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

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245285**

2. STATE VENDOR OR MEDICAID NO. (L2) **659561800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS**
(L4) **1301 50TH STREET EAST**
(L5) **INVER GROVE HEIGHTS, MN** (L6) **55077**

4. TYPE OF ACTION: 7 (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **11/04/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sue Reuss, Supervisor 11/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 11/04/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **08/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **10/27/2014** (L33)

DETERMINATION APPROVAL

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,

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,

Anne Kleppe

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

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245285	A. Building B. Wing	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 55077

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	**10/24/2014**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	**10/24/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**10/24/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**10/24/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**10/24/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**10/24/2014**
ID Prefix **F0412** Reg. # **483.55(b)** LSC	**10/24/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	**10/24/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	**10/23/2014**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	11/04/2014	16022	11/04/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/18/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245285	A. Building B. Wing 01 - MAIN BUILDING 01	10/22/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0064	**09/24/2014**	ID Prefix Reg. # **NFPA 101** LSC K0144	**09/24/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/AK	11/04/2014	25822	10/22/2014

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/16/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: NVOD
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(L3) **GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS**
(L4) **1301 50TH STREET EAST**
(L5) **INVER GROVE HEIGHTS, MN** (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
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **09/18/2014** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **52** (L18)
13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mary Heim, HPR-Social Work Specialist 10/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/23/2014 (L20)

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

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

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21. 1. Statement of Financial Solvency (HCFA-2572)
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3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **08/01/1985** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of 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.

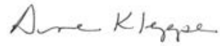
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

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

Feel free to contact me if you have questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. BUILDING ______ B. WING ______	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER 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) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. For the purposes of any allegations that the center is not in substantial compliance with federal compliance with federal requirements of participation. This response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and document review, the facility failed to ensure the call light was in reach for 1 of 1 resident (R27); failed to accommodate 1 of 1 resident (R2) with comfortably fitting incontinence brief and failed to ensure 1 of 2 residents (R18) was accommodated for bathing preferences. Findings include: The facility failed to ensure a call light was in reach for R27.	F 246		10/24/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: October 15, 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. BUILDING ______ B. WING ______	09/18/2014

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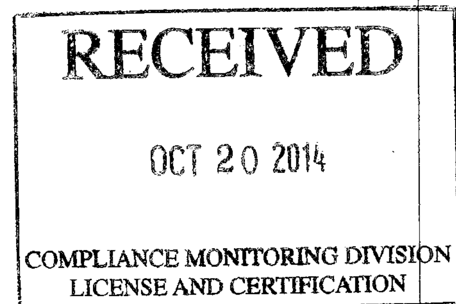
F 246	Continued From page 1 R27 was observed lying in bed on 9/16/14, at 8:20 a.m., and the pressure pad call light was sitting on the bedside nightstand out of reach. R27 was asked if able to reach the call ligh. R27 attempted to move hand toward the bedside nightstand but was not able to reach the call light and asked the observer to place the call light on. At 8:31 a.m., the assistant director of nursing registered nurse (RN)-A answered call light. Interview with RN-A revealed R27 was able to use the pressure pad call light and confirmed it was not in reach of R27. On 9/18/14, 9:50 a.m. an interview was conducted with the director of nursing (DON) related to R27's call light not being within reach on 9/16/14. The DON stated that the expectation was that all call lights should be in reach of the residents. R27's care plan last revised on 1/19/13, for communication problem indicated, "ensure/provide a safe environment: pressure pad for call light." The policy and procedure for call lights last revised on 1/09, indicated, "When resident's call light is observed/heard, go to resident's room promptly. Respond to request as soon as possible. Turn call light off and inquire about resident's request in a friendly manner. When leaving the room, place call light within easy reach of resident if in bed. If out of bed, stretch call light cord across bed so resident is able to reach it. For residents unable to use call light, staff need to make frequent visits or provide an adaptive call light."	F 246	{R27} was immediately provided the call light to ensure it was within reach; {R2} was assessed immediately 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. 	

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COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

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F 246	Continued From page 2 The facility failed to ensure R2 had properly fitting incontinence briefs. On 9/17/14, at 8:20 a.m., NA-A completed R2's peri care and applied a clean incontinence brief while rolling resident back/forth with R2's help using grab bar. R2 moaned and stated, "That hurts. Ow, ow, oh gosh it hurts." R2 asked NA-A to adjust the incontinence brief and stated, "It's too small. It's not comfortable at all." On 9/17/14, at 8:22 a.m. an interview was conducted with R2 (while waiting for NA-A to return with help to transfer R2 out of bed) to see what hurt when was moved. R2 stated again the incontinence brief was too tight and not comfortable. 9/17/14, at 8:45 a.m. NA-B came to help NA-A to get R2 out of bed. R2 stated to both NA-A and NA-B, "The pad is too small. I need a special size" as NA-A stated, "That's the biggest size we have." The NA's, via mechanical lift, transfered R2 out of bed and into a wheelchair. At 8:56 a.m. NA-A wheeled R2 into the dining room where she visited with tablemates while waiting for breakfast. There was no report to the registered nurse or other nursing staff the incontinence brief was too tight according to R2. R2's most current care plan for bladder and bowel incontinence last revised on 3/28/14, indicated, "Resident uses incontinent products tENA [sic] Super Stretch L/XL. Long extended TENA product needed both waking/sleeping to maintain skin integrity, dignity, individual care, needed to maintain incontinence." On 9/18/14, at 9:50 a.m. an interview was	F 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 assessments. 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.	

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F 246	Continued From page 3 conducted with RN-A related to R2's concern related to incontinence brief being too tight, and R2 letting staff know during morning cares on 9/17/14. RN-A stated was not aware of R2's concern and looked to see if a "Tena notification" was filled out or if the floor nurse was notified so a more appropriate size could be provided. Although RN-A did note R2 was recently measured by Tena on 6/10/14, there was no "Tena notification" or report to the floor nurse of R2's concern related to the incontinence brief being too tight. R18 had bilateral leg amputations and was not provided bathing choices. R18's annual Minimum Data Set (MDS) dated 12/31/14, revealed the following question, "While you are in this facility how important is it to you to choose between a tub bath, shower, bed bath or sponge bath?" R18's response was "very important". R18's most recent quarterly MDS dated 7/1/14, indicated R18 had moderate cognitive impairment, was totally dependent for bathing and required one person physical assist. R18's most recent Care Area Assessment (CAA) for activities of daily living and rehabilitation dated 12/31/13, noted "He needs extensive assist with bathing, hygiene, dressing, grooming. He is able to participate by moving extremities and washing own face, hands and teeth. Staff completes remainder of cares. All needs anticipated by staff. Requires a total lift for all transfers. Requires 1 assist to turn in bed and 2 to boost. Has w/c (wheelchair) with bilat (bilateral) elevating foot pedals. Is able to self propel short distances and	F 246	The facility will re-educate all nursing staff on the policy and procedure of accommodating resident needs and preferences specifically related to placing the call light within reach of the resident; identifying and reporting an ill-fitting 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.	

