DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: NVOD Facility ID: 00022

(L1) 245285	(T.2)				NVER GROVE HEIGHTS	4. TYPE OF ACTION	2. Recertification
(L2) 659561800	10.	(L5) INVER GRO			(L6) 55077	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other er Complaint
6. DATE OF SURVEY 11/04/ 8. ACCREDITATION STATUS:	2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/III	14 CORF D 15 ASC	FISCAL YEAR END	ING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	<u> </u>	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	' IS CERTIFIED	AS:		·	
From (a):		X A. In Complia	nce With		And/Or Approved Waivers O		nents:
To (b):			equirements e Based On:		2. Technical Personne 3. 24 Hour RN	6. Scope of So 7. Medical Di	
12.Total Facility Beds	52 (L18)	•	cceptable POC		4. 7-Day RN (Rural Sl		om Size
13.Total Certified Beds	52 (L17)		npliance with Properties and/or Appli			(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
52							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Sue Reuss, Supervisor		11/04/2	2014	(L19)	Anne Kleppe, Enforcen	nent Specialist	11/04/2014 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIBII	JTY		IPLIANCE WITI	H CIVIL	21. 1. Statement of Fina	ancial Solvency (HCFA-25 rol Interest Disclosure Stm	
X 1. Facility is Eligible to I	Participate	Rioi	noner.		3. Both of the Abov		(1011 1313)
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREE!	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	I:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 0	<u>INVOLU</u>	NTARY
08/01/1985					01-Merger, Closure		Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburg		Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	OTHER	l G Cl
	A. Suspension	n of Admissions:	(L44)		or other reason for whiteham	00-Active	der Status Change
(L27)	B. Rescind St	uspension Date:	(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS		
	2)	00140					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAI	L DATE			
	(L32)	10/27/2014		(L33)	DETERMINATION APP	PROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245285

November 4, 2014

Ms. Pamela Schultz, Administrator Good Samaritan Society - Inver Grove Heights 1301 - 50th Street East Inver Grove Heights, Minnesota 55077

Dear Ms. Schultz:

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 October 24, 2014 the above facility is certified for:

52 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 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,

Are Klegge

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health

Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

November 4, 2014

Ms. Pamela Schultz, Administrator Good Samaritan Society - Inver Grove Heights 1301 50th Street East Inver Grove Heights, Minnesota 55077

RE: Project Number S5285023

Dear Ms. Schultz:

On October 2, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 18, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 4, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 22, 2014 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 September 18, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 24, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 18, 2014, effective October 24, 2014 and therefore remedies outlined in our letter to you dated October 2, 2014, 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,

Dre Kleese

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245285	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/4/2014
Name of Facility		Street Address, City, State, Zip Code		
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS		1301 50TH STREET EAST		
			INVER GROVE HEIGHTS MN 5507	77

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).

Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Correctio	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	Item	(Y5)	Date
Reg. # 483.15(e)(1)				Completed					Completed					Completed
Correction Correction Correction Correction Correction Correction Completed ID Prefix F0282 10/24/2014 ID Prefix F0312 10/24/2014 Reg. # 483.29(k)(3)(li) LSC LS	ID Prefix	F0246		10/24/2014		ID Prefix	F0272		10/24/2014		ID Prefix	F0279		10/24/2014
Correction Completed ID Prefix F0282 10/24/2014 ID Prefix F0312 10/24/2014 ID Prefix F0329 10/24/2014 Reg. # 483.25(in) LSC Completed LSC LSC Completed LSC Completed LSC LSC Completed LSC LSC	_	483.15(e)(1)				-	483.20(b)(1)				-	483.20(d), 483.2	0(k)(1)	_
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LSC	Reg. #	483.20(k)(3)(ii)		-		Reg.#	483.25(a)(3)		-		Reg. #	483.25(I)		
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Reg. # 483.55(b)	ID Prefix	F0412		•		ID Prefix	F0428		•		ID Prefix	F0465		•
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Reviewed By Reviewed By Date: Signature of Surveyor: Date: State Agency SR/AK 11/04/2014 16022 11/04/2014 Reviewed By Reviewed By Date: Signature of Surveyor: Date: CMS RO	Reg. #					Reg. #					Reg. #			
State Agency SR/AK 11/04/2014 16022 11/04/2014 Reviewed By Reviewed By Date: Signature of Surveyor: Date: Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies.	LSC					LSC					LSC			 _
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9/10/2014 TES NO	-	9/18/2	014					-				_	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245285	(Y2) Multiple Cons A. Building B. Wing		IN BUILDING 01	(Y3) Date of Revisit 10/22/2014
Name	e of Facility			Street Address, City, State, Zip Code	
GC	OOD SAMARITAN SOCIETY - INVER	GROVE HEIGHT	1301 50TH STREET EAST		

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).

INVER GROVE HEIGHTS, MN 55077

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix		Correction Completed 09/24/2014	ID Prefix		Correction Completed 09/24/2014		ID Prefix		Correction Completed
Reg. #	NFPA 101		Reg. # N				Reg. #		
LSC	K0064		LSC F	C 0144	-		LSC		_
		Correction			Correction				Correction
		Completed			Completed				Completed
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Reg. # LSC			Reg. # LSC		-		Reg. # LSC		
		Correction			Correction				Correction
		Completed			Completed				Completed
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Reg. #	-		Reg. #		-		Reg. #		
LSC			LSC _				LSC		_
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ID Prefix					=		ID Prefix		
Reg. # LSC			Reg. # LSC		-		Reg. #		<u> </u>
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix		Completed
Reg. #			Reg. #		-				
					-		LSC		
Reviewed I	By Ro	eviewed By	Date:	Signature of Sur	rveyor:			Date:	
State Agen	cy P	S/AK	11/04/201	.4			25822	10/2	22/2014
Reviewed I	By R	eviewed By	Date:	Signature of Sur	rveyor:			Date:	
CMS RO									
Followup t	to Survey Comp	leted on:		Check for any Unco					
	9/16/20)14		Uncorrected Defic	ciencies (CN	15-256	() Sent to the Fa	icility? YES	NO

Event ID: NVOD22 Page 1 of 1 Form CMS - 2567B (9-92)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL TE SURVEY AGENCY	ID: NVOD Facility ID: 00022
MEDICARE/MEDICAID PROVIDER N (L1) 245285 2.STATE VENDOR OR MEDICAID NO. (L2) 659561800	2.STATE VENDOR OR MEDICAID NO.				NVER GROVE HEIGHTS (L6) 55077	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
(L9)		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD		8. Full Survey After Complaint
6. DATE OF SURVEY 09/18/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/II 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	52 (L18) 52 (L17)	Compliance1. Ac X B. Not in Com	nce With equirements e Based On: ecceptable POC	gram	2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN	ſ				15. FACILITY MEETS	
18 SNF 18/19 SNF 52 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARK	KS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Mary Heim, HPR-Social Wo	ork Specialis	<u>t</u> 1	0/21/2014	(L19)	Anne Kleppe, Enforcen	ment Specialist 10/23/2014 (L2
PART	II - TO BE	COMPLETED B	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY
DETERMINATION OF ELIGIBILITY			PLIANCE WITH ITS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e:
22. ORIGINAL DATE 22	3. LTC AGREEN	MENT 24	LTC AGREEM	IENT	26. TERMINATION ACTION:	: (L30)
OF PARTICIPATION 08/01/1985	BEGINNING	DATE	ENDING DAT	ΓΕ	VOLUNTARY 00 01-Merger, Closure	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	** - *** - *** - **********************
25. LTC EXTENSION DATE: 27.		VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
(L27)	B. Rescind Su	uspension Date:	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00140				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE		

(L33)

DETERMINATION APPROVAL

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4776

October 2, 2014

Ms. Pamela Schultz, Administrator Good Samaritan Society - Inver Grove Heights 1301 50th Street East Inver Grove Heights, Minnesota 55077

RE: Project Number S5285023

Dear Ms. Schultz:

On September 18, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Email: susanne.reuss@state.mn.us

Telephone: (651) 201-3793

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 28, 2014, 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 October 28, 2014 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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 may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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 December 18, 2014 (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 March 18, 2015 (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 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Dire Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 10/03/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
	<i>.</i> **	245285	B. WING		09/	18/2014	
	PROVIDER OR SUPPLIER	- INVER GROVE HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP COD 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 550	DE ,	10/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
SS=D	as your allegation of Department's accellation of the first property of the used as verifical. Upon receipt of an revisit of your facility validate that substate regulations has been your verification. 483.15(e)(1) REAS OF NEEDS/PREFER A resident has the services in the facility accommodations of preferences, except the individual or other endangered. This REQUIREME by: Based on observative review, the facility was in reach for 1 accommodate 1 of comfortably fitting it ensure 1 of 2 residuaccommodated for Findings include:	of correction (POC) will serve of compliance upon the ptance. Your signature at the page of the CMS-2567 form will tion of compliance. acceptable POC an on-site ty may be conducted to antial compliance with the en attained in accordance with CONABLE ACCOMMODATION ERENCES right to reside and receive lity with reasonable of individual needs and of when the health or safety of the residents would be NT is not met as evidenced tions, interview, and document failed to ensure the call light of 1 resident (R27); failed to 1 resident (R2) with incontinence brief and failed to ents (R18) was bathing preferences.	F 2	Preparation and execute this response and plan correction does not compliance of the state of the facts alleged or conset forth in the statement deficiencies. The plan correction is prepared executed solely because required by the provising federal and state law. purposes of any allegate that the center is not in substantial compliance of federal requirements of participation. This response is the center of allegation of compliance accordance with section 7305 of the State Operations Manual.	of onstitute ment truth of occursions ent of of serit is on of For the tions ent of conse series in on on	(X6) DATE	
	MINO AL	Pauller &	Alde	enistrates Oto	by B	2014	

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245285	B. WING			09/1	8/2014
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- INVER GROVE HEIGHTS		13	TREET ADDRESS, CITY, STATE, ZIP CODE 301 50TH STREET EAST NVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 246	8:20 a.m., and the sitting on the bedsi R27 was asked if a attempted to move nightstand but was and asked the obse At 8:31 a.m., the as registered nurse (FInterview with RN-/ use the pressure p was not in reach of On 9/18/14, 9:50 a conducted with the related to R27's ca on 9/16/14. The DO was that all call light residents. R27's care plan last communication pro-	lying in bed on 9/16/14, at pressure pad call light was de nightstand out of reach. ble to reach the call ligh. R27 hand toward the bedside not able to reach the call light erver to place the call light on. ssistant director of nursing RN)-A answered call light. A revealed R27 was able to ad call light and confirmed it R27. .m. an interview was director of nursing (DON) Il light not being within reach DN stated that the expectation at should be in reach of the	F	246	{R27} was immediately provided the call light to ensure it was within reach; {R2} was assessed immediat for need of a properly fitting incontinence brief. Needs were discussed with the incontinence product representative and recommendations were received. A proper sized brief was ordered. The ordered brief was utilized upon delivery; {R18} was re-interviewed for bathing preferences.		
	revised on 1/09, in light is observed/he promptly. Respond possible. Turn call resident's request leaving the room, preach of resident if call light cord acrost reach it. For reside	cedure for call lights last dicated, "When resident's call eard, go to resident's room I to request as soon as light off and inquire about in a friendly manner. When place call light within easy in bed. If out of bed, stretch as bed so resident is able to ents unable to use call light, a frequent visits or provide an			RECEIV. OCT 20 2016 COMPLIANCE MONITORIN LICENSE AND CERTIFI	t IG D IVIS I	ON .

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245285	B. WING			09/-	18/2014
	PROVIDER OR SUPPLIER	/ - INVER GROVE HEIGHTS		130	EET ADDRESS, CITY, STATE, ZIP CODE 1 50TH STREET EAST VER GROVE HEIGHTS, MN 55077	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 246	The facility failed to incontinence briefs. On 9/17/14, at 8:2 peri care and apply while rolling reside using grab bar. Row, ow, oh to adjust the incontoo small. It's not too small. It'	o ensure R2 had properly fitting s. 0 a.m., NA-A completed R2's ied a clean incontinence brief ent back/forth with R2's help 2 moaned and stated, "That gosh it hurts." R2 asked NA-A attinence brief and stated, "It's comfortable at all." 2 a.m. an interview was 2 (while waiting for NA-A to transfer R2 out of bed) to see as moved. R2 stated again the was too tight and not a.m. NA-B came to help NA-A to R2 stated to both NA-A and too small. I need a special red, "That's the biggest size we via mechanical lift, transfered into a wheelchair. At 8:56 a.m. into the dining room where she hates while waiting for was no report to the registered sing staff the incontinence brief ording to R2. care plan for bladder and the last revised on 3/28/14, and uses incontinent products are care plan for bladder and the last revised on 3/28/14, and uses incontinent products are care plan for bladder and the last revised on 3/28/14, and uses incontinent products are care plan for bladder and the last revised on 3/28/14, and uses incontinent products are care plan for bladder and the last revised on 3/28/14, and uses incontinent products are plan for bladder and the last revised on 3/28/14, and uses incontinent products are plan for bladder and the last revised on 3/28/14, and uses incontinent products are plan for bladder and the last revised on 3/28/14, and uses incontinent products are plan for bladder and the last revised on 3/28/14, and uses incontinent products are plan for bladder and the last revised on 3/28/14, and uses incontinent products are plan for bladder and the last revised on 3/28/14, and uses incontinent products are plan for bladder and the last revised on 3/28/14, and uses incontinent products are plan for bladder and the last revised on 3/28/14, and uses incontinent products are plan for bladder and the last revised on 3/28/14, and uses incontinent products are plan for bladder and the last revised on 3/28/14, and uses are plan for bladder and the last revised on 3/28/14, and uses are plan for bladder and the	F2	246	The facility will complete call light placement audits on all residents on every shift x 7 days to ensure accommodation of resident needs and preferences. The facility re-assessed all residents using incontinence briefs for proper size and fitting, and for uncomfortable/ improperly fittings briefs with the incontinence product representative present for the assessment The facility will conduct An audit on all resident bathing preferences. The policy and procedure for accommodating resident needs and preferences was reviewed as related to call lights placed within reach of resident, properly fitting incontinence briefs and bathing preferences.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245285	B. WING_		09/	18/2014	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- INVER GROVE HEIGHTS	7.00	STREET ADDRESS, CITY, STATE, ZIP CO 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	, ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 246	conducted with RN related to incontine R2 letting staff kno 9/17/14. RN-A state concern and looked was filled out or if the amore appropriate Although RN-A did measured by Tena "Tena notification" R2's concern related being too tight. R18 had bilateral leprovided bathing concern related being too tight. R18's annual Minit 12/31/14, revealed you are in this facily choose between a sponge bath?" R18 important". R18's most recent indicated R18 had impairment, was to and required one provided by most recent for activities of dail 12/31/13, noted "For bathing, hygiene, or to participate by mown face, hands a remainder of cares Requires a total lift assist to turn in be (wheelchair) with be the staff or the staff	-A related to R2's concernence brief being too tight, and w during morning cares on ted was not aware of R2's do to see if a "Tena notification" he floor nurse was notified so e size could be provided. The R2 was recently on 6/10/14, there was no or report to the floor nurse of ed to the incontinence brief eg amputations and was not	F 2	The facility will re-educa all nursing staff on the policy and procedure of accommodating residen needs and preferences specifically related to placing the call light within reach of the resident; identifying and reporting an ill-fittin and/or uncomfortable incontinence briefs, and providing bathing preferences. The facility, with quarterly and periodic audits, will monitor call light placement; residents for proper fitting incontinence products and resident bathing preferences.	t ng		

