current residents care interventions are being followed according to their individualized care plans. Staff educated regarding the need to follow the residents individualized care plans

3. All resident Care Plans will be followed by staff. Staff education will continue monthly at nursing staff meetings regarding Care Plan documentation and interventions and importance of following CP.

4. DON will complete visual spot audits to ensure that specific fall interventions are being followed and that behavior interventions are being followed based on resident's individualized Care Plan compliance weekly x2months. Audit results will be reviewed and recommendations made by Quality Assurance Committee.

5. Corrective Action will be completed by 3-27-12.

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F309 Provide Care/Services for Highest Wellbeing

1. R28

   Comprehensive Pain Assessment Completed on 2-21-12 resident denied need for further medication stating she would get too sleepy on any stronger medication than Motrin or Tylenol. She stated rest, quiet, heat, ice, elevation of extremities do help which has been updated on CP. Also nursing staff to evaluate all c/o pain, use clinical judgment regarding pain control. MD notified and discussed change in treatment options, resident agreeable to trying a new scheduled medication which was ordered. The CP was updated to reflect chronic arthritis and migraines with CP approaches as mentioned previously such as heat, ice, rest, quiet calm environment, elevation. Prior treatment facility contacted for past medical records that had no indication of head injury or pain control issues.

   R25-

   Comprehensive Pain Assessment completed on 3-8-12.
   CP updated to reflect current changes. Nonpharmocological interventions include, heat, ice, rest, relaxation, remove footwear for short periods or when resting if causing discomfort, evaluate footwear for pressure or abnormalities. MD notified and new scheduled pain medications ordered 2-15-12. CP updated to reflect behavioral issues that do interfere with assessment of resident pain. Resident was seen immediately after incident by podiatry on 2-16-12 and brace was adjusted per Bemidji Medical Equipment on 2-17-12. Care plan updated to direct staff to regularly monitor shoe wear, pressure reducing devices and transfer devices to ensure there is not increased pressure to bony prominences. Skin checks completed daily per CNA and weekly per LN. New Positioning tool completed.

2. All resident charts reviewed to ensure that if they have been identified with having some type of pain that their pain assessment is current and accurate and care plans updated if indicated and non-medication type interventions are attempted prior to a medication being given.

3. All residents will be assessed for pain upon admission and with any new type of pain as well as a quarterly review will be completed. CP will reflect current treatment. Behaviors will be care planned to assist caregivers with treatment. MD's will be notified with change in condition. MD will be addresses regarding further treatment options for pain that is not relieved with nonpharmocological or current treatment to treat residents' pain.
   Education was done with all nursing staff to review pain interventions- including the need to attempt non-medication type interventions prior to a medication as well as reviewing the use of the pain scale, prior to and after receiving a pain

medication and identifying residents' goal with pain. This education was held on 2-22-12 & 2-23-12. Further education planned for 3-21-12 to reinforce content. Discussion included pain is what the resident states it is and then we are objective in our documentation and do not make judgments regarding the residents pain.

4. DNS/MDS nurse will complete audits on all residents identified as having pain , including current residents with prn orders and new admissions identified as having pain and current residents experiencing a new pain to ensure pain assessments are completed, non-medication interventions are attempted, pain scale identified and used prior to and after a pain medication has been used. These audits will be done 2 x weeks for 2months with results to QA for further recommendations.

5. Corrective Action will be implemented by 3-27-12.

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F315
No Catheter/Prevent UTI/Restore Bladder

1.
R28
Has been interviewed, new comprehensive Pain Assessment on 2-21-12 and Bladder Assessments on 3-9-12, along with bladder diary have been completed; CP has been updated to reflect changes.
Follow up was completed with past hospital that treated resident to determine any further workup that was completed and treatment interventions. Kegal exercises have been added to restorative FMP. Incontinence has been identified as Mixed & Functional incontinence. Urology consult has been scheduled for physiological workup of resident's condition in May 2012.
R2
A new comprehensive Bladder assessment was completed 3-9-12 along with bladder diary. Updates made to CP to reflect changes. Resident interviewed and she does not want to see Urology or specialist for incontinence says she has had it for years. Incontinence identified as Mixed incontinence. Kegal exercises have been added to restorative FMP.

2. All residents reviewed for accuracy, completion of Comprehensive Bladder assessments with incontinence type identified, Care Plans updated as needed to reflect current plan of care.

3. All residents will be comprehensively assessed upon admission, annually, and with significant change. All resident assessments will be reviewed and revised quarterly and with changes. CP will reflect changes in care. Behaviors will also be care planned to assist staff in dealing with and treating. Reeducation will be completed on 3-21-12 regarding assessment completion and instruction with RN staff, and LN educated on notification processes to alert staff to changes.

4. DON/MDS Coordinator will complete audits biweekly x 2 months on new admits, residents with condition changes and change in incontinence to ensure appropriate completion and care planning. Audit results will be reviewed and recommendations made by Quality Assurance Committee.

5. Corrective Action will be completed by 3-27-12

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F323
Free of Accident Hazards/Supervision/Devices

1. R24: Resident is receiving interventions and on-going supervision according to the care plan.
   Resident interviewed and informed staff that she did not want staff poking there heads in to check on her, she wanted her privacy and not be bothered so often. Every 30 minute safety checks were preferred. Care Plan was changed to reflect this.