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F 246	Continued From page 4 staff propels to final destination. He has had no recent falls, does use seatbelt in w/c for positioning and is able to self release on command. Belt keeps his hips aligned and safe when self propelling w/c." The assessment did not include an interdisciplinary analysis or rationale for R18 not being able to bathe in a tub, instead of receiving only bed baths. R18's care plan for activities of daily living self care deficit dated 3/31/14, indicated R18 had a left below the knee amputation and a right above the knee amputation. "Bathing: Bedbath [sic] every week on Sunday." The 30 day bathing log dated 8/24/14, 8/31/14, and 9/14/14, indicated R18 received only bed baths. On 9/16/14, at 1:31 p.m. and 9/18/14, at 9:30 a.m. R18 shared he wanted two baths each week. On 9/17/14, at 8:30 a.m. R18 clarified would like a tub bath, but instead received bed baths. On 9/18/14, at 9:30 a.m. R18 reconfirmed was receiving bed baths, but wanted two tub baths each week. R18 shared took tub baths at home, but was not given the choice of type of bath at the facility. On 9/17/14, at 3:00 p.m. a nursing assistant (NA)-D reported R18 was typically bathed during the day. NA-D believed R18 was given bed baths due to safety reasons, as residents were to be allowed choices in how they bathed. On 9/18/14, at 9:35 a.m. the assistant director of nursing and the MDS nurse reported R18 was unable to use the bath tub because an assessment by occupational therapy (OT)	F 246	The facility will review results 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 monitoring. The DNS is responsible for overall compliance.	

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F 246	Continued From page 5 indicated R18 had poor trunk control. On 9/18/14, at 9:56 a.m. an interview conducted with OT-A revealed R18's ability to bathe in a tub was never assessed. On 9/18/14, at 1:50 p.m. the director of nursing (DON) reported no assessment was done to determine R18 was unable to bathe in the tub, and reported it would not be something the facility would normally complete. On 9/18/14, at 2:00 p.m. the director of social services (SS) reviewed R18's most recent Resident Interview and Observation, dated 6/11/14, offering resident bathing choices. R18's response recorded was, "You know more than I do can't get into tub." The SS confirmed R18's response. R18 was not offered bathing choices.	F 246	Completion Date: October 24, 2014	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns;	F 272	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.	10/24/14

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F 272	Continued From page 6 Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively and accurately assess 1 of 4 residents (R40) for oral/dental needs. Findings include: During an interview with R40 on 9/16/14, at 11:20 a.m. R40 stated was having dental issues (did not say what the dental issues were) and was seeing a dentist. The annual minimum data set (MDS) was completed on 5/20/14. Under the dental section the staff documented no issues. No Care Area	F 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.	

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F 272	Continued From page 7 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 dentist 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, aside 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 was on the MDS. When asked about the condition of R40's mouth and the assessment done in May 2014, agreed that if the dentist found that many issues then the staff did not thoroughly assess R40's mouth in May.	F 272	Completion Date: October 24, 2014	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279		

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F 279	Continued From page 8 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan related to pain and acetaminophen use for 1 of 5 residents (R16) and mood and behavior medications for 1 of 5 residents (R62) reviewed for unnecessary medications. Findings include: The facility failed to develop a plan of care for R16 related to pain and the use of narcotics containing acetaminophen and plain acetaminophen. The resident had the potential to receive over the recommended guidelines of 4000 mg of acetaminophen a day. 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.	F 279	A care plan was reviewed and revised for R16 to provide directions related to use of acetaminophen or acetaminophen products to assist R16 to manage pain. A care plan was reviewed and revised for R62 to address mood, behavior, sleep and side effect monitoring of medications. The facility will review, and revise as needed, resident care plans related to pain and acetaminophen use and to mood and behavior medications to ensure residents' needs are identified and met. The policy and procedure for developing care plans was reviewed.	10/24/14

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F 279	Continued From page 9 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. R62's care plan was not developed to address mood, behavior, sleep and side effect monitoring of medications. On 9/15/14, at 5:30 p.m. R62 was observed seated at the dining room table. R62 had no behaviors. On 9/16/14, at 3:30 p.m. R62 was	F 279	The facility will re-educate licensed staff on the policy and procedure for developing care plans as related to pain and acetaminophen use and related to mood and behavior medications to meet residents' needs. IDT will monitor resident care plans to ensure they are developed related to pain and acetaminophen use during monthly Pain Management meetings. Care plans related to mood and behavior medications will be monitored during monthly behaviors meetings.	

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F 279	Continued From page 10 seated in the resident lounge and no behaviors were exhibited. On 9/17/14, at 11:30 p.m. R62 was sleeping comfortable in the chair and no behaviors were noted. R62's Physician's Orders dated 9/2/14, indicated Ativan (antianxiety) 20 mg as needed, BuSpar (antidepressant) 5 mg daily, and Sertraline (antidepressant) 75 mg daily. R62's annual Minimum Data Set (MDS) dated 8/19/14, identified diagnoses which included 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. R62 required extensive assistance with activities of daily living (ADLs) with one to two staff. The Mood category did not indicate R62 had trouble falling, 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." R62's Physician's Progress Notes dated 8/15/14, 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. R62's care plan printed 8/28/14, did address the side effects of the use of hypnotics however, the care plan lacked evidence of the antidepressant use, antianxiety use, non-drug interventions and monitoring of adverse effects.	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.	

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F 279	Continued From page 11 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 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."	F 279	Completion Date: October 24, 2014	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was followed for 1 of 3 residents (R14) reviewed for activities of daily living. Findings include:	F 282	The individualized care plan for nail care for R14 was reviewed and nail care was provided. The facility will review all resident care plans and will complete nail care audits to ensure that the care provided matches the care plan.	10/24/14

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F 282	Continued From page 12 The facility failed to ensure R14's activities of daily living care plan was followed to ensure nails were clean and properly trimmed. Review of R14's 8/5/14, Minimum Data Set (MDS) revealed R14 required extensive assistance with personal hygiene and one person physical assistance. R14's activities of daily living care plan last revised 8/6/14, directed staff "Personal Hygiene: Resident requires extensive assist of 1 staff. Resident will wash hands, face, upper torso with set up. Staff does all other grooming." and "NAR (nursing assistant) clip and clean nails." On 9/16/14, at 10:18 a.m. R14's nails were observed with dark matter under the fingernails. On 9/17/14, at 7:30 a.m. R14 was observed resting in bed but dressed for the day. R14 had two jagged fingernails and dark matter under all fingernails. On 9/17/14, at 3:45 p.m. R14 still had dark matter under the nails. Registered nurse (RN)-D confirmed R14's fingernails were dirty and needed to be cleaned. RN-D added expected staff to clean R14's nails during morning cares if they were dirty. On 9/17/14, at 4:00 p.m. the director of nursing (DON) reported nail care should be done on bath days and R14 had a shower on Monday and Friday.	F 282	The policy and procedure for care plan utilization was reviewed. The facility will re-educate all nursing staff on the care plan process, including following individual resident care needs specifically addressing nail care. The facility will monitor, with periodic audits, all resident nail care to ensure that the care matches the care plan. The facility will review results at the monthly QAPI 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. Completion Date: October 24, 2014	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312		

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F 312	Continued From page 13 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R14) reviewed for activities of daily living had clean and properly trimmed nails. Findings include: On 9/16/14, at 10:18 a.m. R14's had dark matter under the fingernails. On 9/17/14, at 7:30 a.m. while R14 was resting in bed, observed two jagged fingernails and dark matter under all fingernails. On 9/17/14, at 3:45 p.m. R14 still had dark matter under all the fingernails. Registered nurse (RN)-D confirmed R14's fingernails were dirty and needed to be cleaned. RN-D added, expected staff to clean R14's nails during morning cares if they were dirty. R14's 8/5/14, Minimum Data Set (MDS) revealed R14 required extensive assistance with personal hygiene and one person physical assistance. R14's activities of daily living care plan last revised 8/6/14, directed staff "Personal Hygiene: Resident requires extensive assist of 1 staff. Resident will wash hands, face, upper torso with set up. Staff does all other grooming." and "NAR (nursing assistant) clip and clean nails." On 9/17/14, at 4:00 p.m. the director of nursing (DON) reported nail care was expected to be	F 312	R14 was provided nail care to maintain good grooming. The facility assessed all residents' nails for good grooming and nail care was provided as needed. The policy and procedure for nail care was reviewed. The facility re-educated all nursing staff on the policy and procedure for providing nail care to residents. The facility will monitor, via audits, resident nails for good grooming weekly x 4 weeks, then randomly thereafter and nail care will be provided as needed. The facility will review results at the monthly QAPI meetings to ensure ongoing compliance.	10/24/14