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245285	B. WING		09/18/2014		
	PROVIDER OR SUPPLIEF	Y - INVER GROVE HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST NVER GROVE HEIGHTS, MN 55077			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTION		
F 246	staff propels to fin recent falls, does positioning and is command. Belt ke when self propellinot include an interationale for R18 instead of receiving R18's care plan for care deficit dated left below the knee amputate every week on Su. The 30 day bathin and 9/14/14, indicated betweek. On 9/16/14, at 1:3 a.m. R18 shared week. On 9/17/14 would like a tub be baths. On 9/18/14 was receiving betweek baths each week home, but was no bath at the facility On 9/17/14, at 3:3 (NA)-D reported if the day. NA-D bedue to safety reas allowed choices in On 9/18/14, at 9:3 nursing and the Nature of the safety reas allowed choices in On 9/18/14, at 9:3 nursing and the Nature of the safety reas allowed choices in On 9/18/14, at 9:3 nursing and the Nature of the safety reas allowed choices in On 9/18/14, at 9:3 nursing and the Nature of the safety reas allowed choices in On 9/18/14, at 9:3 nursing and the Nature of the safety reas allowed choices in On 9/18/14, at 9:3 nursing and the Nature of the safety reas allowed choices in On 9/18/14, at 9:3 nursing and the Nature of the safety reas allowed choices in On 9/18/14, at 9:3 nursing and the Nature of the safety reas allowed choices in On 9/18/14, at 9:3 nursing and the Nature of the safety reas allowed choices in On 9/18/14, at 9:3 nursing and the Nature of the safety reas allowed choices in One 9/18/14, at 9:3 nursing and the Nature of the safety reas allowed choices in One 9/18/14, at 9:3 nursing and the Nature of the safety reas allowed choices in One 9/18/14, at 9:3 nursing and the Nature of the safety reas allowed choices in One 9/18/14, at 9:3 nursing and the Nature of the safety reas allowed choices in One 9/18/14 at 9:3 nursing and the Nature of the safety reas allowed choices in One 9/18/14 at 9:3 nursing and the Nature of the safety reas allowed choices in One 9/18/14 at 9:3 nursing and the Nature of the safety reas allowed choices in One 9/18/14 at 9:3 nursing and the Nature of the safety reas allowed choices in One 9/18/14 at 9:3 nursing and the Nature of the safety	al destination. He has had no use seatbelt in w/c for able to self release on seps his hips aligned and safeing w/c." The assessment diderdisciplinary analysis or not being able to bathe in a tub, no only bed baths. or activities of daily living self 3/31/14, indicated R18 had a e amputation and a right above ion. "Bathing: Bedbath [sic] anday." or glog dated 8/24/14, 8/31/14, eated R18 received only bed at 8.30 a.m. R18 clarified ath, but instead received bed 4, at 9:30 a.m. R18 reconfirmed d baths, but wanted two tub at 8.18 shared took tub baths at ot given the choice of type of	F 246	The facility will review results at the monthly QAPI committee meeting to ensure ongoing compliance. The DNS, SDC and/or Designee {s} will be responsible for overall monitoring. The DNS is responsible for overall monitoring. The DNS is responsible for overall compliance.			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
	•	245285	B. WING_		09/-	18/2014
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- INVER GROVE HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	. ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 246	indicated R18 had On 9/18/14, at 9:56 with OT-A revealed	ooor trunk control. a.m. an interview conducted R18's ability to bathe in a tub	F 24	6		
	(DON) reported no determine R18 was	p.m. the director of nursing assessment was done to unable to bathe in the tub, ald not be something the facility			•	
F 272 SS=D	services (SS) revie Resident Interview 6/11/14, offering re response recorded do can't get into tul response. R18 was 483.20(b)(1) COM	p.m. the director of social wed R18's most recent and Observation, dated sident bathing choices. R18's was, "You know more than I b." The SS confirmed R18's not offered bathing choices. PREHENSIVE	F 27	Completion Date: October 24	, 2014	
	a comprehensive, reproducible asses functional capacity A facility must mak assessment of a reresident assessment by the State. The least the following:	e a comprehensive esident's needs, using the ent instrument (RAI) specified assessment must include at lemographic information;		R40 was reassessed for oral/dental needs and a follow up dental appointment was scheduled. The facility will reassess all residents for oral/dental issues and dental visits will be scheduled as needed.	nt	19/24

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION	1 COMPLE	
		245285	B. WING			09/-	18/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INVER GROVE HEIGHTS			301 50TH STREET EAST NVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	Continence; Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentia Documentation of sthe additional asse areas triggered by Data Set (MDS); an Documentation of potential of the additional asse areas triggered by Data Set (MDS); and Documentation of potential of the additional asse areas triggered by Data Set (MDS); and Documentation of potential of the additional asse areas triggered by Data Set (MDS); and Documentation of potential of the additional asse areas triggered by Data Set (MDS); and Documentation of potential assertion of potential assertion of potential assertion of the additional asse	peing; g and structural problems; and health conditions; nal status; and procedures; [; summary information regarding ssment performed on the care the completion of the Minimum		272	The policy and procedure for comprehensive assessments oral/dental needs was reviewed. The facility will provide education to licensed nursing staff on comprehensive oral/dental assessments. The facility will conduct annual, quarterly and periodic comprehensive oral/dental assessments. MDS nurses will monitor comprehensive oral/dental assessment. The facility will review results at the monthly QAPI committee meetings to ensure ongoing compliance. The DNS, MDS and/or designee{s} will be responsible for overall monitoring. The DNS is responsible for overall compliance.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, .	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245285	B. WING		09/18/2014
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- INVER GROVE HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	. ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 272	Assessment (CAA) dental issues identification of the nurse tooth and threw it a 9/6/14, at 12:55 p.r "Exam of the moutiapproximately half front almost broker denied pain and incidentist in "years." Dental visit on 9/11 fillings 6 teeth. Has Appointments set uwhen interviewed registered nurse (F conduct an oral/de the MDS. If a resid	triggered as there were no	F 272		
F 279 SS=D	on 9/18/14, at 10:2 oral/dental assess asked about the coassessment done dentist found that rnot thoroughly assessed 483.20(d), 483.20(COMPREHENSIVE A facility must use to develop, review comprehensive plantage of the comprehensive plantage or assessment done of the comprehensive plantage or assessment done or asses	E CARE PLANS the results of the assessment and revise the resident's	F 279	Completion Date: October 24,	2014

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED
		245285	B. WING _		09/	18/2014
	PROVIDER OR SUPPLIER	- INVER GROVE HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 5507		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	plan for each resided objectives and time medical, nursing, an eeds that are ider assessment. The care plan musto be furnished to a highest practicable psychosocial well-began with the faction of the resident services and any services be required under due to the resident services and any services and any services and any services are to the facility of the faction of the facti	ent that includes measurable etables to meet a resident's and mental and psychosocial of tified in the comprehensive attain or maintain the resident's physical, mental, and being as required under services that would otherwise \$483.25 but are not provided be exercise of rights under the right to refuse treatment at the right to refuse treatment acetaminophen use for 1 of 5 d mood and behavior of 5 residents (R62) reviewed edications.	F 27	A care plan was reviewed and revised for R16 to provide directions related to use of acetaminophen prodict of assist R16 to manage pain. A care plan was reviewed and revised for R62 to address mood, be sleep and side effect monitoring of medication. The facility will review, revise as needed, reside care plans related to parand acetaminophen use and to mood and behave medications to ensure residents' needs are identified and met. The policy and procedute for developing care plans reviewed.	ed n ucts or ehavior, and ent in e	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245285	B. WING_		09	/18/2014
	PROVIDER OR SUPPLIER	' - INVER GROVE HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CO 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	· ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	received a narcotic acetaminophen. R orders dated 9/3/1 was receiving the Acetaminophen 50 daily (qid) which exacetominophen in tab qid started 9/5/2 the order read maneded (prn). R16 mg of acetaminophydrocodone with twice a day (bid) phydrocodone with twice a day (bid) phydrocodon	n on 9/17/14, at 9:30 a.m. R16 c pain medication containing eview of the curent physician 4, and 9/5/14, revealed R16 following medications for pain: 00 milligrams (mg) four times qualed 2000 mg of 24 hours. Norco 5/325 mg 1 /14, to end 9/19/14. However, y continue the medication as was currently receiving 1300 hen with the Norco. acetaminophen 5/325 mg 1 rn. ylenol) 650 mg every 6 hours	F 2'	The facility will re-edulicensed staff on the policy and procedure developing care plant related to pain and acetaminophen use a related to mood and behavior medication to meet residents' not plans to ensure they developed related to and acetaminophen during monthly Pain Management meeting Care plans related to behavior medication monitored during monthly monitored during monitored during monitored during monitored during monitored during monitored meetings.	for s as and s eeds. dent care pain use mood and s will be	
		as not developed to address leep and side effect monitoring				
	seated at the dinir	0 p.m. R62 was observed ng room table. R62 had no 6/14, at 3:30 p.m. R62 was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	(X3) DATE SURVEY COMPLETED			
		245285	B. WING		09/1	8/2014
	PROVIDER OR SUPPLIE AMARITAN SOCIET	Y - INVER GROVE HEIGHTS	13	O9/18/2014 ET ADDRESS, CITY, STATE, ZIP CODE SOTH STREET EAST R GROVE HEIGHTS, MN 55077 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) The facility will review monitors at the monthly QAPI committee meetings to ensure ongoing compliance. The DNS, SDC and/or designee{s} will be responsible for overall monitoring. The DNS is responsible for overall		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	(X5) COMPLETION DATE
F 279	seated in the residuere exhibited. O was sleeping combehaviors were not behaviors were not heaviors with an indicated R62 had within the eightee pleasure in doing concentrating on assistance with a with one to two stindicate R62 had sleeping too much the admission Codated 8/25/14, incormood disorder manage and treat R62's Physician's did not address a In addition, there rationale for the buse of multiple minimal pharmacological R62's care plan pside effects of the care plan lacked	dent lounge and no behaviors in 9/17/14, at 11:30 p.m. R62 afortable in the chair and no oted. Orders dated 9/2/14, indicated by 20 mg as needed, BuSpar 5 mg daily, and Sertraline 75 mg daily. Imum Data Set (MDS) dated a diagnoses which included by and insomnia. The MDS is directived the antidepressants in days and little interest or things, also trouble things. R62 required extensive of things. R62 required extensive of things, staying asleep or how the same of the antidepressant are evidence of the antidepressant and receives medication to the same of the same of the antidepressant are of hypnotics however, the evidence of the antidepressant are, non-drug interventions and	F 279	The facility will review monitors at the monthly QAPI committee meetings to ensure ongoing compliance. The DNS, SDC and/or designee{s} will be responsible for overall monitoring. The DNS is responsible for overall compliance.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		DNSTRUCTION		SURVEY PLETED
		245285	B. WING			. 09/-	18/2014
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	' - INVER GROVE HEIGHTS		1301	ET ADDRESS, CITY, STATE, ZIP CODE 50TH STREET EAST R GROVE HEIGHTS, MN 55077	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	· ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From pa	age 11	F 2	79		:	
	of social service (S not address the us antidepressant me R62's care plan did effects or the effect antidepressant me non-pharmacological developed for R62	15 a.m. the DON and director (SS) verified R62's care plan did se of antianxiety and edications. The SS also noted do not include monitoring side edications. Also cal interventions were not and edications. The DON stated the sused because R62 could not					
F 282 SS=D	"Residents will reconecessary care and maintain the higher accordance with the An initial/temporary by nursing upon accordance is identified 483.20(k)(3)(ii) SE	RVICES BY QUALIFIED	F 2		Completion Date: October 24	١, 2014	
	must be provided b	ded or arranged by the facility by qualified persons in ach resident's written plan of			The individualized care plan for nail care for R14 was reviewed and nail care was provided.		10/24/14
	by: Based on observa	eNT is not met as evidenced ation, interview and document failed to ensure the care plan of 3 residents (R14) reviewed ly living.			The facility will review all resident care plans and will complete nail care audits to ensure that the care provided matches the care plan.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		E SURVEY IPLETED
		245285	B. WING		09/	18/2014
	PROVIDER OR SUPPLIER	- INVER GROVE HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 282	daily living care pla were clean and pro- Review of R14's 8 (MDS) revealed R	o ensure R14's activities of an was followed to ensure nails	F 2	The policy and proced for care plan utilization was reviewed. The fact will re-educate all nursing staff on the care plan process, including following individual resident car needs specifically	n ility	
•	physical assistance R14's activities of revised 8/6/14, dir Resident requires Resident will wash set up. Staff does (nursing assistant) On 9/16/14, at 10: observed with dar			The facility will monitoring with periodic audits, a resident nail care to e that the care matches the care plan. The facility will review	all Insure	
	resting in bed but two jagged fingern fingernails. On 9/1 dark matter under (RN)-D confirmed needed to be cleastaff to clean R14 they were dirty. On 9/17/14, at 4:0 (DON) reported neadys and R14 had	dressed for the day. R14 had hails and dark matter under all 7/14, at 3:45 p.m. R14 still had the nails. Registered nurse R14's fingernails were dirty and ned. RN-D added expected is nails during morning cares if 0 p.m. the director of nursing ail care should be done on bath if a shower on Monday and		at the monthly QAPI to ensure ongoing co The DNS, SDC and/or designee {s} will be responsible for overa monitoring. The DNS responsible for overa compliance.	meetings mpliance. Ill S is	
F 312 SS=D	DEPENDÊNT RE		F:	Completion Date: Octo	ober 24, 2014	
	A resident who is	unable to carry out activities of				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245285	B. WING		09/18/2014
	PROVIDER OR SUPPLIER	/ - INVER GROVE HEIGHTS		STREET ADDRESS, CITY, STATE, 1301 50TH STREET EAST INVER GROVE HEIGHTS, M	ZIP CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	. ID PREFI TAG		OTION SHOULD BE COMPLETION DATE
F 312	maintain good nutrand oral hygiene. This REQUIREME by: Based on observareview, the facility (R14) reviewed for clean and properly. Findings include: On 9/16/14, at 10: under the fingerna while R14 was resigged fingernails fingernails. On 9/1 dark matter under nurse (RN)-D condirty and needed texpected staff to comorning cares if the R14's 8/5/14, Mini R14 required extered staff to comorning cares if the R14's activities of revised 8/6/14, dir. Resident requires Resident will wash set up. Staff does (nursing assistant) On 9/17/14, at 4:0	s the necessary services to rition, grooming, and personal services. The services are evidenced ation, interview and document failed to ensure 1 of 3 residents activities of daily living had arimmed nails. 18 a.m. R14's had dark matter ils. On 9/17/14, at 7:30 a.m. ting in bed, observed two and dark matter under all 7/14, at 3:45 p.m. R14 still had all the fingernails. Registered irmed R14's fingernails were to be cleaned. RN-D added, elean R14's nails during	F3	R14 was provided a maintain good groot The facility assesse residents' nails for grooming and nail was provided as new The policy and proof for nail care was returning staff on the and procedure for pail care to residen The facility will more audits, resident nail good grooming weeks, then randor thereafter and nail will be provided as The facility will reviat the monthly QAF to ensure ongoing of	d all good care eeded. cedure viewed. cated all e policy providing ts. nitor, via ls for ekly x 4 mly care needed. ew results Pl meetings