2. All residents identified at risk for falls are receiving falls interventions according to their care plans.

3. All residents admitted will have a fall assessment completed and fall interventions put into place and on care plan as indicated and interventions being followed according to the plan of care. Nursing staff educated at monthly meeting on following Care Plan for each individual resident, stressed importance of fall precautions and safety interventions. All resident Care Plans will be followed by staff. Staff education will continue monthly at nursing staff meetings regarding Care Plan documentation and interventions and importance of following CP.

4. DON will complete visual spot audits to ensure that fall interventions and supervision are being followed according to the POC of residents identified at risk for falls. These audits will be done weekly for 2 months with results to QA for further recommendations

5. Corrective Action will be completed by 3-27-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245523	A. BUILDING 01 - 1953 BUILDING WITH ADI B. WING	02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS	K 000		

DC: 03.28.2012

EXIT: 02.16.2012

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 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. At the time of this survey Good Samaritan Society Clearbrook 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

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

PATRICK SHEEHAN
SUPERVISOR
STATE FIRE MARSHAL DIVISION
444 CEDAR STREET, SUITE 145
ST PAUL, MN 55101-5145
Email: pat.sheehan@state.mn.us

Please see Attached POC

RECEIVED
MAR 22 2012
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

POC ok
PS 3-26-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	3-16-12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - CLEARBROOK	305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634

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K 000	Continued From page 1 Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Good Samaritan Society Clearbrook is a one story building with a full basement. The main building was built in 1953 and has a wood roof system making this building a Type V (000). The facility has additions built in 1962 and 1966, one to the south and one to the east of the original building, which are one story buildings with basements and are Type II (111) construction. These additions are separated with 2- hour fire barriers. In 1999 a basement laundry addition was added to the west of the north wing and was determined to be Type II(111) construction. The basement level is call 1st floor and the 1st story is called 2nd floor. The facility is completely protected by an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and installed in	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245523	A. BUILDING 01 - 1953 BUILDING WITH ADI B. WING	02/14/2012

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K 000	Continued From page 2 accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Other hazardous areas have either automatic fire detection, that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The sleeping rooms have battery operated smoke detectors in them. The building is divided into 6 smoke zones by 2 hour and 30 minute fire barriers. The facility has a capacity of 43 beds and had a census of 39 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		

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K 018	Continued From page 3 This STANDARD is not met as evidenced by: Observations showed that two of fifty corridor doors tested did not comply with NFPA 101 "The Life Safety Code" 2000 Edition Section 19.2.2.2. If corridor doors do not positively latch a fire could spread beyond the room of origin and would negatively impact all the patients, visitors and staff. Findings include: During the facility tour on February 14, 2012, between 2:45 pm and 4:15 pm, observations and testing of corridor doors revealed that: 1) Room 122's corridor door latch stuck in the release position and did not positively latch, and 2) Room 231's corridor door's latch did not hold the door tightly closed. The Administrator (AN) verified these findings during the facility tour.	K 018		
K 020 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Observations revealed that the one of of ten	K 020		

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K 020	Continued From page 4 basement stairway doors did not latch as required by NFPA 101 "The Life Safety Code" 2000 edition section 19.3.1.1. This deficient practice could allow the products of combustion to travel vertically throughout the building, which will negatively impact all the residents, visitors and staff of the facility. Findings include: During the facility tour on February 14, 2012, between 2:45 pm and 4:15 pm, observations and testing all stairway doors revealed that the upper level stairway door near the kitchen stuck in the released position and did not latch nor stay tightly closed. The Administrator (AN) verified this finding during the facility tour.	K 020		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Observations revealed that one of two kitchen doors is not in accordance with NFPA 101 "The	K 029		

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K 029	Continued From page 5 Life Safety Code" 2000 edition (LSC) section 19.3.2.1. This deficient practice could allow the products of combustion to travel from one area to another if a fire occurs within this hazardous area, which could negatively impact all patients, visitors and staff. Findings include: During the facility tour on February 14, 2012, between 2:45 pm and 4:15 pm, observations and testing of the kitchen doors revealed that the south kitchen door did not close completely nor latch, due to air movement through the doorway, when released and allowed to be come self-closing.. The Administrator (AN) verified this finding during the facility tour.	K 029		

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CLEARBROOK

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K 018

Room 122's corridor door latch has been fixed and now positively latches.
Room 231's corridor door latch has been fixed and now hold the door tightly closed.

All corridor door latches have been placed on a monthly preventative maintenance program to ensure that door latches are in working order at all times.

Corrective action completed by 3-27-12

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K 020

The upper level stairway door near the kitchen has been fixed and no longer sticks in the release position. The door now latches and stays tightly closed.

All stairway door have been placed on a monthly preventative maintenance program to ensure that door are in working order at all times.

Corrective action completed by 3-27-12

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K 029

The south kitchen door closure has been adjusted to put more pressure on the door when closing to ensure that even when air movement through the doorway the door is able to self close. Kitchen employees have been educated to ensure that the door is closed and latched all times. A new door closer has also been purchased to ensure that the door will always close properly.

Corrective action completed by 3-27-12