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F 312	Continued From page 14 completed on bath days and R14 had a shower on Monday and Friday. The Nail Care policy last revised November 2013, directed staff "4. Soak resident's hands in basin with soapy water for about 10 minutes. 5. Remove hands and rinse with warm, clear water. 6. Push cuticles back gently with washcloth. 7. Dry hands and nails with towel. 8. Clean under nails with file or orange stick. 9. File nails with nail file or emery board. 10. For thick nails, cut straight across with scissors or nail clippers."	F 312	The DNS, SDC and/or designee{s} will be responsible for overall monitoring. The DNS is responsible for overall compliance. Completion Date: October 24, 2014	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	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 anti-anxiety medications and corrections were made.	10/24/14

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F 329	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that scheduled and "as needed" medications with Acetaminophen (Tylenol) would not potentially exceed the safe dosage amount for one resident (R16) and failed to ensure medication regimens were free of unnecessary medications for one resident (R62) of 5 residents reviewed for unecessary medications. Findings include: The facility failed to establish parameters for the use of medications containing acetaminophen. R16 had the potential of exceeding the recommended guidelines of 4000 mg per day. On 9/17/14 at 9:30 a.m. R16 was observed receiving a narcotic pain medication containing acetaminophen. When the physician orders for R16 were reviewed, the orders revealed that R16 was receiving the following medications for pain: Acetaminophen 500 mg [milligrams] qid [four times per day] since 7/23/14 which equaled 2000 mg of acetaminophen a day. Norco 5/325 mg 1 tab qid started 9/5/14 and to end 9/19/14. However, the order read may continue the medication as needed (prn) after 9/19/14. Currently R16 was receiving 1300 mg of Acetaminophen with the Norco. Hydrocodone with Acetaminophen 5/325 mg 1 twice a day (bid) prn (started 8/8/14). The resident received this medication on 9/4, 9/5, 9/10, 9/13, and 9/15. If utilized by the resident as	F 329	The facility will review, and correct as needed, all resident drug regimens related to "as needed" and 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. The policy and procedure for Unnecessary Medications was reviewed.	

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F 329	Continued From page 16 prescribed, the resident would receive 650 mg of acetaminophen a day. Acetaminophen (Tylenol) 650 mg every 6 hours (q6hrs) prn pain (started 7/14/14). The resident was administered this medication twice on 9/3, once on 9/5, once on 9/12. If utilized by the resident as prescribed the resident would receive 2600 mg of acetaminophen a day. The physicians orders did not reflect how much acetaminophen the resident could take in a day to alleviate the risk of possible liver damage. Although the resident did not receive more than 4000 mg of acetaminophen, there was potential for this to happen if the resident utilized all of the acetaminophen prescribed. On 9/18/14 at 4:20 p.m. the director of nursing (DON) indicated she had no specific policy that addressed acetaminophen and the amount to be given. She would expect 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). She would expect that to be addressed on the residents plan of care. She indicated there was no physician parameters as to how much acetaminophen the resident could receive and there probably should be. When interviewed on 9/18/14 at 3:55 p.m., pharmacist (P)-A confirmed it would be preferred that parameters for the use of acetaminophen containing medications be established. The consultant pharmacist should recognize the use of medications containing acetaminophen and recommend to the staff to obtain parameters from the physician.	F 329	The facility will re-educate all nursing staff on the policy and procedure for unnecessary medications to recognize the potential for exceeding acetaminophen safe dosing amount, and to recognize unnecessary use of anti-depressant and anti-anxiety medications. Licensed nurses will monitor new acetaminophen physician 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.	

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F 329	Continued From page 17 R62 was prescribed anti-anxiety and anti-depressant medications without adequate analysis to justify use, regular monitoring of symptoms and side effects and non-drug interventions. R62 was observed seated in the dining room on 9/15/14 at 5:30 p.m., no behaviors noted and resident was well groomed. On 9/16/14 at 3:30 p.m., R62 was observed seated in the resident lounge, no behaviors exhibited. On 9/17/14 at 11:30 p.m., resident was sleeping comfortable in his chair, no behaviors noted. R62 had Physician's Orders dated 9/2/14, Ativan (antianxiety) 20 milligram (mg) as needed and BuSpar (antidepressant) 5 mg daily, which included Sertraline (antidepressant) 75 milligrams (mg) daily, R62 ' s annual Minimum Data Set (MDS) dated 8/19/14, identified diagnoses which included 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 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."	F 329	The facility will review results 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.	

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F 329	Continued From page 18 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. 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 antidepressant use, antianxiety use, and monitoring of adverse effects. On 9/18/14, at 10:15 a.m. the director of nursing (DON) and social service director (SSD) verified the care plan lacked addressing the use of antianxiety and antidepressants medications. It also did not include monitoring the effectiveness or side effects for the use of antianxiety and antidepressant medications, and non-pharmacological interventions had not been developed for R62. The DON stated the medications were used for R62 because he could not sleep The Buspirone Package Insert packaged and	F 329		

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F 329	Continued From page 19 distributed by American Health Packaging last revised: 28 May 2013 noted the "Busprione can cause serious side effects. Read this entire Medication Guide for more information about these serious side effects. Common side effects reported in studies of tachycardia, dizziness, drowsiness, nervousness, insomnia, major depressive disorder, lightheadedness, decreased concentration, excitement, anger, confusion, depression, blurred vision, gastrointestinal, nauseas, dry mouth, diarrhea, constipation, vomiting, musculoskeletal, aches/pains, numbness, incoordination, tremor, skin rash, headache, fatigue and weakness" The Sertraline Package Insert and Label Information by Pfizer Inc. last revised on 8/2014, noted the following: "Common possible side effects in people who take Sertraline include: suicidal thoughts, allergic reactions, abnormal bleeding, seizures or convulsions, changes in appetite, visual problems, dizziness, drowsiness, dry mouth, diarrhea, upset stomach and trouble sleeping may occur. " The Ativan Package Insert and Label Information by Biovail Pharmaceuticals last revised on 7/2008, noted the following: " fatigue, drowsiness, amnesia, confusion, depression, vertigo, headache, slurred speech, change in libido, change in appetite, constipation, skin rash, insomnia, agitation and hallucinations. " The Psychopharmacologic Medication Use policy revised 1/2007, indicated, "To evaluate behavior interventions and alternatives before using psychopharmacological medications and sedatives/hypnotics. To eliminate unnecessary psychopharmacological medications and sedative/hypnotics. "	F 329	Completed Date: October 24, 2014	

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

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F 412	Continued From page 20	F 412		
F 412 SS=E	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 4 residents reviewed for dental (R40, R24, R18 and R14) received emergency and routine dental services. Findings include: The facility failed to ensure timely dental care for R40. During an interview with R40 on 9/16/14, at 11:20 a.m. revealed had dental issues and was not seeing a dentist. R40 was observed independently brushing his teeth after set up. The annual minimum data set (MDS) was completed on 5/20/14. Under the dental section the staff documented no issues. No Care Area Assessment (CAA) triggered as there were no dental issues identified. The quarterly MDS dated 8/14, revealed no dental issues.	F 412	Dental services were scheduled for R40, R24, R18, and R14. The facility will assess all residents for dental needs, and dental services will be offered and scheduled per resident preference. Emergency dental needs will be referred to outside sources. The policy and procedure for Oral/Dental Health Services and Assessments was reviewed.	