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245285	B. WING			09/1	8/2014
	PROVIDER OR SUPPLIEF	Y - INVER GROVE HEIGHTS		13	REET ADDRESS, CITY, STATE, ZIP CODE 101 50TH STREET EAST IVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	completed on bath on Monday and Firm Nail Care policities of the Nail Care policities	n days and R14 had a shower riday. icy last revised November 2013, Soak resident's hands in basin for about 10 minutes. 5. Indicate the rinse with warm, clear water. ack gently with washcloth. 7. ils with towel. 8. Clean under range stick. 9. File nails with nail d. 10. For thick nails, cut th scissors or nail clippers." REGIMEN IS FREE FROM		312	The DNS, SDC and/or designee(s) will be responsi for overall monitoring. The DNS is responsible for overall compliance. Completion Date: October 24 Scheduled and "as needed" acetaminophen dosing for R16 was reviewed and corrected to ensure that the acetaminophen would not exceed the safe dosage amount. R62's drug regimen was reviewed for unnecessary drug use of anti-depressant and antianxiety medications and corrections were made.	-	The state of the s

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		245285	B. WING			09/	18/2014
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- INVER GROVE HEIGHTS		13	TREET ADDRESS, CITY, STATE, ZIP CODE 301 50TH STREET EAST NVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	This REQUIREMENT by:	nge 15 NT is not met as evidenced tion, interview and document	F3	29	The facility will review, and correct as needed, all resident drug regimens related to "as needed" and scheduled asstantiants.	:	
	review, the facility f and "as needed" m Acetaminophen (Ty exceed the safe do (R16) and failed to were free of unnec	ailed to ensure that scheduled edications with vlenol) would not potentially sage amount for one resident ensure medication regimens essary medications for one residents reviewed for			scheduled acetaminophen use to ensure acetaminophen will not exceed the safe dosing amount. The facility will review, and correct as needed, any unnecessary drug use of anti-depressant and anti- anxiety medications.		
	use of medications R16 had the potent	establish parameters for the containing acetaminophen. tial of exceeding,the delines of 4000 mg per day.			The policy and procedure for Unnecessary Medications was reviewed.		
·	receiving a narcotic acetaminophen. W R16 were reviewed was receiving the f Acetaminophen 50 times per day] since mg of acetaminophen Norco 5/325 mg 1 end 9/19/14. Howe continue the medic 9/19/14. Currently Acetaminophen will Hydrocodone with twice a day (bid) president received to	tab qid started 9/5/14 and to ever, the order read may eation as needed (prn) after R16 was receiving 1300 mg of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED			
		245285	B. WING _		09/1	18/2014
	PROVIDER OR SUPPLIER	/ - INVER GROVE HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077		,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	acetaminophen a Acetaminophen (T (q6hrs) prn pain (s was administered once on 9/5, once resident as prescr 2600 mg of acetar. The physicians or acetaminophen th alleviate the risk of Although the resident at 4000 mg of acetar for this to happen acetaminophen proceedings of the consultant plant was no physician acetaminophen the residents plant was no physician acetaminophen the pharmacist (P)-A that parameters for consultant pharms of medications consultant	sident would receive 650 mg of day. ylenol) 650 mg every 6 hours started 7/14/14). The resident this medication twice on 9/3, on 9/12. If utilized by the libed the resident would receive minophen a day. ders did not reflect how much e resident could take in a day to f possible liver damage. ent did not receive more than minophen, there was potential if the resident utilized all of the rescribed. D.p.m. the director of nursing he had no specific policy that minophen and the amount to be expect nurses to use good offessional standards and to lings on the acetaminophen ted not to exceed 4 gms (4000 expect that to be addressed on of care. She indicated there parameters as to how much e resident could receive and	F 32	The facility will re-educate all nursing staff on the policy and procedure for unnecessary medications to recognize the potential for exceeding acetaminoph safe dosing amount, and to recognize unnecessary use of anti-depressant and anti-anxiety medications. Licensed nurses will monito new acetaminophen physic orders to ensure that there is no potential for exceeding acetaminophen safe dosage amount. Acetaminophen dosage amounts will be monitored during monthly Pain Management meetings. Anti-depressant and anti-anxiety medications will be reviewed for unnecessary use during monthly Behaviors meetings.	or cian e	

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	ł ' '		E CONSTRUCTION		SURVEY PLETED
		245285	B. WING			09/1	18/2014
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- INVER GROVE HEIGHTS		13	REET ADDRESS, CITY, STATE, ZIP CODE 801 50TH STREET EAST IVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	analysis to justify u		F	329	The facility will review results at the monthly QAPI committee meetings to ensure ongoing compliance.	:	
	9/15/14 at 5:30 p.n resident was well gp.m., R62 was obs lounge, no behavious chair, no behavious chair, no behavious R62 had Physician (antianxiety) 20 mi BuSpar (antidepre	seated in the dining room on in., no behaviors noted and groomed. On 9/16/14 at 3:30 served seated in the resident ors exhibited. On 9/17/14 at not was sleeping comfortable in viors noted. I's Orders dated 9/2/14, Ativan lligram (mg) as needed and ssant) 5 mg daily, which (antidepressant) 75 milligrams			The DNS, SDC and/or designee(s) will be responsible for overall monitoring. The DNS is responsible for overall compliance.		
·	8/19/14, identified depression, anxiet indicated R62 had within the eighteer pleasure in doing to concentrating on the extensive assistant (ADLs) with one to category did not infalling or staying a The admission Cadated 8/25/14, indepsychiatric or moo	dimum Data Set (MDS) dated diagnoses which included y and insomnia. The MDS received the antidepressants a days and little interest or things, also trouble hings. The resident needs are with activities of daily living two staff assist. The Mood dicate the resident had trouble sleep or sleeping too much. The Area Assessment (CAA) icated "resident has disorder and receives hage and treat condition."					

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING				COMPLETED	
245285			B. WING				09/18/2014	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS				130	EET ADDRESS, CITY, STATE, ZI 1 50TH STREET EAST ER GROVE HEIGHTS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD HE APPROPI	BE :	(X5) COMPLETION DATE
F 329	notes from internal did not address and In addition, there we rationale for the because of multiple med pharmacological of not indicate R62 whealth professional. The pharmacy reviconcerns. The pharmacy reviconcerns and interview. R62's medical recommonitor mood/behard administration recommonitor mood/behard administration recommonitor mood/behard administration recommonitoring of adversant depressant use monitoring of adversant medicons and also did not include or side effects for the antidepressant menon-pharmacologic developed for R62	I had physician's progress medicine dated 8/15/14, which xiety, depression or insomnia. as no documented clinical nefit of, or necessity for, the dications from the same ass. The medical record did as under care of a mental ew dated 8/29/14 stated no rmacist was not available for ord indicated the facility did aviors on the treatment ord (TAR) dated 9/1/14 through the did as noted. The care plan did fects of the use of hypnotics, plan lacked evidence of the antianxiety use, and rese effects. I 5 a.m. the director of nursing service director (SSD) verified ad addressing the use of tidepressants medications. It is monitoring the effectiveness the use of antianxiety and	F3	329				
	The Buspirone Pag	ckage Insert packaged and						

	IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
	245285			09/18/2014		
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077			
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
revised: 28 May 201 cause serious side of Medication Guide for these serious side of reported in studies of drowsiness, nervous depressive disorder concentration, excit depression, blurred nauseas, dry mouth vomiting, musculos numbness, incoording headache, fatigue at the following: effects in people who suicidal thoughts, a bleeding, seizures of appetite, visual profession may occur the Ativan Package by Biovail Pharmaco 7/2008, noted the followiness, amnes vertigo, headache, libido, change in appinsomnia, agitation the Psychopharmacolosed atives/hypnotics sedatives/hypnotics	can Health Packaging last 3 noted the "Busprione can effects. Read this entire or more information about effects. Common side effects of tachycardia, dizziness, sness, insomnia, major r, lightheadedness, decreased ement, anger, confusion, vision, gastrointestinal, r, diarrhea, constipation, keletal, aches/pains, ration, tremor, skin rash, rand weakness" (age Insert and Label er Inc. last revised on 8/2014, "Common possible side ro take Sertraline include: llergic reactions, abnormal or convulsions, changes in clems, dizziness, drowsiness, r, upset stomach and trouble re Insert and Label Information euticals last revised on collowing: "fatigue, ria, confusion, depression, slurred speech, change in repetite, constipation, skin rash, and hallucinations." recologic Medication Use policy icated, "To evaluate behavior liternatives before using gical medications and recologic medications and recologic medications and recologic medications and recologic medications and	F 329	Completed Date: October 24	, 2014		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245285	B. WING	i		09/	18/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 412	SERVICES IN NF The nursing facilit an outside resourd §483.75(h) of this covered under the dental services to resident; must, if making appointme transportation to a must promptly ref damaged denture This REQUIREMI by: Based on intervice facility failed to er for dental (R40, F emergency and ref Findings include: The facility failed R40. During an intervice a.m. revealed has seeing a dentist. independently brown The annual minin completed on 5/2 the staff docume Assessment (CA)	y must provide or obtain from ce, in accordance with part, routine (to the extent extate plan); and emergency meet the needs of each necessary, assist the resident in ents; and by arranging for and from the dentist's office; and er residents with lost or s to a dentist. ENT is not met as evidenced ew and document review, the issure 4 of 4 residents reviewed 124, R18 and R14) received outline dental services. To ensure timely dental care for ew with R40 on 9/16/14, at 11:20 d dental issues and was not R40 was observed ushing his teeth after set up. The mum data set (MDS) was 10/14. Under the dental section and no issues. No Care Area A) triggered as there were no intified. The quarterly MDS dated	F	412	Dental services were scheduled for R40, R24, R18, and R14. The facility will assess all residents for dental need and dental services will be offered and scheduled peresident preference. Emergency dental needs be referred to outside soon The policy and procedure Oral/Dental Health Service and Assessments was resident preference.	s, e er will urces. e for ces	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245285	B. WING _		09/18/2014	
	PROVIDER OR SUPPLIE	ry - Inver grove Heights				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLÉTION	
F 412	The progress not reported to the not tooth and threw in 9/6/14, at 12:55 p. "exam of the more approximately had front almost broked denied pain and dentist in "years." Dental visit on 9/fillings of 6 teeth partial." Appoint 10/10/14. When interviewe registered nurse not do an oral/de MDS. If a resider pain then an ass. The director of non 9/18/14, at 10 oral/dental assessment com agreed if the der the staff did not in May. The facility failed care for oral/den lost lower dentur. During an intervial.m. R24 reveals had not gotten the staff did not gotten the sta	tes revealed on 9/6/14, R40 ursing staff he had chipped a t away. Upon examination on p.m. the staff documented, uth shows front right upper tooth alf present plus other teeth in the ten back to the gum line." R40 indicated had not been to the " 11/14, revealed "decay, needs . Has upper full and lower ments set up for 10/3 and ad on 9/18/14, at 10:10 a.m. the (RN)-B indicated the facility does ental assessment, aside from the nt was showing signs of mouth essment would be completed. ursing (DON) when interviewed 0:20 a.m. indicated the only esment was on the MDS. When condition of R40's mouth and the npleted May 2014 the DON htist found that many issues then thoroughly assess R40's mouth d to follow their written plan of tal care for R24 related to her		The facility will re-educate licensed staff on the policy and procedure for Oral/Dental Health Services and Assessments and on ensuring residents receive emergency and routine dental care. MDS nurses and/or designee{s}, through annual, quarterly and/or periodic oral/dental assessments, will monitor resident need an provision for dental service DNS is responsible for overall compliance. The facility will review at the QAPI meetings month to ensure ongoing compliance.	nd ces.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245285	B. WING _		09	/18/2014	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 412	"if I'm going to live teeth." The care plan day brushes own teet indicated the lowed dental set up. The care confered indicated left mean need for dental verticated left mean need for dental verticated in the care confered dentist decided here facility lost their conference of the dentures had and was hoping the hospital. The the care confered the dental conference of the dental conference of the dental conference of the dental conference of the policy and persidents are mean will provide or obtained and emergence of the policy and persidents are mean mean mean mean mean mean mean mea	e her lower denture she replied, e for awhile I would like to have ted 8/13/14, indicated R24 h independently. It further er denture was missing, awaiting nce note dated 8/21/14, sage for social worker about isit. Review of the social service eal any dental appointments. It don 9/18/14, at 9:20 a.m. the services (SS) indicated the lental contract in April when the e would no longer come to the adicated the facility had been another dentist. The SS agreed been missing since December the dentures would show up from SS indicated had not acted on note message of 8/21/14. Incocedure, titled Dental/Oral and Assessments revised 1/09, ensure dental needs of all tin a timely manner. The facility tain from an outside source regency dental services. It is a sassisted when necessary in an dannual appointments, ortation and referral to a dentist	F 41	2			
	The facility failed	damaged dentures. I to arrange for annual routine dental appointments for R18,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,		CONSTRUCTION	COMPLETED			
	•	245285	B. WING			09/	18/2014	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CO 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55			`		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 412	who had broken to Review of R18's c date of February 2 During interview a 1:51 p.m. R18 poi mouth and reporte needed to see a d On 9/17/14, at 8:3 brushing and rinsi set up. R18's most recendated 12/31/13, reteeth, some are b A progress note frhis own teeth, sor Awaiting in house 4/11/14, progress teeth, some are b cleaning. Awaiting established." R18's most recen 7/1/14, revealed Fimpairment and repersonal hygiene assist. R18's activities of revised 3/31/14, complete brushin participate as mubroken."	eeth. are plan revealed an admission 2012. Ind observation on 9/16/14, at 10 the left side of the 20 the had teeth problems and 20 entist. O a.m. R18 was observed 10 ng his teeth independently after 11 the left contains a contai		112				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		245285	B. WING _		09/18/2014
	PROVIDER OR SUPPLIE AMARITAN SOCIET	R Y - INVER GROVE HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CO 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETION
F 412	director of social on a list to see a However, that corprovide services terminated in the reported the fami financing dental awas unable to do by the facility to to of dental appoint options. The facility failed and emergency omissing partials. Review of R14's revealed R14 has physical mobility, communication. to be in April of 2 During initial inte R14 reported paiteeth and gums. Review of progree "Has upper partial blackened tooth Will not go out to be seen by in ho She has reported denies at time of agreement to se mouth sores or revealed "Has up daily. Has blacked and solve the seen of the seen of the seen of the seen of agreement to se mouth sores or revealed "Has up daily. Has blacked to the seen of the see	services (SS) reported R18 was contracted in house dentist. Intracted dentist was unable to for the facility and contract was beginning of June. The SS ly was trying to take care of appointments. The SS reported cument any assistance provided the family in arranging financing ments or seeking out low cost to arrange timely annual routine dental visits for R14, who had care plan last revised 8/6/14, d multiple sclerosis, limited and impaired cognition and R14's admission date was noted		2	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	COME	PLETED
•		245285	B. WING	i	*	09/1	8/2014
	PROVIDER OR SUPPLIER	Y - INVER GROVE HEIGHTS	I	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 301 50TH STREET EAST NVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 412	out for appointme redness." A 2/28/- "Has upper partial chewing or swallo 5/27/14 progress and upper partial. Betwisible mouth sore problems noted." "Has own teeth and missing teeth incleworking on securification of the dentist list. Note the dentist list list list. Note the dentist list list list list list list list	her seen as she refuses to go nts. No visible mouth sores or 14 progress notes revealed I, no visible mouth sores. No wing problems noted." A note revealed "Has own teeth Several missing including esident is on the dentist list. No es. No chewing or swallowing A 8/5/14 progress note revealed and upper partial. Has several uding bottom partial. Facility stilling a dentist to come to facility to es. At this point. Resident is on to visible mouth sores. No owing problems noted." ivities of daily living care area and 3/1/14, revealed "Lower as upper partial that fits well. teeth and in need of dentist		412			