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F 412	Continued From page 21 The progress notes revealed 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 had not been to the dentist in "years." Dental visit on 9/11/14, revealed "decay, needs fillings of 6 teeth. Has upper full and lower partial." Appointments set up for 10/3 and 10/10/14. When interviewed on 9/18/14, at 10:10 a.m. the registered nurse (RN)-B indicated the facility does not do an oral/dental assessment, aside from the MDS. If a resident was showing signs of mouth pain then an assessment would be completed. The director of nursing (DON) when interviewed on 9/18/14, at 10:20 a.m. indicated the only oral/dental assessment was on the MDS. When asked about the condition of R40's mouth and the assessment completed May 2014 the DON agreed if the dentist found that many issues then the staff did not thoroughly assess R40's mouth in May. The facility failed to follow their written plan of care for oral/dental care for R24 related to her lost lower denture. During an interview with R24 on 9/16/14, at 11:42 a.m. R24 revealed had lost her lower denture and had not gotten them back. R24 said it happened when in the hospital. When R24 was asked if	F 412	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 and provision for dental services. DNS is responsible for overall compliance. The facility will review at the QAPI meetings monthly to ensure ongoing compliance.	

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F 412	Continued From page 22 would like to have her lower denture she replied, "if I'm going to live for awhile I would like to have teeth."	F 412		

The care plan dated 8/13/14, indicated R24 brushes own teeth independently. It further indicated the lower denture was missing, awaiting dental set up.

The care conference note dated 8/21/14, indicated left message for social worker about need for dental visit. Review of the social service notes did not reveal any dental appointments.

When interviewed on 9/18/14, at 9:20 a.m. the director of social services (SS) indicated the facility lost their dental contract in April when the dentist decided he would no longer come to the facility. The SS indicated the facility had been unable to secure another dentist. The SS agreed the dentures had been missing since December and was hoping the dentures would show up from the hospital. The SS indicated 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 making routine and annual appointments, arranging transportation and referral to a dentist in case of lost or damaged dentures.

The facility failed to arrange for annual routine and emergency dental appointments for R18,

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F 412	Continued From page 23 who had broken teeth. Review of R18's care plan revealed an admission date of February 2012. During interview and observation on 9/16/14, at 1:51 p.m. R18 pointed to the left side of the 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 brushing and rinsing his teeth independently after set up. 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 his own teeth, some are broken and sharp. Awaiting in house dentist to get established." 4/11/14, progress note read "He has his own teeth, some are broken, sharp and in need of a cleaning. Awaiting in house dentist to get established." R18's most recent Minimum Data Set dated 7/1/14, revealed R18 had moderate cognitive impairment and required extensive assistance for personal hygiene, with one staff person physical assist. R18's activities of daily living care plan last revised 3/31/14, directed staff "Oral Care: Staff to complete brushing teeth, offer and cue resident to participate as much as able. Natural teeth, some broken." During interview on 9/18/14, at 9:23 a.m. the	F 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. BUILDING ______ B. WING ______	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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F 412	Continued From page 24 director of social services (SS) reported R18 was on a list to see a contracted in house dentist. However, that contracted dentist was unable to provide services for the facility and contract was terminated in the beginning of June. The SS reported the family was trying to take care of financing dental appointments. The SS reported was unable to document any assistance provided by the facility to the family in arranging financing of dental appointments or seeking out low cost options. The facility failed to arrange timely annual routine and emergency dental visits for R14, who had missing partials. Review of R14's care plan last revised 8/6/14, revealed R14 had multiple sclerosis, limited physical mobility, and impaired cognition and communication. R14's admission date was noted to be in April of 2002. During initial interview on 9/16/14 at 10:12 a.m. R14 reported pain in both her upper and lower teeth and gums. Review of progress notes, dated 10/8/13 revealed "Has upper partial which staff brush daily. Has blackened tooth on bottom and several missing. Will not go out to see dentist, but is agreeable to be seen by in house dentist once they start here. She has reported mouth pain recently, although denies at time of interview and reiterated agreement to see dentist to write. No visible mouth sores or redness." A 1/17/14 progress note revealed "Has upper partial which staff brushes daily. Has blackened tooth on bottom and several missing. Still waiting on in house dentist to get	F 412		

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	245285	A. BUILDING ______ B. WING ______	09/18/2014

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GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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F 412	Continued From page 25	F 412		

established to get her seen as she refuses to go out for appointments. No visible mouth sores or redness." A 2/28/14 progress notes revealed "Has upper partial, no visible mouth sores. No chewing or swallowing problems noted." A 5/27/14 progress note revealed "Has own teeth and upper partial. Several missing including bottom partial. Resident is on the dentist list. No visible mouth sores. No chewing or swallowing problems noted." A 8/5/14 progress note revealed "Has own teeth and upper partial. Has several missing teeth including bottom partial. Facility still working on securing a dentist to come to facility to manage oral cares. At this point. Resident is on the dentist list. No visible mouth sores. No chewing or swallowing problems noted."

Review of the activities of daily living care area assessment, dated 3/1/14, revealed "Lower partial missing, has upper partial that fits well. Some blackened teeth and in need of dentist once in house dentist established."

On 9/18/14 at 2:30 p.m. the director of nursing (DON) reported the facility was waiting for in house dental services to be arranged for R14 to see a dentist. Notes from R14's last dental visit were requested by surveyor but not provided.

During interview on 9/18/14 at 9:23 a.m., the social service director (LSW) reported R14 was on a list to see a contracted in house dentist. However, that contracted dentist was unable to provide services for the facility and contract was terminated in the beginning of June.

The activities of daily living care plan, last revised 8/6/14, directed staff: "ORAL CARE: DENTAL VISITS: In house dentist, routine visits. HUC

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F 412	Continued From page 26 [health unit coordinator] to arrange once in house dentist secured."	F 412	Completed Date: October 24, 2014	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the consulting pharmacist failed to advise the facility on potential irregularities in the medication regimen for 2 of 5 residents reviewed for unnecessary medications (R16 and R62). Findings include: Observation of the medication pass on 9/17/14 at 9:30 a.m. revealed R16 received a narcotic pain medication containing acetaminophen. When the physician orders dated 9/3/14 and 9/5/14 were reviewed, the orders revealed that R16 was receiving the following medications for pain: Acetaminophen 500 mg [milligrams] qid [four times daily] since 7/23/14 which equaled 2000 mg of acetaminophen a day. Norco 5/325 mg 1 tab qid started 9/5/14 and to	F 428	The drug regiments for R16 and R62 were reviewed by the Consulting Pharmacist and any potential irregularities in the medication regimen were reported. The Consulting Pharmacist reviewed all resident drug regimens and reported any potential irregularities in each resident's medication regimen.	10/24/14

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F 428	Continued From page 27 end 9/19/14. However the order read may continue the medication as needed (prn) after 9/19/14. Currently R16 was receiving 1300 mg of Acetaminophen with the Norco. Hydrocodone with Acetaminophen 5/325 mg 1 twice a day (bid) prn (started 8/8/14). The resident received this medication on 9/4, 9/5, 9/10, 9/13, and 9/15. If utilized by the resident as prescribed, the resident would receive 650 mg of acetaminophen a day. Acetaminophen (Tylenol) 650 mg every 6 hours (q6hrs) prn pain (started 7/14/14). The resident was administered this medication twice on 9/3, once on 9/5, once on 9/12. If utilized by the resident as prescribed the resident would receive 2600 mg of acetaminophen a day. The physicians orders failed to reflect the amount of acetaminophen the resident could take in a day to alleviate the risk of possible liver damage. Although the resident did not receive more than 4000 mg of acetaminophen, there was potential for this to happen if the resident utilized all of the acetaminophen prescribed. R16 was admitted on 7/14/14 and the pharmacist assessed the resident on 7/28/14 and again on 8/29/14. The pharmacist did not address the acetaminophen dosage on either visit. When interviewed on 9/18/14 at 3:55 p.m., pharmacist (P)-A confirmed it would be preferred that parameters for the use of acetaminophen containing medications be established. P-A was the supervisor for the regular pharmacist (who was unavailable). P-A did not have ready access	F 428	The policy and procedure for Pharmaceutical Services was reviewed. The facility will provide education to licensed nurses on the policy and procedure for Pharmaceutical Services. The Consulting Pharmacist will continue to review, on a monthly basis, all resident drug regimens and will report any potential irregularities to the attending physician and Director of Nursing and/or designee{s} monthly to discuss the Consulting Pharmacist's drug regimen review.	

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F 428	Continued From page 28 to the pharmacists notes, however P-A indicated the consultant pharmacist should recognize the use of medications containing acetaminophen and recommend to the staff to obtain parameters from the physician. If those directions were not in the notes then he probably did not do it. Surveyor: Soucek, Shawn The consulting pharmacist failed to identify irregularities for R62, reviewed for unnecessary medications. R62 was observed seated in the dining room on 9/15/14 at 5:30 p.m., no behaviors noted and resident was well groomed. On 9/16/14 at 3:30 p.m., R62 was observed seated in the resident lounge, no behaviors exhibited. On 9/17/14 at 11:30 p.m., resident was sleeping comfortable in his chair, no behaviors noted. R62 had Physician's Orders dated 9/2/14, Ativan (antianxiety) 20 milligram (mg) as needed and BuSpar (antidepressant) 5 mg daily, which included Sertraline (antidepressant) 75 milligrams (mg) daily, R62's annual Minimum Data Set (MDS) dated 8/19/14, identified diagnoses which included 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 trouble falling or staying asleep or sleeping too much.	F 428	The facility will review results at the monthly QAPI 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.	

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F 428	Continued From page 29 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 a psychologist care. 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 antidepressant use, antianxiety use, and monitoring of adverse effects. On 9/18/14, at 10:15 a.m. the director of nursing (DON) and social service director (SSD) verified the care plan lacked addressing the use of antianxiety and antidepressants medications. It also did not include monitoring the effectiveness or side effects for the use of antianxiety and antidepressant medications, and non-pharmacological interventions had not been developed for R62. The DON stated the medications were used for R62 because he could not sleep The Buspirone Package Insert packaged and	F 428		

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F 428	Continued From page 30 distributed by American Health Packaging last revised: 28 May 2013 noted the "Busprione can cause serious side effects. Read this entire Medication Guide for more information about these serious side effects. Common side effects reported in studies of tachycardia, dizziness, drowsiness, nervousness, insomnia, major depressive disorder, lightheadedness, decreased concentration, excitement, anger, confusion, depression, blurred vision, gastrointestinal, nauseas, dry mouth, diarrhea, constipation, vomiting, musculoskeletal, aches/pains, numbness, incoordination, tremor, skin rash, headache, fatigue and weakness" The Sertraline Package Insert and Label Information by Pfizer Inc. last revised on 8/2014, noted the following: "Common possible side effects in people who take Sertraline include: suicidal thoughts, allergic reactions, abnormal bleeding, seizures or convulsions, changes in appetite, visual problems, dizziness, drowsiness, dry mouth, diarrhea, upset stomach and trouble sleeping may occur. " The Ativan Package Insert and Label Information by Biovail Pharmaceuticals last revised on 7/2008, noted the following: " fatigue, drowsiness, amnesia, confusion, depression, vertigo, headache, slurred speech, change in libido, change in appetite, constipation, skin rash, insomnia, agitation and hallucinations. " The Psychopharmacologic Medication Use policy revised 1/2007, indicated, "To evaluate behavior interventions and alternatives before using psychopharmacological medications and sedatives/hypnotics. To eliminate unnecessary psychopharmacological medications and sedative/hypnotics."	F 428	Completed Date: October 24, 2014	

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	245285	A. BUILDING ______ B. WING ______	09/18/2014

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F 465	Continued From page 31	F 465		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide housekeeping and maintenance services to maintain a sanitary and comfortable environment for 6 of 30 residents(R28, R14, R40, R1, R45, R2) observed and impacted 38 of 38 resident rooms at the facility with paint chipping on the door frames. Findings include: On 9/15/14, at 7:17 p.m. a urine smell was noted and R28 expressed concerns about the cleanliness of the bathroom. On 9/16/14, at 10:19 a.m. R14 expressed concerns about cleanliness in the bathroom. On 9/18/14, at 12:05 p.m. during the environmental tour with the housekeeping and maintainence directors R14's room had paint chipped on the door frame entering the bathroom and black scuff marks on the wall. On 9/16/14, at 11:39 a.m. R40 and R1's room had wrappers, dust, and garbage under the beds. A large dark spot was on the ceiling over R1's bed. Both privacy curtains had multicolor dark spots. A cord near the ceiling blocked the closet	F 465	Resident rooms of R28, R14, R40, were recleaned. Privacy curtain was replaced and ceiling repainted. Doorways of resident rooms with chipped 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.	10/23/14

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F 465	Continued From page 32 door from fully shutting, and paint was peeling from the walls. An interview conducted at the time with R1's family member (F)-A revealed dissatisfaction with overall maintenance and cleanliness of the room and bathroom. F-A shared had reported to the facility numerous times these concerns. On 9/18/14, at 12:05 p.m. the housekeeping and maintainence directors verified the room for R40 and R1 had debris under the beds, the curtain dividing the room had dark stains, and there were large yellow water stains on the ceiling above R1's bed. There was also paint chipped and black marks on the walls and doorway to the room. During a follow up interview on 9/18/14, at approximately 2:00 p.m. with F-A, concerns were reiterated about the upkeep of R1's room. During the interview a large red spot was noted on the privacy curtain, scuffs on the floor and dust on the bed frame. The environmental tour was conducted on 9/18/14, at 12:05 p.m. with the housekeeping and maintenance directors. The following areas of concern were reviewed: Paint was chipping or worn on doorways for 38 out of 38 resident rooms. R45's room had paint chipped on the doorway entering the room and black scuff marks. There was also a two inch hole in the wall by the floor near the bed. R2's doorway had a large amount of paint missing the lower level of the doorway and chipped paint on the doorways. There was also black scuff marks on the doors and walls. During the environmental tour on 9/18/14, at 12:05 p.m. the housekeeping director stated	F 465	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.	