PRINTED: 10/03/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		SURVEY PLETED
		245285	B. WING		09/	18/2014
,	PROVIDER OR SUPPLIE	Y - INVER GROVE HEIGHTS	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 301 50TH STREET EAST NVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 412 F 428 SS=D	dentist secured."	inator] to arrange once in house REGIMEN REVIEW, REPORT	F 412 F 428	Completed Date: October 24	1, 2014	
	The drug regimer reviewed at least pharmacist. The pharmacist representation of the attending physical regimes.	n of each resident must be once a month by a licensed nust report any irregularities to sician, and the director of e reports must be acted upon.		The drug regiments for R10 R62 were reviewed by the Consulting Pharmacist and any potential irregularities in the medication regimenwere reported.		19241:4
	by: Based on observed review the consumedication regime for unnecessary Findings include: Observation of the 9:30 a.m. reveals medication contains physician orders reviewed, the ordered receiving the followed.	ne medication pass on 9/17/14 at ed R16 received a narcotic pain alining acetaminophen. When the dated 9/3/14 and 9/5/14 were ders revealed that R16 was bowing medications for pain: 500 mg [milligrams] qid [four et 7/23/14 which equaled 2000 mg		The Consulting Pharmacis reviewed all resident drug regimens and reported an potential irregularities in each resident's medicatio regimen.	y Y	
	Norco 5/325 mg	1 tab qid started 9/5/14 and to				

Event ID: NVOD11

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION		E SURVEY IPLETED
		245285	B. WING		09/	18/2014
	PROVIDER OR SUPPLIE	Y - INVER GROVE HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 428	end 9/19/14. How continue the med 9/19/14. Currently Acetaminophen with twice a day (bid) president received 9/10, 9/13, and 9/ prescribed, the reacetaminophen at Acetaminophen ((q6hrs) prn pain (was administered once on 9/5, once resident as prescribed as prescribed acetaminophen to alleviate the risched the sessed the rescribed the rescribed acetaminophen processed the rescribed acetaminophen of the supervisor for this to happer acetaminophen of the supervisor for the supervisor fo	vever the order read may ication as needed (prn) after a R16 was receiving 1300 mg of with the Norco. Acetaminophen 5/325 mg 1 forn (started 8/8/14). The this medication on 9/4, 9/5, 1/15. If utilized by the resident as esident would receive 650 mg of day. Tylenol) 650 mg every 6 hours started 7/14/14). The resident if this medication twice on 9/3, if on 9/12. If utilized by the ribed the resident would receive aminophen a day. Tributed to reflect the amount on the resident could take in a day sk of possible liver damage. In the resident utilized all of the		The policy and proce Pharmaceutical Serv reviewed. The facility will proveducation to license nurses on the policy procedure for Pharm Services. The Consulting Pharcontinue to review, monthly basis, all redrug regimens and vany potential irregulto the attending phy and Director of Nursell and/or designee (s) to discuss the Consulting Pharmacist's drug review.	rices was ide id and naceutical macist will on a esident will report larities ysician sing monthly ulting	

PRINTED: 10/03/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245285	B. WING		09/1	8/2014
	PROVIDER OR SUPPLIE AMARITAN SOCIET	Y - INVER GROVE HEIGHTS	1	TREET ADDRESS, CITY, STATE, ZIP CODE 301 50TH STREET EAST NVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 428	to the pharmacist the consultant ph use of medication and recommend from the physicia the notes then he Surveyor: Souce The consulting phirregularities for Federal medications. R62 was observe 9/15/14 at 5:30 president was well p.m., R62 was oblounge, no behave 11:30 p.m., resident in the chair, no behave 11:30 p.m., resident was well p.m., R62 was oblounge, no behave 11:30 p.m., resident was well p.m., resident was well p.m., R62 was oblounge, no behave 11:30 p.m., resident was well p.m., resident was w	s notes, however P-A indicated armacist should recognize the as containing acetaminophen to the staff to obtain parameters in. If those directions were not in probably did not do it. A, Shawn harmacist failed to identify a62, reviewed for unnecessary and seated in the dining room on am, no behaviors noted and groomed. On 9/16/14 at 3:30 pserved seated in the resident processer of the seated in the resident processer of the seated in the resident processer. On 9/17/14 at the sent was sleeping comfortable in	F 428	The facility will review result at the monthly QAPI meeting To ensure ongoing compliant The DNS, SDC and/or designee(s) will be responsifor overall monitoring. The DNS is responsible for overall compliance.	nce. ble	

Event ID:NVOD11

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		E SURVEY IPLETED
		245285	B. WING		1	09	18/2014
	PROVIDER OR SUPPLIEI	Y - INVER GROVE HEIGHTS		130	REET ADDRESS, CITY, STATE, ZIP CODE 01 50TH STREET EAST VER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	. ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	The medical reconvotes from International In addinical rationale for, the use of musame pharmacoldid not indicate Forms. The pharmacy reconcerns. The phan interview. R62's medical remonitor mood/be administration reg/18/14 R62's care plant and the following address the side however, the carantidepressant umonitoring of addinical antianxiety and also did not incluor side effects for antidepressant in non-pharmacold developed for Rimedications were could not sleep	and had Physician's Progress hal medicine dated 8/15/14, dress anxiety, depression or lition, there was no documented for the benefit of, or necessity altiple medications from the logical class. The medical record 862 was under a psychologist eview dated 8/29/14 stated no narmacist was not available for exercise on the treatment locord (TAR) dated 9/1/14 through printed 8/28/14 was reviewed a was noted. The care plan did beffects of the use of hypnotics, re plan lacked evidence of the use, antianxiety use, and		428			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION	COMPLETED
		245285	B. WING		09/18/2014
	ROVIDER OR SUPPLIER	- INVER GROVE HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP C 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	A DOOR DEFENSION TO THE	SHOULD BE COMPLETION
F 428	revised: 28 May 20 cause serious side Medication Guide f these serious side reported in studies drowsiness, nervoudepressive disorde concentration, excidepression, blurred nauseas, dry mout vomiting, musculos	rican Health Packaging last 13 noted the "Busprione can effects. Read this entire or more information about effects. Common side effects of tachycardia, dizziness, usness, insomnia, major ir, lightheadedness, decreased tement, anger, confusion, d vision, gastrointestinal, h, diarrhea, constipation, skeletal, aches/pains, dination, tremor, skin rash,	F 4	428	
	Information by Pfiz noted the following effects in people w suicidal thoughts, a bleeding, seizures appetite, visual prodry mouth, diarrhe sleeping may occu. The Ativan Packag by Biovail Pharma 7/2008, noted the drowsiness, amne vertigo, headache libido, change in a insomnia, agitation The Psychopharm revised 1/2007, incinterventions and a psychopharmacole sedatives/hypnotice	ge Insert and Label Information ceuticals last revised on following: "fatigue, sia, confusion, depression, slurred speech, change in ppetite, constipation, skin rash, and hallucinations." acologic Medication Use policy dicated, "To evaluate behavior alternatives before using orgical medications and es. To eliminate unnecessary orgical medications and		Completed Date: Oct	ober 24, 2014

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245285	B. WING		09/	18/2014
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- INVER GROVE HEIGHTS	13	TREET ADDRESS, CITY, STATE, ZIP CODE 301 50TH STREET EAST IVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	. ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 465 F 465 SS=F	483.70(h) SAFE/FUNCTION E ENVIRON The facility must p sanitary, and comfortance and comfortable eresidents (R28, R1 and impacted 38 of facility with paint of facility and facility with paint of facility and facility with paint of facility and f	rovide a safe, functional, ortable environment for d the public. ENT is not met as evidenced ation, interview, and document failed to provide housekeeping services to maintain a sanitary nvironment for 6 of 30 4, R40, R1, R45, R2) observed of 38 resident rooms at the hipping on the door frames. 7 p.m. a urine smell was noted ad concerns about the bathroom. 19 a.m. R14 expressed eanliness in the bathroom. 05 p.m. during the r with the housekeeping and ctors R14's room had paint or frame entering the bathroom.	F 465 F 465	Resident rooms of R28, R14, were recleaned. Privacy curtain was replaced and ceiling repainted. Doorways of resident rooms with chipp or worn paint were repainted. All resident rooms were audited for issues of cleanliness and clean privacy curtains. All resident room doors and doorways were audited for chipped pain and wall repairs. Resident room ceilings were audited for stains.		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245285	B. WING	1.440.000.000	09/18/2014
	PROVIDER OR SUPPLIE	TY - INVER GROVE HEIGHTS	1	TREET ADDRESS, CITY, STATE, ZIP CODE 301 50TH STREET EAST NVER GROVE HEIGHTS, MN 55077	
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTY DEFICIENCY)	D BE COMPLÉTIC
F 465	door from fully she from the walls. A time with R1's far dissatisfaction will cleanliness of the shared had report times these conditions these conditions these conditions these conditions and R1 had debrigged the formular and R1's bed. There marks on the wall approximately 2: reiterated about the interview a laprivacy curtain, shed frame. The environment golf and the frame. The environment golf and the frame was also from the floor near large amount of the doorway and there was also frame was also from the doorway and the floor near large amount of the doorway and the doorway and the floor had walls.	nutting, and paint was peeling An interview conducted at the mily member (F)-A revealed ith overall maintenance and e room and bathroom. F-A rted to the facility numerous		Cleaning procedures were reviewed for accuracy. Painting schedule was reviewed and updated to meet center needs. Housekeeping staff were reeducated on cleaning procedures. All staff were reeducated on timely reporting and how to report Maintenance issues. Random painting and cleaning audits will be done monthly to assure ongoing compliance. Audits will be reviewed at monthly Quality Assessment and Assurance Meetings for compliance.	

	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		245285	B. WING		<u> </u>	09/1	8/2014
	PROVIDER OR SUPPLIER	- INVER GROVE HEIGHTS		130	REET ADDRESS, CITY, STATE, ZIP CODE 11 50TH STREET EAST VER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	the rooms listed ab maintenance direct resident doorways, The maintenance opaint and black ma The maintenance of the wat addition, the mainte was not a log to tramade in each room. Review of the unda Purpose of the Houleskeeping Proceed and healthful staff, and visitors. It and safety, to meet regulations regardi. Review of the unda Checklists Overviem aintenance had to paintenance had to paintenance in the maintenance of the contract of the unda contract of the un	re cleaned daily, and verified ove were not clean. The or stated they only painted the and walls every six months. lirector verified the chipped rks on the doorways and walls. lirector also stated was er stains on R40's ceiling. In enance director reported there ck/document any repairs litted facility policy titled usekeeping Department cedures directed to maintain surrounding for the residents, To maintain cleanliness, order all federal and state ng housekeeping.	F4	65			
					ž.		
					Completion date: October 23	3, 2014	

5285022 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 09/16/2014 245285 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1301 50TH STREET EAST **GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS** INVER GROVE HEIGHTS, MN 55077 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 POC 0k FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Good Samaritan Society - Inver Grove Heights 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: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH OCT 1 5 2014 DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: MN DEPT. OF PUBLIC SAFETY 1. A description of what has been, or will be, done STATE FIRE MARSHAL DIVISION to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person (X6) DATE TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE SCIGNATURE

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

PRINTED: 10/03/2014

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMP	SURVEY LETED
AND I DAN OI	COMMEDITION	(BEITH JOAN JOHN NOMBER III) - MAIN BUILDING OT		
NAME OF D	ROVIDER OR SUPPLIER	245285	B. WING		FREET ADDRESS, CITY, STATE, ZIP CODE	09/1	6/2014
		- INVER GROVE HEIGHTS		13	301 50TH STREET EAST		
GOOD SA				IN	IVER GROVE HEIGHTS, MN 55077	NI T	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Good Samaritan Sa a 1-story building was constructed at determined to be of 1981 and 1983, ad North Wing that was II(111) construction added to the South be of Type II (111) original building an same type of constbuildings, the facilit building. The building is fully fire alarm system of detection and space monitored for auto notification.	rection and monitoring to ence of the deficiency. Deciety - Inver Grove Heights, is with no basement. The building 4 different times. The original ructed in 1963 and was f Type II(111) construction. In ditions were constructed to the as determined to be of Type II. In 1999 an addition was II. Wing that was determined to construction. Because the dithe 3 additions are of the truction allowed for existing the was surveyed as one If sprinklered. The facility has a with full corridor smoke the sees open to the corridors that is matic fire department It spacity of 52 beds and had a set time of the survey.	K	0000			
K 064 SS=D	NOT MET as evide NFPA 101 LIFE SA Portable fire exting health care occupa	t 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD guishers are provided in all ancies in accordance with S, NFPA 10	K	064			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245285