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F 465	Continued From page 33 resident rooms were cleaned daily, and verified the rooms listed above were not clean. The maintenance director stated they only painted the resident doorways, and walls every six months. The maintenance director verified the chipped paint and black marks on the doorways and walls. The maintenance director also stated was unaware of the water stains on R40's ceiling. In addition, the maintenance director reported there was not a log to track/document any repairs made in each room. Review of the undated facility policy titled Purpose of the Housekeeping Department Housekeeping Procedures directed to maintain clean and healthful surrounding for the residents, staff, and visitors. To maintain cleanliness, order and safety, to meet all federal and state regulations regarding housekeeping. Review of the undated facility policy Maintenance Checklists Overview Policy indicated maintenance had the critical task of caring for the grounds, buildings and the equipment in each center.	F 465	Completion date: October 23, 2014	

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

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

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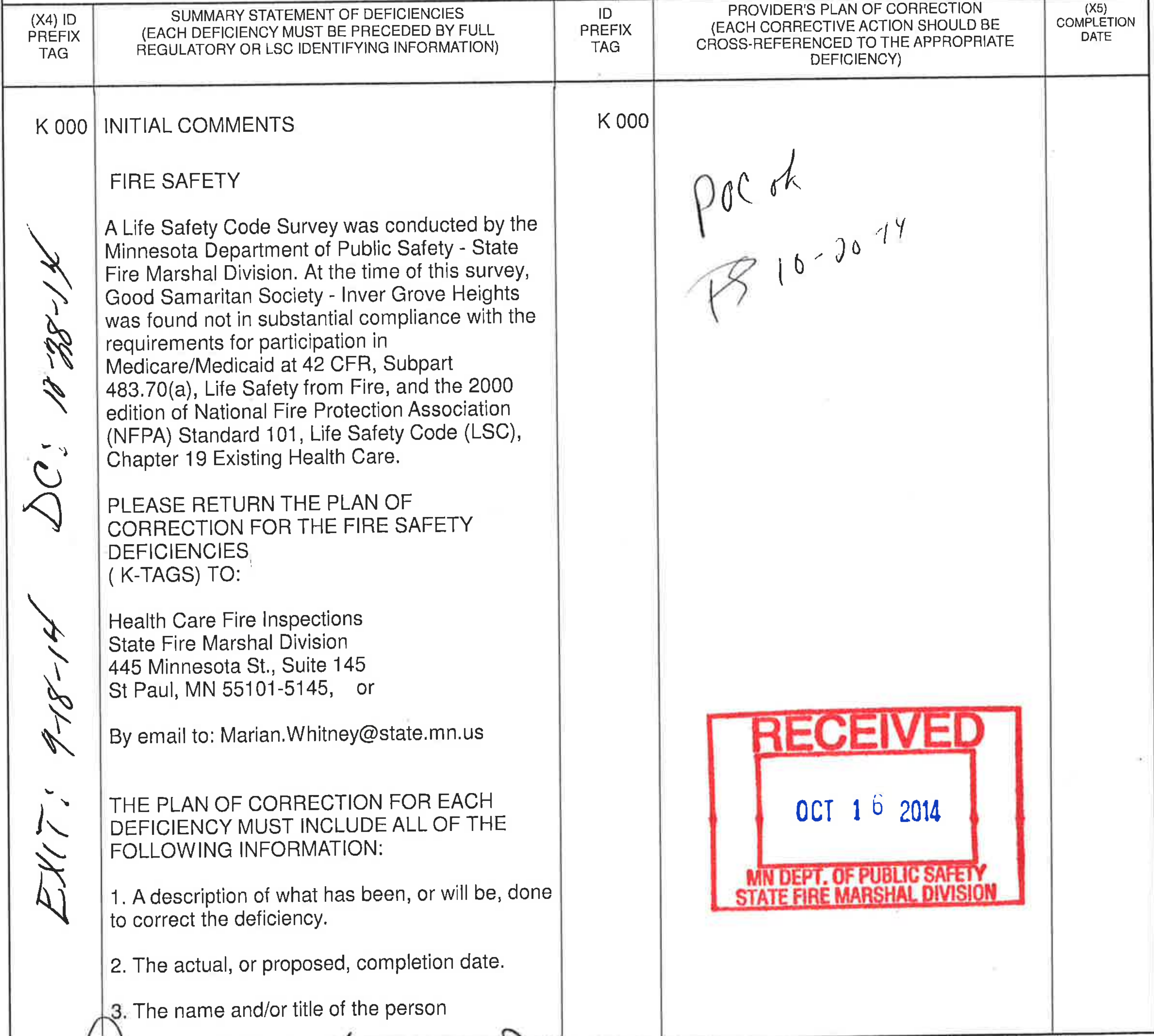
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077



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K 000	INITIAL COMMENTS	K 000	POC ok TB 10-20-14	

EXIT: 9-18-14 DC: 10-28-14

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 DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

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

2. The actual, or proposed, completion date.

3. The name and/or title of the person

RECEIVED
OCT 16 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	10-14-14

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

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	245285	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/16/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	**1301 50TH STREET EAST** **INVER GROVE HEIGHTS, MN 55077**

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K 000	Continued From page 1 responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society - Inver Grove Heights, is a 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1981 and 1983, additions were constructed to the North Wing that was determined to be of Type II(111) construction. In 1999 an addition was added to the South Wing that was determined to be of Type II (111) construction. Because the original building and the 3 additions are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 44 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. BUILDING **01 - MAIN BUILDING 01** B. WING ________	**09/16/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	**1301 50TH STREET EAST** **INVER GROVE HEIGHTS, MN 55077**

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K 064	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to maintain portable fire extinguisher in accordance with NFPA 101-2000 edition, Section 9.7.4.1 and NFPA 10. This deficient practice could affect 7 out of 41 residents. Findings include: On facility tour between 10:30 AM and 1:00 PM on 09/16/2014, observation revealed that the fire extinguisher located in the east conference room A, has not been monthly visually inspected in February and August 2014 according to the tag on the fire extinguisher. This deficient practice was confirmed by the maintenance (CW) at the time of discovery.	K 064	K - 064 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. .Completed: September 24, 2014	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by:	K 144		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**09/16/2014**

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

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

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,

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(s)

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00022	A. BUILDING: ______ B. WING ______	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On September 15-18 , 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	RECEIVED OCT 20 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION 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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE October 15, 2014

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2 000	Continued From page 1 Certification Program, P.O. Box 64900 St. Paul, MN 55164-0900	2 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive	2 540		

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2 540	Continued From page 2	2 540		

resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405.

Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information:

A. medically defined conditions and prior medical history;
B. medical status measurement;
C. physical and mental functional status;
D. sensory and physical impairments;
E. nutritional status and requirements;
F. special treatments or procedures;
G. mental and psychosocial status;
H. discharge potential;
I. dental condition;
J. activities potential;
K. rehabilitation potential;
L. cognitive status;
M. drug therapy; and
N. resident preferences.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to comprehensively and accurately assess 1 of 4 residents (R40) for oral/dental needs.

Findings include:

During an interview with R40 on 9/16/14, at 11:20 a.m. R40 stated was having dental issues (did not say what the dental issues were) and was seeing a dentist.

The annual minimum data set (MDS) was completed on 5/20/14. Under the dental section

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2 540	Continued From page 3	2 540		

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 dentist 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, aside 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 was on the MDS. When asked about the condition of R40's mouth and the assessment done in May 2014, agreed that if the dentist found that many issues then the staff did not thoroughly assess R40's mouth in May.

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 develop procedures to ensure implementation.

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2 540	Continued From page 4 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.	2 540		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan related to pain and acetaminophen use for 1 of 5 residents (R16) and mood and behavior medications for 1 of 5 residents (R62) reviewed for unnecessary medications. Findings include: The facility failed to develop a plan of care for R16 related to pain and the use of narcotics containing acetaminophen and plain acetaminophen. The resident had the potential to receive over the recommended guidelines of 4000 mg of acetaminophen a day.	2 560		

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2 560	Continued From page 5	2 560		

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.

R62's care plan was not developed to address mood, behavior, sleep and side effect monitoring of medications.