B. WING

09/16/2014

		245205	B. 111110			10/2014
NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS		INVED CROVE HEIGHTS	1301 50TH STREET EAST			
GOOD SA	AMARITAN SUCIETY	- INVER GROVE REIGHTS		IN	IVER GROVE HEIGHTS, MN 55077	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID P:REFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 064	Continued From pa	age 2	Κú	064	K - 064	
K 144 SS=F	Based on observa determined that the portable fire exting NFPA 101-2000 ed NFPA 10. This deficit of 41 residents. Findings include: On facility tour betwon 09/16/2014, obsextinguisher locate A, has not been marked and the fire extinguity on the fire extinguity. This deficient pracmaintenance (CW) NFPA 101 LIFE SA	tice was confirmed by the) at the time of discovery. AFETY CODE STANDARD spected weekly and exercised minutes per month in	K	144	Listing of center fire extinguishers was reviewed and approved for accuracy. Fire extinguisher audit inspection will be used monthly to assure all fire extinguishers are inspected monthly. Inspections will be done by maintenance supervisor or designee monthly. Audits will be reviewed at monthly safety meetings and monthly QAPI meetings for compliance. Administrator will be responsible for overall compliance.	
	This STANDARD	is not met as evidenced by:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245285

B. WING

09/16/2014

GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHT	S

STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

GOOD S	AMARITAN SOCIETY - INVER GROVE HEIGHTS	11	NVER GROVE HEIGHTS, MN 55077	
(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) GOMPLETION DATE
K 144	Continued From page 3 Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 44 residents. Findings include: On facility tour between 10:30 AM and 1:00 PM on 09/16/2014, documentation review of the weekly inspection logs for the emergency generator revealed the following: 1. TELS documentation for the emergency generator weekly inspections from 9/22/13 to 2/3/14, indicated that not all weekly inspections were documented. 2. The emergency generator weekly inspection logs from 2/10/14 to 9/11/14, indicated that the week of 7/21/14 was missed These deficient practices were confirmed by the maintenance (CW) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144	K-144 Generator is and will be inspected weekly with appropriate documentation kept at center level. Weekly inspections will be done by maintenance supervisor or designee. Weekly inspections will be audited by administrator or designee for compliance. Weekly inspection will be reviewed at monthly safety meetings and monthly QAPI meetings for ongoing compliance. Administrator will be responsible for overall compliance. Completed: September 24, 2014	
			- *	



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4776

October 2, 2014

Ms. Pamela Schultz, Administrator Good Samaritan Society - Inver Grove Heights 1301 50th Street East Inver Grove Heights, Minnesota 55077

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5285023

Dear Ms. Schultz:

The above facility was surveyed on September 15, 2014 through September 18, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

Good Samaritan Society - Inver Grove Heights October 2, 2014 Page 2

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to:

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

Email: susanne.reuss@state.mn.us

Telephone: (651) 201-3793

Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Dre Klegge

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health

Email: anne.kleppe@state.mn.us

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Enclosure(s)

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 00022 09/18/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST GOOD SAMARITAN SOCIETY - INVER GROVE **INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 000 2 000 Initial Comments *****ATTENTION***** RECEIVED NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued OCT 20 2014 pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation COMPLIANCE MONITORING DIVISION not corrected shall be assessed in accordance LICENSE AND CERTIFICATION with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. **INITIAL COMMENTS:** Minnesota Department of Health is On September 15-18, 2014, surveyors of this Department's staff, visited the above provider and documenting the State Licensing Correction Orders using federal software. the following correction orders are issued. When Tag numbers have been assigned to corrections are completed, please sign and date, make a copy of these orders and return the Minnesota state statutes/rules for Nursing original to the Minnesota Department of Health. Homes. Division of Compliance Monitoring, Licensing and

Minnesota Department of Health LABORATORY DIRECTOR'S OR PRO

SUPPLIER BETRESENTATIVE'S SIGNATURE

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TITLE

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STATE FORM

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If continuation sheet 1 of 3

(X3) DATE SURVEY

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	E!ED
		00022	B. WING		09/18	3/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INVER GROVE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa Certification Progra MN 55164-0900	ige 1	2 000	The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule number and corresponding text of the state statut out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the sumfindings are the Suggested Metho Correction and the Time Period For Correction. PLEASE DISREGARD THE HEARTHE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Tag." the tute/rule ies" ply" his s which after the s veyors d of or DING OF TO THIS	
2 540	Subpart 1. Assess conduct a comprel resident's needs, v capability to perfor significant impairm nursing assessme Minnesota Statutes	on Subp. 1 & 2 Comprehensive ent sment. A nursing home must hensive assessment of each which describes the resident's m daily life functions and hents in functional capacity. A nt conducted according to s, section 148.171, subdivision as part of the comprehensive	2 540			

(X2) MULTIPLE CONSTRUCTION

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE	
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	00022	B. WING		09/1	8/2014
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GOOD SAMARITAN SOCIETY	- INVER GROVE	H STREET EAROVE HEIGH	AST TS, MN 55077		:
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comprehensive resused to develop, recomprehensive plate 4658.0405. Subp. 2. Inform comprehensive resinclude at least the A. medically demedical history; B. medical stance. C. physical and D. sensory and E. nutritional stance. F. special treated G. mental and H. discharge plate 1. dental condituing J. activities pook. rehabilitation L. cognitive stance. M. drug therapen N. resident president	ent. The results of the sident assessment must be eview, and revise the resident's an of care as defined in part ation gathered. The sident assessment must afollowing information: efined conditions and prior tus measurement; d mental functional status; d physical impairments; atatus and requirements; tentas or procedures; psychosocial status; potential; tion; tential; on potential; atus; y; and	2 540			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER OR SUPPLIER O0022 STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST INVER GROVE HEIGHTS, NM S5077 (EACH DEFICIENCY) (EACH DEFICIENCY MUST BE PRECIDED BY FULL TAG CONTINUED From 1 10 1 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Minneso	ta Department of He	ealth			FUNIVI	AFFROVED
MAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INVER GROVE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077 PRETIX REGULATORY OR LSC IDENTIFYING INFORMATION) 2 540 Continued From page 3 the staff documented no issues. No Care Area Assessment (CAA) triggered as there were no dental issues identified. The progress notes revealed that on 9/6/14, R40 reported to the nursing staff he had chipped a tooth and threw it away. Upon examination on 9/6/14, at 12:55 p.m. the staff documented, "Exam of the mouth shows front right upper tooth approximately half present plus other teeth in the front almost broken back to the gum line." R40 denied pain and indicated he had not been to the denist in "years." Dental visit on 9/11/14, revealed "decay needs fillings 6 teeth. Has upper full and lower partial." Appointments set up for 10/3/14, and 10/10/14. When interviewed on 9/18/14, at 10:10 a.m. the registered nurse (RN)-B indicated they did not conduct an oral/dental assessment, askide from the MDS. If a resident was showing signs of mouth pain then they would complete an assessment. The director of nursing (DON) when interviewed on 9/18/14, at 10:20 a.m. indicated the only oral/dental assessment as on the MDS. When asked about the condition of R40's mouth and the assessment done in May 2014, agreed that if the denist found that many issues then the staff did	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '			
GOOD SAMARITAN SOCIETY - INVER GROVE CAN ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION CIEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PROVIDERS PLAN OF CORRECTIVE AND OF COMPLETE PREFIX PROVIDERS PLAN OF CORRECTIVE AND OF COMPLETE PREFIX PREFIX PROVIDERS PLAN OF CORRECTIVE AND OF COMPLETE PREFIX PREFIX			00022	B. WING		09/-	18/2014
INVER GROVE HEIGHTS, MN 55077 INVER GROVE HEIGHTS, MN 5507	NAME OF F	PROVIDER OR SUPPLIER					
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A SUGGESTED METHOD FOR CORRECTION: The facility interdisciplinary team [IDT] or designee could review, revise and/or develop policies and procedures to ensure that residents are comprehensively assessed. The IDT or designee could educate all staff on how to complete a comprehensive assessment and	2 540	the staff documents Assessment (CAA) dental issues idention The progress notes reported to the nurstooth and threw it a 9/6/14, at 12:55 p.r "Exam of the mout approximately half front almost broker denied pain and indentist in "years." Dental visit on 9/11 fillings 6 teeth. Has Appointments set if When interviewed registered nurse (Foonduct an oral/dethe MDS. If a resid mouth pain then the assessment. The director of nur on 9/18/14, at 10:2 oral/dental assess asked about the coassessment done dentist found that in not thoroughly ass A SUGGESTED M The facility interdis designee could repolicies and proce are comprehensive designee could edisignee could edisign	ed no issues. No Care Area triggered as there were no ified. Se revealed that on 9/6/14, R40 sing staff he had chipped a tway. Upon examination on m. the staff documented, he shows front right upper tooth present plus other teeth in the near back to the gum line." R40 dicated he had not been to the dicated he had not been to the large for 10/3/14, and 10/10/14. On 9/18/14, at 10:10 a.m. the large for 10/3/14, and 10/10/14. On 9/18/14, at 10:10 a.m. the large for 10/3/14, and 10/10/14. On 9/18/14, at 10:10 a.m. the large for 10/3/14, and 10/10/14. On 9/18/14, at 10:10 a.m. the large for more large for the large for more large for the large for more large for the large for large for the large for large		DEI ROLLINGT)		

Minnesota Department of Health STATE FORM

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	.5150
		00022	B. WING		09/18	8/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INVER GROVE	H STREET EA	AST TS, MN 55077		
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2 540	Continued From pa	age 4	2 540			
	ensure ongoing cor	evelop monitoring systems to mpliance and report the lity Assurance Committee.		·	!	1
:	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty one				
2 560	MN Rule 4658.040 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			:
	comprehensive pla objectives and time long- and short-term and mental and psi identified in the corn assessment. The must include the in	of plan of care. The an of care must list measurable stables to meet the resident's m goals for medical, nursing, ychosocial needs that are mprehensive resident comprehensive plan of care dividual abuse prevention plan sota Statutes, section 626.557, ragraph (b).				
	by: Based on observate review, the facility related to pain and residents (R16) an	tion, interview and document failed to develop a care plan acetaminophen use for 1 of 5 d mood and behavior of 5 residents (R62) reviewed edications.				
	Findings include:					
	R16 related to pair containing acetam acetaminophen. The	he resident had the potential to commended guidelines of				

FORM APPROVED Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING _____ 09/18/2014 00022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST **GOOD SAMARITAN SOCIETY - INVER GROVE INVER GROVE HEIGHTS, MN 55077**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 5 Review of R16's care plan dated 7/24/14, revealed no directions related to use of acetaminophen or acetaminophen products to assist R16 to manage pain. During observation on 9/17/14, at 9:30 a.m. R16 received a narcotic pain medication containing acetaminophen. Review of the curent physician orders dated 9/3/14, and 9/5/14, revealed R16 was receiving the following medications for pain: Acetaminophen 500 milligrams (mg) four times daily (qid) which equaled 2000 mg of acetominophen in 24 hours. Norco 5/325 mg 1 tab qid started 9/5/14, to end 9/19/14. However, the order read may continue the medication as needed (prn). R16 was currently receiving 1300 mg of acetaminophen with the Norco. Hydrocodone with acetaminophen 5/325 mg 1 twice a day (bid) prn. Acetaminophen (Tylenol) 650 mg every 6 hours (q 6hrs) prn for pain. The physicians orders did not include parameters related to the use of acetaminophen. On 9/18/14, at 4:20 p.m. the director of nursing (DON) indicated there was no specific policy that addressed acetaminophen and the amount to be given. The DON expected nurses to use good judgement and professional standards and to abide by the warnings on the acetaminophen label which indicated not to exceed 4 gms (4000 mg) in 24 hours. The DON expected medication parameters to be addressed on R16's plan of care.	2 560	DEFICIENCY)	
	R62's care plan was not developed to address mood, behavior, sleep and side effect monitoring of medications.			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIAND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	E CONSTRUCTION	(X3) DATE COMPI	
			A. BUILDING.			
		00022	B. WING		09/1	8/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INVERGROVE	H STREET EA ROVE HEIGH	AST TS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 560	Continued From pa	uge 6	2 560			
	On 9/15/14, at 5:30 seated at the dining behaviors. On 9/16 seated in the reside were exhibited. On was sleeping comformation behaviors were not R62's Physician's Ontivan (antianxiety) (antidepressant) 5 (antidepressant) 75 (antidepression, anxiety) indicated R62 had within the eighteen pleasure in doing the concentrating on the assistance with act with one to two stars on 9/16 seated R62 had within the eighteen pleasure in doing the concentrating on the assistance with act with one to two stars on 9/16 seated R62 had within the eighteen pleasure in doing the concentrating on the assistance with act with one to two stars on 9/16 seated R62 had within the eighteen pleasure in doing the concentrating on the assistance with act with one to two stars on 9/16 seated in the residence of the concentration of 9/16 seated in the residence of the concentration of 9/16 seated in the residence	p.m. R62 was observed groom table. R62 had no /14, at 3:30 p.m. R62 was ent lounge and no behaviors 9/17/14, at 11:30 p.m. R62 ortable in the chair and no red. Orders dated 9/2/14, indicated 20 mg as needed, BuSpar mg daily, and Sertraline 5 mg daily. num Data Set (MDS) dated diagnoses which included y and insomnia. The MDS received the antidepressants days and little interest or hings, also trouble nings. R62 required extensive tivities of daily living (ADLs) ff. The Mood category did not rouble falling, staying asleep or				
	dated 8/25/14, indi-	re Area Assessment (CAA) cated "resident has psychiatric and receives medication to condition."				
	did not address an In addition, there w rationale for the be	Progress Notes dated 8/15/14, xiety, depression or insomnia. vas no documented clinical enefit of, or necessity for, the dications from the same lass.				
	side effects of the	inted 8/28/14, did address the use of hypnotics however, the vidence of the antidepressant				