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2 560	Continued From page 6	2 560		

On 9/15/14, at 5:30 p.m. R62 was observed seated at the dining room table. R62 had no behaviors. On 9/16/14, at 3:30 p.m. R62 was seated in the resident lounge and no behaviors were exhibited. On 9/17/14, at 11:30 p.m. R62 was sleeping comfortable in the chair and no behaviors were noted.

R62's Physician's Orders dated 9/2/14, indicated Ativan (antianxiety) 20 mg as needed, BuSpar (antidepressant) 5 mg daily, and Sertraline (antidepressant) 75 mg daily.

R62's annual Minimum Data Set (MDS) dated 8/19/14, identified diagnoses which included 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. R62 required extensive assistance with activities of daily living (ADLs) with one to two staff. The Mood category did not indicate R62 had trouble falling, 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."

R62's Physician's Progress Notes dated 8/15/14, 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.

R62's care plan printed 8/28/14, did address the side effects of the use of hypnotics however, the care plan lacked evidence of the antidepressant

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2 560	Continued From page 7	2 560		

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 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.

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2 565	Continued From page 8	2 565		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was followed for 1 of 3 residents reviewed for activities of daily living (R14). Findings include: The facility failed to ensure R14's activities of daily living care plan was followed to ensure nails were clean and properly trimmed. Review of R14's 8/5/14 minimum data set [MDS] revealed R14 required extensive assistance with personal hygiene and one person physical assistance. R14's activities of daily living care plan, last revised 8/6/14 directed staff "Personal Hygiene: Resident requires extensive assist of 1 staff. Resident will wash hands, face, upper torso with set up. Staff does all other grooming." and "NAR [nursing assistant] clip and clean nails." On 9/16/14 at 10:18 a.m. R14's nails were observed to have dark matter under the fingernails. On 9/17/14 at 7:30 a.m. R14 was observed resting in bed but dressed for the day.	2 565		

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2 565	Continued From page 9 R14 had two jagged fingernails and dark matter under all fingernails. On 9/17/14 at 3:45 p.m. R14 was observed to have dark matter under her nails. A registered nurse, (RN)-D, confirmed R14's fingernails were dirty and needed to be cleaned. RN-D added she would expect staff to clean R14's nails during morning cares if they were dirty. On 9/17/14 at 4:00 p.m. the director of nursing, (DON) reported nail care should be done on bathing days and that R14 bathed by shower on Monday and Friday. A SUGGESTED METHOD FOR CORRECTION: The interdisciplinary team [IDT]could review, revise and/or develop policies and procedures to ensure that staff comply with residents' care plans. The IDT or designee could educate all staff on how to follow 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.	2 565		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed.	2 860		

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2 860	Continued From page 10 This MN Requirement is not met as evidenced by: F312 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' nail care is performed to ensure clean and trimmed nails. The IDT or designee could educate all staff on nail care 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.	2 860		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 4 of 4 residents	21325		

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21325	Continued From page 11 reviewed for dental (R40, R24, R18 and R14) received emergency and routine dental services. Findings include: The facility failed to ensure timely dental care for R40. During an interview with R40 on 9/16/14 at 11:20 a.m., he revealed he was having dental issues and was seeing a dentist. The annual minimum data set (MDS) was completed on 5/20/14. Under the dental section the staff documented no issues. No care area assessment (CAA) triggered as there were no dental issues identified. The quarterly MDS dated 8/14 revealed no dental issues. The progress notes revealed that on 9/6/14, R40 reported to the nursing staff that 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." Resident denied pain and indicated he had not been to the dentist in "years." Dental visit on 9/11/14 revealed, "decay, needs fillings of 6 teeth. Has upper full and lower partial." Appointments set up for 10/3 and 10/10/14. When interviewed on 9/18/14 at 10:10 a.m. the registered nurse (RN)-B indicated the facility does not do a oral/dental assessment, aside from the MDS. If a resident is showing signs of mouth pain then the facility would do one.	21325		

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21325	Continued From page 12 The director of nursing (DON) when interviewed on 9/18/14 at 10:20 a.m. indicated the only oral/dental assessment was on the MDS. When asked about the condition of the residents mouth and the assessment done in May she agreed that if the dentist found that many issues then the staff did not thoroughly assess his mouth in May. The facility failed to follow their written plan of care for oral/dental care for R24 related to her lost lower denture. During an interview with R24 on 09/16/2014 at 11:42 a.m., R24 revealed that she had lost her lower denture and had not gotten them back. R24 said it happened when in the hospital. When asked if she would like to have her lower denture she replied, "if I'm going to live for awhile I would like to have teeth." The care plan dated 8/13/14 indicated R24 brushes own teeth independently. It further indicated the lower denture was missing, awaiting dental set up. The care conference note dated 8/21/14 indicated, left message for social worker about need for dental visit. Review of the social service notes did not reveal any dental appointments. When interviewed on 9/18/14 at 9:20 a.m. the social worker (LSW) indicated the facility lost their dental contract in April when the dentist decided he would no longer come to the facility. She indicated the facility had been unable to secure another dentist. She agreed the dentures have been missing since December and she was hoping the dentures would show up from the	21325		

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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 making routine and annual appointments, arranging transportation and referral to a dentist in case of lost or damaged dentures.

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

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

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21325	Continued From page 14 his own teeth, some are broken and sharp. Awaiting in house dentist to get established." A 4/11/14 progress note noted "He has his own teeth, some are broken, sharp and in need of a cleaning. Awaiting in house dentist to get established." R18's most recent Minimum data set, dated 7/1/14 revealed R18 had moderate cognitive impairment and required extensive assistance for personal hygiene, with one staff person physical assist. R18's activities of daily living care plan, last revised 3/31/14 directed staff "Oral Care: Staff to complete brushing teeth, offer and cue resident to participate as much as able. Natural teeth, some broken." The care plan did not address dental appointments. During interview on 9/18/14 at 9:23 a.m., the social service director (LSW) reported R18 was on a list to see a contracted in house dentist. However, that contracted dentist was unable to provide services for the facility and contract was terminated in the beginning of June. LSW reported the family was trying to take care of financing dental appointments. LSW reported she was unable to document any assistance provided by the facility to the family in arranging financing of dental appointments or seeking out low cost options. Surveyor requested R18's notes from R18's last dental visit. This was not provided by the facility. The facility failed to arrange timely annual routine and emergency dental visits for R14, who had missing partials.	21325		

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21325	Continued From page 15 Review of R14's care plan, last revised 8/6/14, revealed R14 had multiple sclerosis, limited physical mobility, and impaired cognition and communication. R14's admission date was noted to be in April of 2002. During initial interview on 9/16/14 at 10:12 a.m. R14 reported pain in both her upper and lower teeth and gums. Review of progress notes, dated 10/8/13 revealed "Has upper partial which staff brush daily. Has blackened tooth on bottom and several missing. Will not go out to see dentist, but is agreeable to be seen by in house dentist once they start here. She has reported mouth pain recently, although denies at time of interview and reiterated agreement to see dentist to write. No visible mouth sores or redness." A 1/17/14 progress note revealed "Has upper partial which staff brushes daily. Has blackened tooth on bottom and several missing. Still waiting on in house dentist to get established to get her seen as she refuses to go out for appointments. No visible mouth sores or redness." A 2/28/14 progress notes revealed "Has upper partial, no visible mouth sores. No chewing or swallowing problems noted." A 5/27/14 progress note revealed "Has own teeth and upper partial. Several missing including bottom partial. Resident is on the dentist list. No visible mouth sores. No chewing or swallowing problems noted." A 8/5/14 progress note revealed "Has own teeth and upper partial. Has several missing teeth including bottom partial. Facility still working on securing a dentist to come to facility to manage oral cares. At this point. Resident is on the dentist list. No visible mouth sores. No chewing or swallowing problems noted."	21325		

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Review of the activities of daily living care area assessment, dated 3/1/14, revealed "Lower partial missing, has upper partial that fits well. Some blackened teeth and in need of dentist once in house dentist established."