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PATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 560 Continued From page 7 use, antianxiety use, non-drug interventions and monitoring of adverse effects. On 9/18/14, at 10:15 a.m. the DON and director of social service (SS) verified R62's care plan did not address the use of antianxiety and antidepressant medications. The SS also noted		NT OF DEFICIENCIES LOF CORRECTION	identification num		, ,	E CONSTRUCTION		PLETED
GOOD SAMARITAN SOCIETY - INVER GROVE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077			00022		B. WING		09/	18/2014
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 560 Continued From page 7 use, antianxiety use, non-drug interventions and monitoring of adverse effects. On 9/18/14, at 10:15 a.m. the DON and director of social service (SS) verified R62's care plan did not address the use of antianxiety and antidepressant medications. The SS also noted			- INVER GROVE	1301 50TH	STREET EA	AST		
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R62's care plan did not include monitoring side effects or the effectiveness of antianxiety and antidepressant medications. Also non-pharmacological interventions were not developed for R62. The DON stated the medications were used because R62 could not sleep. The Care Plan policy revised 1/2009, indicated "Residents will receive and be provided the necessary care and services to attain and maintain the highest practicable well-being in accordance with the comprehensive assessment. An initial/temporary care plan will be developed by nursing upon admission as soon as the problem is identified." A SUGGESTED METHOD FOR CORRECTION: The interdisciplinary team [IDT]could review, revise and/or develop policies and procedures to ensure that residents have care plans based on a comprehensive assessment. The IDT or designee could educate all staff on how to complete a care plan and develop procedures to ensure implementation. The facility could develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560	use, antianxiety use monitoring of adversing of adversing of social service (S not address the use antidepressant mer R62's care plan did effects or the effect antidepressant men non-pharmacologic developed for R62 medications were usleep. The Care Plan poli "Residents will rece necessary care and maintain the higher accordance with the An initial/temporary by nursing upon accordance with the Assurance complete a care pleasure implementation accordance with the Assurance Committee accordance with the	e, non-drug interventions effects. 15 a.m. the DON and of S) verified R62's care see of antianxiety and dications. The SS also denot include monitoring tiveness of antianxiety dications. Also cal interventions were. The DON stated the used because R62 control of the comprehensive assigned and the comprehensive assigned as a state of the comprehensive assigned to the comprehensive and processes are processes and processes are processes and processes and processes are processes are processes and processes are processes and processes are processes are processes and processes are processes are processes and	director e plan did o noted ng side y and not dicated the nd ing in sessment. veloped he ECTION: view, edures to ased on a r to edures to d develop e Quality				

Minnesota Department of Health

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2 565	Continued From pa	age 8	2 565			
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		:	
		omprehensive plan of care Il personnel involved in the t.				
	by: Based on observat review, the facility f	tion, interview and document failed to ensure the care plan of 3 residents reviewed for ving (R14).				
	Findings include:					
		o ensure R14's activities of an was followed to ensure nails operly trimmed.				
	revealed R14 requ	/5/14 minimum data set [MDS] ired extensive assistance with and one person physical				
	revised 8/6/14 dire Resident requires Resident will wash set up. Staff does	daily living care plan, last octed staff "Personal Hygiene: extensive assist of 1 staff. hands, face, upper torso with all other grooming." and "NAR clip and clean nails."				
	observed to have of fingernails. On 9/1	8 a.m. R14's nails were dark matter under the 7/14 at 7:30 a.m. R14 was n bed but dressed for the day.				

Minnesota Department of Health STATE FORM

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2 565	Continued From pa	ige 9	2 565			
	R14 had two jagger under all fingernails was observed to ha nails. A registered in R14's fingernails with cleaned. RN-D additional clean R14's nails divere dirty. On 9/17/14 at 4:00 (DON) reported nails bathing days and the Monday and Friday. A SUGGESTED M The interdisciplinar revise and/or develonate that staff could procedure to ensure that staff could develop monogoing compliance could develop monogoing compliance Quality Assurance. TIME PERIOD FO (21) days. MN Rule 4658.052 Proper Nursing Caste Subp. 2. Criteria for proper care. The cadequate and proper care and at proper care and at proper care and at the register of the cadequate and proper care and at the register of the cadequate and proper care and at the register of the cadequate and proper care and at the register of the cadequate and proper care and at the register of	d fingernails and dark matter s. On 9/17/14 at 3:45 p.m. R14 ave dark matter under her nurse, (RN)-D, confirmed ere dirty and needed to be led she would expect staff to uring morning cares if they p.m. the director of nursing, il care should be done on nat R14 bathed by shower on the director of nursing, in care should be done on nat R14 bathed by shower on the designee could review, lop policies and procedures to comply with residents' care designee could educate all low a care plan and develop ure implementation. The facility ditoring systems to ensure the and report the findings to the Committee. R CORRECTION: Twenty one of Subp. 2 F. Adequate and deriteria for determining adequate and criteria for determining				
	trimmed.					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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2 860	Continued From pa	ge 10	2 860			
	This MN Requirements by: F312	ent is not met as evidenced				
	The facility interdisc designee could rev policies and proced nail care is perform trimmed nails. The educate all staff on procedures to ensu could develop mon	ETHOD FOR CORRECTION: ciplinary team [IDT] or view, revise and/or develop dures to ensure that residents' ned to ensure clean and IDT or designee could nail care and develop are implementation. The facility itoring systems to ensure e and report the findings to the Committee.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty one				
21325	MN Rule 4658.072 Emergency Oral H	5 Subp. 1 Providing Routine & ealth Ser	21325			
	home must provid resource, routine d needs of each resid include dental exar fillings and crowns, oral surgery, bridge orthodontic proced that are provided for	e dental services. A nursing e, or obtain from an outside ental services to meet the dent. Routine dental services minations and cleanings, root canals, periodontal care, es and removable dentures, ures, and adjunctive services or similar dental patients in the e, as limited by third party icies.				
	by: Based on observat	ent is not met as evidenced tion, interview and document failed to ensure 4 of 4 residents				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00022	B. WING		09/1	8/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INVERGROVE	H STREET EA	AST TS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21325	Continued From pa	ige 11	21325			
		(R40, R24, R18 and R14) by and routine dental services.				
	Findings include:					:
	The facility failed to R40.	ensure timely dental care for				
		with R40 on 9/16/14 at 11:20 ne was having dental issues dentist.				
	completed on 5/20, the staff document assessment (CAA)	orm data set (MDS) was (14. Under the dental section ed no issues. No care area triggered as there were no ified. The quarterly MDS dated ental issues.				
	reported to the nur a tooth and threw i 9/6/14 at 12:55 p.n of the mouth show approximately half front almost broken	s revealed that on 9/6/14, R40 sing staff that he had chipped taway. Upon examination on the staff documented, "exam front right upper tooth present plus other teeth in the back to the gum line." ain and indicated he had not in "years."				
	fillings of 6 teeth. H	/14 revealed, "decay, needs las upper full and lower ents set up for 10/3 and				
	registered nurse (Finot do a oral/denta	on 9/18/14 at 10:10 a.m. the RN)-B indicated the facility does I assessment, aside from the is showing signs of mouth pain uld do one.				

(X3) DATE SURVEY

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		00022	B. WING		09/1	8/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INVER GROVE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21325	The director of nurs on 9/18/14 at 10:20 oral/dental assess asked about the co and the assessmer if the dentist found did not thoroughly a	sing (DON) when interviewed a.m. indicated the only ment was on the MDS. When indition of the residents mouth a done in May she agreed that that many issues then the staff assess his mouth in May.				
	care for oral/dental lost lower denture. During an interview 11:42 a.m., R24 relower denture and said it happened wasked if she would she replied, "if I'm elike to have teeth."	o follow their written plan of care for R24 related to her with R24 on 09/16/2014 at vealed that she had lost her had not gotten them back. R24 hen in the hospital. When like to have her lower denture going to live for awhile I would d 8/13/14 indicated R24				
	brushes own teeth indicated the lower dental set up. The care conference indicated, left mess need for dental vision notes did not reveated. When interviewed social worker (LSW dental contract in A he would no longer indicated the facility another dentist. Sheen missing since	independently. It further denture was missing, awaiting to enote dated 8/21/14 sage for social worker about it. Review of the social service all any dental appointments. on 9/18/14 at 9:20 a.m. the light when the dentist decided roome to the facility. She y had been unable to secure the agreed the dentures have the December and she was the would show up from the				

(X2) MULTIPLE CONSTRUCTION

Minnesota Department of Health

PRINTED: 10/03/2014 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 00022 09/18/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST **GOOD SAMARITAN SOCIETY - INVER GROVE INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21325 21325 Continued From page 13 hospital. The LSW indicated she had not acted on the care conference message of 8/21/14. The policy and procedure, titled Dental/Oral Health Services and Assessments revised 1/09, directed staff to ensure dental needs of all residents are met in a timely manner. The facility will provide or obtain from an outside source routine and emergency dental services. Residents will be assisted when necessary in

The facility failed to arrange for annual routine and emergency dental appointments for R18, who had broken teeth.

making routine and annual appointments, arranging transportation and referral to a dentist

in case of lost or damaged dentures.

Review of R18's care plan revealed an admission date of February 2012.

During initial interview and observation on 9/16/14 at 1:51 p.m., R18 pointed to the left side of his mouth and reported he had teeth problems and needed to see a dentist.

On 9/17/14 at 8:30 a.m. R18 was observed to brush and rinse his teeth independently after set up. R18 brushed for a few minutes and included all areas of his mouth.

R18's most recent dental care area assessment, dated 12/31/13, revealed "He has his own natural teeth, some are broken."

A progress note from 12/31/13 revealed "He has

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE	
·· - · · · · · · · · · · · · · · · · ·		00022	B. WING		09/1	8/2014
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INVER GROVE	H STREET EA ROVE HEIGH	AST TS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21325	Continued From pa	age 14	21325			·
	Awaiting in house of 4/11/14 progress in teeth, some are brocleaning. Awaiting established." R18's most recent 7/1/14 revealed R1 impairment and receptor personal hygiene, vassist. R18's activities of or revised 3/31/14 direcomplete brushing	de are broken and sharp. Identist to get established." A ote noted "He has his own oken, sharp and in need of a in house dentist to get Minimum data set, dated 8 had moderate cognitive quired extensive assistance for with one staff person physical daily living care plan, last ected staff "Oral Care: Staff to teeth, offer and cue resident to				
	participate as much as able. Natural teeth, some broken." The care plan did not address dental appointments.					
	social service direction a list to see a condition of the	on 9/18/14 at 9:23 a.m., the ctor (LSW) reported R18 was contracted in house dentist. It acted dentist was unable to or the facility and contract was beginning of June. LSW was trying to take care of epointments. LSW reported she ument any assistance provided be family in arranging financing tents or seeking out low cost requested R18's notes from isit. This was not provided by				
		o arrange timely annual routine ental visits for R14, who had				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00022	B. WING	·	09/18	8/2014
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INVERGROVE	OVE HEIGH	TS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21325	Continued From pa	ge 15	21325			
	revealed R14 had rephysical mobility, a communication. R1 to be in April of 200 During initial interview R14 reported pain teeth and gums. Review of progress "Has upper partial blackened tooth on Will not go out to see seen by in hous She has reported redenies at time of in agreement to see of mouth sores or recrevealed "Has upper daily. Has blackened missing. Still waiting established to get lout for appointment redness." A 2/28/14 "Has upper partial, chewing or swallow 5/27/14 progress in and upper partial. See visible mouth sores problems noted." A "Has own teeth and missing teeth inclusion working on securing manage oral cares the dentist list. No	are plan, last revised 8/6/14, multiple sclerosis, limited and impaired cognition and 4's admission date was noted 12. ew on 9/16/14 at 10:12 a.m. In both her upper and lower and several missing. The dentist, but is agreeable to be dentist, but is agreeable to be dentist once they start here. In outh pain recently, although terview and reiterated dentist to write. No visible the partial which staff brushes and tooth on bottom and several gon in house dentist to get the seen as she refuses to go ts. No visible mouth sores or 4 progress notes revealed no visible mouth sores. No ving problems noted." A ote revealed "Has own teeth Several missing including sident is on the dentist list. No as No chewing or swallowing a 8/5/14 progress note revealed dupper partial. Has several ding bottom partial. Facility stilling a dentist to come to facility to. At this point. Resident is on visible mouth sores. No ving problems noted."				

Minneso	ta Department of He	ealth			T OTTIVIT	ALL HOVED
AND DIAN OF CODDECTION DENTIFICATION NUMBER		1 ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00022	B. WING		09/1	8/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INVER GROVE	'H STREET E <i>l</i> ROVE HEIGH	AST TS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21325	Continued From pa	age 16	21325	3 - 500		
	assessment, dated partial missing, has Some blackened to once in house dent On 9/18/14 at 2:30 (DON) reported the house dental services a dentist. Note were requested by	p.m. the director of nursing e facility was waiting for in ces to be arranged for R14 to s from R14's last dental visit surveyor but not provided.				
	social service direction a list to see a conditional However, that continues	n 9/18/14 at 9:23 a.m., the etor (LSW) reported R14 was contracted in house dentist. racted dentist was unable to r the facility and contract was eginning of June.				
	8/6/14, directed sta VISITS: In house d	ily living care plan, last revised aff: "ORAL CARE: DENTAL lentist, routine visits. HUC nator] to arrange once in house			į	
	The facility interdis designee could repolicies and proced receive routine der could educate all sineeds and develop implementation. The monitoring system compliance and reassurance Commi	ETHOD FOR CORRECTION: ciplinary team [IDT] or view, revise and/or develop dures to ensure residents ntal care. The IDT or designee taff on residents' routine dental procedures to ensure ne facility could develop s to ensure ongoing port the findings to the Quality ttee. R CORRECTION: Twenty one				
	(21) days.	•				

FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 00022 09/18/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST **GOOD SAMARITAN SOCIETY - INVER GROVE INVER GROVE HEIGHTS, MN 55077** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 21530 21530 MN Rule 4658,1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is

the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	A. BUILDING:		COMPLETED	
		00022	B. WING		09/	18/2014
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- INVER GROVE 1301 50	DDRESS, CITY, S I'H STREET EA BROVE HEIGH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21530	Continued From pa	age 18	21530			
	by: Based on observat review the consulti the facility on poter medication regime reviewed for unnect R62). Findings include: Observation of the 9:30 a.m. revealed medication contain physician orders d reviewed, the orde receiving the follow Acetaminophen 50	tion, interview and document ing pharmacist failed to advise intial irregularities in the infor 2 of 5 residents reviewed dessary medications (R16 and medication pass on 9/17/14 at R16 received a narcotic pain ing acetaminophen. When the ated 9/3/14 and 9/5/14 were irrs revealed that R16 was wing medications for pain: 00 mg [milligrams] qid [four 7/23/14 which equaled 2000 mg at a state of the control of the	t (
	Norco 5/325 mg 1 end 9/19/14. How continue the medic 9/19/14. Currently Acetaminophen with twice a day (bid) president received 9/10, 9/13, and 9/10, 9/13, 9/	tab qid started 9/5/14 and to ever the order read may cation as needed (prn) after R16 was receiving 1300 mg o				
	(q6hrs) prn pain (s was administered	Tylenol) 650 mg every 6 hours started 7/14/14). The resident this medication twice on 9/3, on 9/12. If utilized by the				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00022	B. WING		09/18	8/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD		TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INIVER GROVE	H STREET EA ROVE HEIGH	AST TS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	Continued From pa	age 19	21530			
	resident as prescrib 2600 mg of acetam	oed the resident would receive ninophen a day.				
	of acetaminophen	ers failed to reflect the amount the resident could take in a day of possible liver damage.				
	4000 mg of acetam	ent did not receive more than ninophen, there was potential f the resident utilized all of the escribed.				
	assessed the resid 8/29/14. The pharm	on 7/14/14 and the pharmacist lent on 7/28/14 and again on nacist did not address the sage on either visit.				
	pharmacist (P)-A of that parameters for containing medical the supervisor for the was unavailable). If to the pharmacists the consultant phateuse of medications and recommend to from the physician	on 9/18/14 at 3:55 p.m., confirmed it would be preferred refered the use of acetaminophen tions be established. P-A was the regular pharmacist (who P-A did not have ready access notes, however P-A indicated rmacist should recognize the secontaining acetaminophen of the staff to obtain parameters. If those directions were not in probably did not do it				
		armacist failed to identify 62, reviewed for unnecessary				
	9/15/14 at 5:30 p.r resident was well of p.m., R62 was obs lounge, no behavio	d seated in the dining room on m., no behaviors noted and groomed. On 9/16/14 at 3:30 served seated in the resident ors exhibited. On 9/17/14 at nt was sleeping comfortable in				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00022	B. WING		09/-	8/2014
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- INVER GROVE 1301 50T	H STREET E	TATE, ZIP CODE AST TS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21530	Continued From pa	age 20	21530			
	his chair, no behav	riors noted.				
	(antianxiety) 20 mil BuSpar (antidepres	's Orders dated 9/2/14, Ativan lligram (mg) as needed and ssant) 5 mg daily, which (antidepressant) 75 milligrams				
	8/19/14, identified of depression, anxiety indicated R62 had within the eighteen pleasure in doing t concentrating on the extensive assistan (ADLs) with one to category did not in	num Data Set (MDS) dated diagnoses which included y and insomnia. The MDS received the antidepressants days and little interest or hings, also trouble nings. The resident needs ce with activities of daily living two staff assist. The Mood dicate the resident had trouble sleep or sleeping too much.				
	Notes from International which did not addrinsomnia. In addit clinical rationale for, the use of multisame pharmacological results in the control of the con	d had Physician's Progress all medicine dated 8/15/14, ess anxiety, depression or ion, there was no documented or the benefit of, or necessity tiple medications from the gical class. The medical records was under a psychologist				
		iew dated 8/29/14 stated no armacist was not available for				
	monitor mood/beh	ord indicated the facility did aviors on the treatment ord (TAR) dated 9/1/14 through				
	R62's care plan pr	inted 8/28/14 was reviewed				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
THE LETT	5. 55///E5/10/V	DECTION OF TOMBET	A. BUILDING:			
		00022	B. WING		09/1	8/2014
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INVER GROVE	H STREET E <i>l</i> ROVE HEIGH	AST TS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21530	Continued From pa	age 21	21530			
	address the side of however, the care pantidepressant use monitoring of adver					
	(DON) and social sethe care plan lacked antianxiety and antialso did not include or side effects for tantidepressant menon-pharmacologic developed for R62.	15 a.m. the director of nursing service director (SSD) verified ed addressing the use of tidepressants medications. It is monitoring the effectiveness the use of antianxiety and adications, and cal interventions had not been the DON stated the used for R62 because he				
	distributed by Ame revised: 28 May 20 cause serious side Medication Guide f these serious side reported in studies drowsiness, nervoid depressive disorder concentration, excidepression, blurred nauseas, dry mout vomiting, musculos numbness, incoord headache, fatigue	ckage Insert and Label				
	Information by Pfiz noted the following effects in people w	zer Inc. last revised on 8/2014, g: "Common possible side who take Sertraline include: allergic reactions, abnormal				

Minnesot	form APPROVED ### Innesota Department of Health									
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE S COMPL					
		00022	B. WING		09/18	8/2014				
NAME OF P	ROVIDER OR SUPPLIER			TATE, ZIP CODE						
GOOD SA	AMARITAN SOCIETY	- INVER GROVE	H STREET EA ROVE HEIGH	TS, MN 55077						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE				
21530	dry mouth, diarrheasleeping may occur. The Ativan Packag by Biovail Pharmacon 7/2008, noted the form of drowsiness, amnes vertigo, headache, libido, change in an insomnia, agitation. The Psychopharma revised 1/2007, indinterventions and a psychopharmacolosedatives/hypnotics sedatives/hypnotics. A SUGGESTED Maches The facility interdisted designee could repolicies and procedured irregularities report director of nursing designee could ed related to medicati develop procedure. The facility could densure ongoing confindings to the Quarter and procedure of the facility out the quarter of the facility could densure ongoing confindings to the Quarter of the facility that the quarter of the facility could densure ongoing confindings to the Quarter of the facility that the quarter of the facility could densure ongoing confindings to the Quarter of the facility that the quarter of the facility could densure ongoing confindings to the Quarter of the facility could densure ongoing to the Quarter of the facility of of the facili	blems, dizziness, drowsiness, a, upset stomach and trouble r. " e Insert and Label Information reuticals last revised on ollowing: "fatigue, sia, confusion, depression, slurred speech, change in opetite, constipation, skin rash, and hallucinations. "acologic Medication Use policy licated, "To evaluate behavior liternatives before using gical medications and s. To eliminate unnecessary gical medications and		DEFICIENCY)						
21535	(21) days.	5 Subp.1 ABCD Unnecessary	21535							

Minnesota Department of Health

	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION		SURVEY PLETED
		00022	B. WING		09/	18/2014
	DF PROVIDER OR SUPPLIER SAMARITAN SOCIETY	INVER GROVE 1301 50TH	DRESS, CITY, ST H STREET EA ROVE HEIGHT			
(X4) I PREF TAG	X (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
215	Subpart 1. Gener must be free from unnecessary drug A. in excessive therapy; B. for excessive C. without ade D. in the prese which indicate the discontinued. In addition to the copart 4658.1310, the with provisions in the Code of Federal Results (1) found in Coperations Manual Long-Term Care For Department of Health Care Finant This standard is in available through the system and the Standard is in available through the system and the Standard is in available through the system and the Standard is in available through the system and the Standard in a seeded in Acetaminophen (1) exceed the safe do (R16) and failed to were free of unnecessary medical individual control of the safe do (R16) and failed to were free of unnecessary medical individual control of the safe do (R16) and failed to were free of unnecessary medical control of the safe do (R16) and failed to were free of unnecessary medical control of the safe do (R16) and failed to were free of unnecessary medical control of the safe do (R16) and failed to were free of unnecessary medical control of the safe do (R16) and failed to were free of unnecessary medical control of the safe do (R16) and failed to were free of unnecessary medical control of the safe do (R16) and failed to were free of unnecessary medical control of the safe do (R16) and failed to were free of unnecessary medical control of the safe do (R16) and failed to	al. A resident's drug regimen unnecessary drugs. An is any drug when used: e dose, including duplicate drug we duration; equate indications for its use; or ence of adverse consequences dose should be reduced or drug regimen review required in the nursing home must comply he Interpretive Guidelines for egulations, title 42, section a Appendix P of the State II, Guidance to Surveyors for acilities, published by the alth and Human Services, cing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan ate Law Library. It is not to change. The is not met as evidenced tion, interview and document failed to ensure that scheduled medications with Sylenol) would not potentially osage amount for one resident of ensure medications for one of residents reviewed for	21535			
	Findings include: The facility failed to	o establish parameters for the				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	MPLETED	
		00022	B. WING		09/-	18/2014	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- INVER GROVE 1301 50TI	H STREET EA	TATE, ZIP CODE AST TS, MN 55077			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
21535	use of medications and on two occasion recommended guide on 9/17/14 at 9:30 receiving a narcotic acetaminophen. WR16 were reviewed was receiving the formal of acetaminophen for this to happen in acetaminophen with twice a day (bid) processident received the sectaminophen of twice and 9/19/14. Currently lacetaminophen with twice a day (bid) processident received the sectaminophen at twice a day (bid) processident received the sectaminophen and acetaminophen (Tyles) processident as prescribled to once on 9/5, once resident as prescribed to once on 9/5, once on	containing acetaminophen on R16 exceeded the delines of 4000 mg per day. a.m. R16 was observed a pain medication containing then the physician orders for the orders revealed that R16 collowing medications for pain: 0 mg [milligrams] qid [four to 7/23/14 which equaled 2000 then a day. Itab qid started 9/5/14 and to ever, the order read may that in a sneeded (prn) after R16 was receiving 1300 mg of the Norco. Acetaminophen 5/325 mg 1 mg (started 8/8/14). The this medication on 9/4, 9/5, 5. If utilized by the resident as ident would receive 650 mg of day. If we have the resident would receive this medication twice on 9/3, on 9/12. If utilized by the bed the resident would receive the possible liver damage. Item did not receive more than an inophen, there was potential for the resident utilized all of the	21535				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			,	E CONSTRUCTION		COMPLETED	
		00022		B. WING		09/-	18/2014
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- INVER GROVE	1301 50TH	I STREET EA	TATE, ZIP CODE AST TS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	-ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21535	(DON) indicated shaddressed acetamigiven. She would e judgement and proabide by the warnir label which indicate mg). She would exthe residents plan of the tresidents plan of the tresidents plan of the tresidents plan of medications containing medicat consultant pharmacof medications contecommend to the the physician. R62 was prescribe anti-depressant meanalysis to justify usymptoms and side interventions. R62 was observed 9/15/14 at 5:30 p.m. resident was well gp.m., R62 was obslounge, no behavior 11:30 p.m., resider his chair, no behavior 11:30 p.m., resider his chair h	e had no specific polinophen and the amore expect nurses to use gressional standards and ges on the acetaminophed not to exceed 4 gm poet that to be address of care. In 9/18/14 at 3:55 p.m confirmed it would be the use of acetaminophed in the use of acetaminophed in the obtain paramed and anti-anxiety and edications without adese, regular monitoring effects and non-drug effects and non-drug seated in the dining in the company of the erved seated in the representations of the erved seated in the error of the e	unt to be good and to other as (4000 seed on one other and other other and other other and other other and other oth	21535			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077 (X4) ID PREFIX TAG (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) 21535 Continued From page 26 depression, anxiety and insomnia. The MDS indicated R62 had received the antidepressants within the eighteen days and little interest or pleasure in doing things, also trouble concentrating on things. The resident needs extensive assistance with activities of daily living (ADLs) with one to two staff assist. The Mood category did not indicate the resident had rouble falling or staying asleep or sleeping too much. The admission Care Area Assessment (CAA) dated 8/25/14, indicated "resident has psychiatric or mood disorder and receives medication to manage and treat condition." The medical record had physician's progress notes from internal medicine dated 8/15/14, which did not address anxiety, depression or insomnia. In addition, there was no documented clinical rationale for the benefit of, or necessity for, the use of multiple medications from the same pharmacological class. The medical record did not indicate the R62 was under care of a mental health professional.	Minneso	linnesota Department of Health								
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INVER GROVE SUMMARY STATEMENT OF DEFICIENCIES FREEDLY TAG CONTINUED FROM LIST IDENTIFYING INFORMATION) 21535 Continued From page 26 depression, anxiety and insomnia. The MDS indicated R62 had received the antidepressants within the eighteen days and little interest or pleasure in doing things, also trouble concentrating on things. The resident had trouble falling or staying asleep or sleeping too much. The admission Care Area Assessment (CAA) dated 8/25/14, indicated "resident has psychiatric or mood disorder and receives medication to manage and treat condition." The medical record had physician's progress notes from internal medicine dated 8/15/14, which did not address anxiety, depression or insomnia. In addition, there was no documented clinical rationale for the benefit of, or necessity for, the use of multiple medications from the same pharmacological class. The medical record did not indicate R62 was under care of a mental health professional.	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION					
AMME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INVER GROVE 1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077 INVER GROVE HEIGHTS, MN 55077 SUMMARY STATEMENT OF DEFICIENCIESES TAG SUMMARY STATEMENT OF DEFICIENCIESES TAG SUMMARY STATEMENT OF DEFICIENCIESES TAG SUMMARY STATEMENT OF DEFICIENCIESES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG COMPLETE DATE PREFIX TAG CHOSS-REFERENCED TO THE APPROPRIATE DATE CHOSS-REFERENCED TO THE APPROPRIATE DATE CHOSS-REFERENCED TO THE APPROPRIATE DATE OAME CHOSS-REFERENCED TO THE APPROPRIATE D	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMF	PLETED			
CAUTION CAUT			00022	B. WING		09/1	18/2014			
(X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21535 Continued From page 26 depression, anxiety and insomnia. The MDS indicated R62 had received the antidepressants within the eighteen days and little interest or pleasure in doing things. The resident needs extensive assistance with activities of daily living (ADLs) with one to two staff assist. The Mood category did not indicate the resident had trouble falling or staying asleep or sleeping too much. The admission Care Area Assessment (CAA) dated 8/25/14, indicated "resident has psychiatric or mood disorder and receives medication to manage and treat condition." The medical record had physician's progress notes from internal medicine dated 8/15/14, which did not address anxiety, depression or insomnia. In addition, there was no documented clinical rationale for the benefit of, or necessity for, the use of multiple medications from the same pharmacological class. The medical record did not indicate R62 was under care of a mental health professional.	NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE					
PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) 21535 Continued From page 26 depression, anxiety and insomnia. The MDS indicated R62 had received the antidepressants within the eighteen days and little interest or pleasure in doing things, also trouble concentrating on things. The resident needs extensive assistance with activities of daily living (ADLs) with one to two staff assist. The Mood category did not indicate the resident has psychiatric or mood disorder and receives medication to manage and treat condition." The admission Care Area Assessment (CAA) dated 8/25/14, indicated " resident has psychiatric or mood disorder and receives medication to manage and treat condition." The medical record had physician's progress notes from internal medicine dated 8/15/14, which did not address anxiety, depression or insomnia. In addition, there was no documented clinical rationale for the benefit of, or necessity for, the use of multiple medications from the same pharmacological class. The medical record did not indicate R62 was under care of a mental health professional.	GOOD S	AMARITAN SOCIETY	- INVER GROVE							
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The pharmacy review dated 8/29/14 stated no concerns. The pharmacist was not available for an interview. R62's medical record indicated the facility did monitor mood/behaviors on the treatment administration record (TAR) dated 9/1/14 through 9/18/14 R62's care plan printed 8/28/14 was reviewed and the following was noted. The care plan did address the side effects of the use of hypnotics, however, the care plan lacked evidence of the	21535	depression, anxiety indicated R62 had within the eighteen pleasure in doing the concentrating on the extensive assistance (ADLs) with one to category did not incompare and the admission Cardated 8/25/14, indicated 8/25/14, indicated 8/25/14, indicated and the following with the medical record notes from internal did not address and in addition, there we rationale for the because of multiple medication to manifold the pharmacological of the pharmacological	v and insomnia. The MDS received the antidepressants days and little interest or nings, also trouble sings. The resident needs be with activities of daily living two staff assist. The Mood dicate the resident had trouble sleep or sleeping too much. The Area Assessment (CAA) beated "resident has disorder and receives age and treat condition." The had physician's progress medicine dated 8/15/14, which exiety, depression or insomnia. The medical record did as under care of a mental limetit of, or necessity for, the dications from the same ass. The medical record did as under care of a mental limetit was not available for the dicated the facility did aviors on the treatment ord (TAR) dated 9/1/14 through sinted 8/28/14 was reviewed was noted. The care plan did ffects of the use of hypnotics,		DELINCT)					

Minneso	ta Department of He	alth					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPP IDENTIFICATION N			E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00022		B. WING		09/1	8/2014
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INVER GROVE		H STREET EA ROVE HEIGH	AST TS, MN 55077		, ,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCY MUST BE PRECEDED E SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 27		21535			
	On 9/18/14, at 10:1 (DON) and social s the care plan lacked antianxiety and antialso did not include or side effects for thantidepressant medications were used to be a could not sleep. The Buspirone Paction of the Buspir	ervice director (SS d addressing the undepressants medical monitoring the effect of an addressing the use of antianxier dications, and all interventions has the DON stated the sed for R62 becaused for R63 becaused for R64 for R65 for R66 for R66 for R67 for R68	D) verified se of cations. It ectiveness ty and d not been ne use he ged and ging last prione can entire n about ide effects ziness, major decreased fusion, estinal, eation, as, n rash,				
	The Sertraline Pacilinformation by Pfizinoted the following effects in people with suicidal thoughts, a bleeding, seizures appetite, visual prodry mouth, diarrheasleeping may occulthe Ativan Packag by Biovail Pharmac	er Inc. last revised: "Common possible take Sertraline allergic reactions, a or convulsions, chablems, dizziness, ca, upset stomach a r."	on 8/2014, ble side include: bnormal anges in drowsiness, nd trouble				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		00022	B. WING		09/18	B/2014
	PROVIDER OR SUPPLIER	STREET ADI	STREET EA	TATE, ZIP CODE AST TS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	DBE	(X5) COMPLETE DATE
21535	vertigo, headache, libido, change in apinsomnia, agitation The Psychopharma revised 1/2007, indinterventions and apsychopharmacolo sedatives/hypnotics psychopharmacolo sedative/hypnotics A SUGGESTED M The facility interdis designee could repolicies and proced medications. The I all staff on procedum medications and dimplementation. The monitoring system compliance and re Assurance Commi	ollowing: "fatigue, sia, confusion, depression, slurred speech, change in opetite, constipation, skin rash, and hallucinations." acologic Medication Use policy licated, "To evaluate behavior alternatives before using origical medications and so To eliminate unnecessary or eview, revise and/or develop dures to ensure that residents' ns are free of unnecessary DT or designee could educate ures related to unnecessary evelop procedures to ensure ne facility could develop so to ensure ongoing port the findings to the Quality	21535			
21685	MN Rule 4658.141 Housekeeping, Op	5 Subp. 2 Plant peration, & Maintenance	21685			
	including walls, flor systems, and equi continuous state o with regard to the	plant. The physical plant, ors, ceilings, all furnishings, pment must be kept in a f good repair and operation health, comfort, safety, and esidents according to a written				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00022		B. WING		09/	18/2014
	PROVIDER OR SUPPLIER	- INVER GROVE 13	01 50TH	STREET EA	TATE, ZIP CODE AST TS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21685	routine maintenanc	e and repair program.		21685			
	by: Based on observation review, the facility for and maintenance some and comfortable enteresidents (R28, R14) and impacted 38 of	ent is not met as evider ion, interview, and docur ailed to provide houseke ervices to maintain a sa evironment for 6 of 30 I, R40, R1, R45, R2) obs 38 resident rooms at the hipping on the door fram	ment eeping nitary served				
	Findings include:						
		p.m. a urine smell was doncerns about the pathroom.	noted				
		9 a.m. R14 expressed anliness in the bathroor	n.				
	maintainence direc	with the housekeeping stors R14's room had pa or frame entering the bat	int				
	had wrappers, dusing A large dark spot with bed. Both privacy of spots. A cord near door from fully shufrom the walls. An time with R1's familial dissatisfaction with cleanliness of the respective of the results of the results and the spots of the spo	89 a.m. R40 and R1's rot, and garbage under the vas on the ceiling over Fourtains had multicolor dethe ceiling blocked the ceiting, and paint was peeinterview conducted at lify member (F)-A revealed overall maintenance are soom and bathroom. F-A ed to the facility numerourns.	e beds. R1's clark closet ling the ed ad				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			COMPLETED	
		00022		B. WING		09/	18/2014
NAME OF I	PROVIDER OR SUPPLIER				TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INVER GROVE		I STREET E <i>l</i> OVE HEIGH	AST FS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
21685	Continued From pa	ge 30		21685			
	maintainence direct and R1 had debris dividing the room harge yellow waters R1's bed. There was marks on the walls During a follow up approximately 2:00 reiterated about the the interview a large	tors verified the room under the beds, the cad dark stains, and the stains on the ceiling a as also paint chipped and doorway to the restriction of the p.m. with F-A, conce to upkeep of R1's room e red spot was noted offs on the floor and diffs on the floor and diffs.	for R40 surtain here were bove and black com. at erns were n. During on the				
	9/18/14, at 12:05 p maintenance direct concern were revieworn on doorways rooms. R45's room doorway entering the marks. There was by the floor near the large amount of pathe doorway and of the doorway and of the was also blated and walls. During the environ 12:05 p.m. the hour resident rooms we the rooms listed at maintenance direct resident doorways. The maintenance opaint and black maintenance of the control of the cont	tour was conducted of the cons. The following are wed: Paint was chipp for 38 out of 38 reside a had paint chipped or the room and black so also a two inch hole in the bed. R2's doorway int missing the lower hipped paint on the dock scuff marks on the mental tour on 9/18/1 sekeeping director stree cleaned daily, and bove were not clean. The constant of the constan	eping and reas of sing or ent on the suff on the wall had a level of corways. The ated verified The ainted the months. The and walls.				

Minnesota Department of Health STATE FORM

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	ECONSTRUCTION	(X3) DATE S COMPL	
		00022	B. WING		09/18	3/2014
	PROVIDER OR SUPPLIER	- INVER GROVE 1301 50TH	STREET EA	TATE, ZIP CODE AST TS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21685	addition, the mainte was not a log to tra made in each room. Review of the unda Purpose of the Housekeeping Procedures and healthful staff, and visitors, and safety, to meet regulations regardi. Review of the unda Checklists Overvie maintenance had t grounds, buildings center. A SUGGESTED M The director(s) of haintenance or de implement policies all areas of the phy and operation. The and maintenance or procedures for ensplant are kept in go facility develop moongoing compliant Quality Assurance. TIME PERIOD FO	er stains on R40's ceiling. In enance director reported there ck/document any repairs in ted facility policy titled usekeeping Department cedures directed to maintain surrounding for the residents, for maintain cleanliness, order all federal and state ing housekeeping. Atted facility policy Maintenance we Policy indicated the critical task of caring for the and the equipment in each ETHOD FOR CORRECTION: Thousekeeping and signee could develop and and procedures to ensure that are in good repair and procedure all staff on suring all areas of the physical pood repair and operation. The intoring systems to ensure the end report the findings to the	21685			
21810	Residents of HC F	4.651 Subd. 6 Patients & ac.Bill of Rights oriate health care. Patients and	21810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00022	B. WING		09/1	8/2014
GOOD SAMARITAN SOCIETY - INVER GROVE 1301 50TH			H STREET EA	STATE, ZIP CODE AST TS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21810	residents shall have medical and persor needs. Appropriate care designed to erhighest level of phy This right is limited reimbursable by pu This MN Requirements assed on observation review, the facility for was in reach for 1 caccommodate 1 of comfortably fitting in ensure 1 of 2 reside accommodated for Findings include: The facility failed to reach for R27. R27 was observed 8:20 a.m., and the sitting on the bedsing R27 was asked if a attempted to move nightstand but was and asked the observation asked the observation with RN-Ause the pressure powas not in reach of On 9/18/14, 9:50 a	e the right to appropriate hal care based on individual care for residents means hable residents to achieve their sical and mental functioning. Where the service is not blic or private resources. ent is not met as evidenced ons, interview, and document ailed to ensure the call light of 1 resident (R27); failed to 1 resident (R2) with montinence brief and failed to ents (R18) was bathing preferences. I ensure a call light was in lying in bed on 9/16/14, at pressure pad call light was de nightstand out of reach. ble to reach the call light. R27 hand toward the bedside not able to reach the call light erver to place the call light. A revealed R27 was able to ad call light and confirmed it R27. Im. an interview was				
		director of nursing (DON)				

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Minneso	ta Department of He	aith				,	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:			1 0		
		D 14/1/10					
		00022		B. WING		09/1	8/2014
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
00000	ANA DITAN COCIETY	INIVED CDOVE	1301 50TH	H STREET EA	AST		
GOOD S	AMARITAN SOCIETY	- INVER GROVE	INVER GF	ROVE HEIGH	TS, MN 55077		
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21810	Continued From pa	ıge 33		21810			
	related to R27's cal on 9/16/14. The DC was that all call ligh residents.	ON stated that the	expectation				
	R27's care plan las communication pro "ensure/provide a s pad for call light."	blem indicated,					
	The policy and procrevised on 1/09, inclight is observed/he promptly. Respond possible. Turn call resident's request ileaving the room, preach of resident if call light cord acrosreach it. For reside staff need to make adaptive call light."	dicated, "When re eard, go to residen to request as soo light off and inquin in a friendly mann place call light with in bed. If out of b ess bed so residen ents unable to use frequent visits or	esident's call nt's room on as re about er. When nin easy ed, stretch t is able to call light,				
	The facility failed to incontinence briefs		properly fitting				
	On 9/17/14, at 8:20 peri care and appli while rolling reside using grab bar. R2 hurts. Ow, ow, oh to adjust the incontoo small. It's not of	ed a clean incontint back/forth with mand stage moaned and stages it hurts." R2 tinence brief and	inence brief R2's help ated, "That asked NA-A stated, "It's				
	On 9/17/14, at 8:22 conducted with R2 return with help to what hurt when wa incontinence brief	! (while waiting for transfer R2 out of as moved. R2 stat	NA-A to f bed) to see ed again the				

Minnesota Department of Health STATE FORM

comfortable.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00022	B. WING		09/1	8/2014
NAME OF F	PROVIDER OR SUPPLIER		•	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INVER GROVE	H STREET E. ROVE HEIGH	AST ITS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21810	Continued From pa	age 34	21810			
	9/17/14, at 8:45 a.r get R2 out of bed. NA-B, "The pad is size" as NA-A state have." The NA's, vR2 out of bed and in NA-A wheeled R2 in visited with tablema breakfast. There was too tight according as too tight as too tight.	m. NA-B came to help NA-A to R2 stated to both NA-A and too small. I need a special ed, "That's the biggest size we via mechanical lift, transfered into a wheelchair. At 8:56 a.m. nto the dining room where she ates while waiting for vas no report to the registered sing staff the incontinence brief ding to R2. Care plan for bladder and elast revised on 3/28/14, nt uses incontinent products tretch L/XL. Long extended ded both waking/sleeping to rity, dignity, individual care, in incontinence." Dialm. an interview was I-A related to R2's concernence brief being too tight, and we during morning cares on ted was not aware of R2's did to see if a "Tena notification" the floor nurse was notified so esize could be provided. note R2 was recently on 6/10/14, there was no or report to the floor nurse of ed to the incontinence brief				
	R18's annual Minir	mum Data Set (MDS) dated				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00022		B. WING	B. WING		8/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INVER GROVE	H STREET E. ROVE HEIGH	AST TS, MN 55077		ļ
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21810	Continued From pa	age 35	21810			
21810	12/31/14, revealed you are in this facili choose between a sponge bath?" R18 important". R18's most recent indicated R18 had impairment, was to and required one p R18's most recent for activities of dail 12/31/13, noted "H bathing, hygiene, d to participate by mown face, hands air remainder of cares Requires a total lift assist to turn in bed (wheelchair) with b pedals. Is able to s	the following question, "While ity how important is it to you to tub bath, shower, bed bath or 3's response was "very quarterly MDS dated 7/1/14,				
	recent falls, does upositioning and is a command. Belt kee when self propellin not include an inter-	use seatbelt in w/c for able to self release on eps his hips aligned and safe og w/c." The assessment did rdisciplinary analysis or ot being able to bathe in a tub,				
	care deficit dated 3 left below the knee	r activities of daily living self 3/31/14, indicated R18 had a e amputation and a right above on. "Bathing: Bedbath [sic] nday."				
	The 30 day bathing log dated 8/24/14, 8/31/14, and 9/14/14, indicated R18 received only bed baths.					

(X3) DATE SURVEY

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION

AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	EIED
		00022	B. WING		09/18	3/2014
GOOD SAMARITAN SOCIETY - INVER GROVE			ODRESS, CITY, S TH STREET EAROVE HEIGH	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21810	Continued From pa	ge 36	21810	No. of the second secon		
	a.m. R18 shared he week. On 9/17/14, would like a tub bat baths. On 9/18/14, was receiving bed he baths each week. Fhome, but was not bath at the facility. On 9/17/14, at 3:00 (NA)-D reported R1 the day. NA-D belied due to safety reason allowed choices in On 9/18/14, at 9:35 nursing and the ME unable to use the bassessment by occindicated R18 had On 9/18/14, at 9:56 with OT-A revealed was never assessed On 9/18/14, at 1:50 (DON) reported no determine R18 was and reported it would normally corresponse recorded do can't get into tul	is a.m. the assistant director of DS nurse reported R18 was eath tub because an supational therapy (OT) poor trunk control. is a.m. an interview conducted R18's ability to bathe in a tubed. in p.m. the director of nursing assessment was done to sunable to bathe in the tub, ald not be something the facility.	y			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		(X3) DATE SURVEY COMPLETED		
AND FEAR OF CONTROLLOR		A. BUILDING:		JOINIT LETED		
		00022	B. WING		09/18	8/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INVER GROVE	H STREET EA	AST TS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT: (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21810	Continued From pa	age 37	21810			
	An interdisciplinary revise and impleme ensure that resider their individualized IDT or designee co facility could develon ensure ongoing confindings to the Quarter of the their individualized individualized their individualized in	team [IDT] could review, ent policies and procedures to ats receive care appropriate to needs and preferences. The old educate all staff. The proposition procedure and report the lity Assurance Committee. R CORRECTION: Twenty one				

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Minnesota Department of Health