On 9/18/14 at 2:30 p.m. the director of nursing (DON) reported the facility was waiting for in house dental services to be arranged for R14 to see a dentist. Notes from R14's last dental visit were requested by surveyor but not provided.

During interview on 9/18/14 at 9:23 a.m., the social service director (LSW) reported R14 was on a list to see a contracted in house dentist. However, that contracted dentist was unable to provide services for the facility and contract was terminated in the beginning of June.

The activities of daily living care plan, last revised 8/6/14, directed staff: "ORAL CARE: DENTAL VISITS: In house dentist, routine visits. HUC [health unit coordinator] to arrange once in house dentist secured."

A SUGGESTED METHOD FOR CORRECTION: The facility interdisciplinary team [IDT] or designee could review, revise and/or develop policies and procedures to ensure residents receive routine dental care. The IDT or designee could educate all staff on residents' routine dental needs 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.

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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.	21530		

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This MN Requirement is not met as evidenced by:
Based on observation, interview and document review the consulting pharmacist failed to advise the facility on potential irregularities in the medication regimen for 2 of 5 residents reviewed reviewed for unnecessary medications (R16 and R62).

Findings include:

Observation of the medication pass on 9/17/14 at 9:30 a.m. revealed R16 received a narcotic pain medication containing acetaminophen. When the physician orders dated 9/3/14 and 9/5/14 were reviewed, the orders revealed that R16 was receiving the following medications for pain: Acetaminophen 500 mg [milligrams] qid [four times daily] since 7/23/14 which equaled 2000 mg of acetaminophen a day.

Norco 5/325 mg 1 tab qid started 9/5/14 and to end 9/19/14. However the order read may continue the medication as needed (prn) after 9/19/14. Currently R16 was receiving 1300 mg of Acetaminophen with the Norco.

Hydrocodone with Acetaminophen 5/325 mg 1 twice a day (bid) prn (started 8/8/14). The resident received this medication on 9/4, 9/5, 9/10, 9/13, and 9/15. If utilized by the resident as prescribed, the resident would receive 650 mg of acetaminophen a day.

Acetaminophen (Tylenol) 650 mg every 6 hours (q6hrs) prn pain (started 7/14/14). The resident was administered this medication twice on 9/3, once on 9/5, once on 9/12. If utilized by the

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resident as prescribed the resident would receive 2600 mg of acetaminophen a day.

The physicians orders failed to reflect the amount of acetaminophen the resident could take in a day to alleviate the risk of possible liver damage.

Although the resident did not receive more than 4000 mg of acetaminophen, there was potential for this to happen if the resident utilized all of the acetaminophen prescribed.

R16 was admitted on 7/14/14 and the pharmacist assessed the resident on 7/28/14 and again on 8/29/14. The pharmacist did not address the acetaminophen dosage on either visit.

When interviewed on 9/18/14 at 3:55 p.m., pharmacist (P)-A confirmed it would be preferred that parameters for the use of acetaminophen containing medications be established. P-A was the supervisor for the regular pharmacist (who was unavailable). P-A did not have ready access to the pharmacists notes, however P-A indicated the consultant pharmacist should recognize the use of medications containing acetaminophen and recommend to the staff to obtain parameters from the physician. If those directions were not in the notes then he probably did not do it

The consulting pharmacist failed to identify irregularities for R62, reviewed for unnecessary medications.

R62 was observed seated in the dining room on 9/15/14 at 5:30 p.m., no behaviors noted and resident was well groomed. On 9/16/14 at 3:30 p.m., R62 was observed seated in the resident lounge, no behaviors exhibited. On 9/17/14 at 11:30 p.m., resident was sleeping comfortable in

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21530	Continued From page 20 his chair, no behaviors noted. R62 had Physician's Orders dated 9/2/14, Ativan (antianxiety) 20 milligram (mg) as needed and BuSpar (antidepressant) 5 mg daily, which included Sertraline (antidepressant) 75 milligrams (mg) daily, R62's annual Minimum Data Set (MDS) dated 8/19/14, identified diagnoses which included 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 trouble falling or staying asleep or sleeping too much. 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 a psychologist care. 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	21530		

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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 antidepressant use, antianxiety use, and monitoring of adverse effects.

On 9/18/14, at 10:15 a.m. the director of nursing (DON) and social service director (SSD) verified the care plan lacked addressing the use of antianxiety and antidepressants medications. It also did not include monitoring the effectiveness or side effects for the use of antianxiety and antidepressant medications, and non-pharmacological interventions had not been developed for R62. The DON stated the medications were used for R62 because he could not sleep

The Buspirone Package Insert packaged and distributed by American Health Packaging last revised: 28 May 2013 noted the "Busprione can cause serious side effects. Read this entire Medication Guide for more information about these serious side effects. Common side effects reported in studies of tachycardia, dizziness, drowsiness, nervousness, insomnia, major depressive disorder, lightheadedness, decreased concentration, excitement, anger, confusion, depression, blurred vision, gastrointestinal, nauseas, dry mouth, diarrhea, constipation, vomiting, musculoskeletal, aches/pains, numbness, incoordination, tremor, skin rash, headache, fatigue and weakness"

The Sertraline Package Insert and Label Information by Pfizer Inc. last revised on 8/2014, noted the following: "Common possible side effects in people who take Sertraline include: suicidal thoughts, allergic reactions, abnormal bleeding, seizures or convulsions, changes in

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21530	Continued From page 22 appetite, visual problems, dizziness, drowsiness, dry mouth, diarrhea, upset stomach and trouble sleeping may occur. " The Ativan Package Insert and Label Information by Biovail Pharmaceuticals last revised on 7/2008, noted the following: " fatigue, drowsiness, amnesia, confusion, depression, vertigo, headache, slurred speech, change in libido, change in appetite, constipation, skin rash, insomnia, agitation and hallucinations. " The Psychopharmacologic Medication Use policy revised 1/2007, indicated, "To evaluate behavior interventions and alternatives before using psychopharmacological medications and sedatives/hypnotics. To eliminate unnecessary psychopharmacological medications and sedative/hypnotics." 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' medication regimens are reviewed monthly and irregularities reported by the pharmacist to the director of nursing and physician. The IDT or designee could educate all staff on procedures related to medication regimen monitoring 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.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General	21535		

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21535	Continued From page 23 Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, 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 and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that scheduled and "as needed" medications with Acetaminophen (Tylenol) would not potentially exceed the safe dosage amount for one resident (R16) and failed to ensure medication regimens were free of unnecessary medications for one resident (R62) of 5 residents reviewed for unecessary medications. Findings include: The facility failed to establish parameters for the	21535		

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use of medications containing acetaminophen and on two occasions R16 exceeded the recommended guidelines of 4000 mg per day.

On 9/17/14 at 9:30 a.m. R16 was observed receiving a narcotic pain medication containing acetaminophen. When the physician orders for R16 were reviewed, the orders revealed that R16 was receiving the following medications for pain:
Acetaminophen 500 mg [milligrams] qid [four times per day] since 7/23/14 which equaled 2000 mg of acetaminophen a day.
Norco 5/325 mg 1 tab qid started 9/5/14 and to end 9/19/14. However, the order read may continue the medication as needed (prn) after 9/19/14. Currently R16 was receiving 1300 mg of Acetaminophen with the Norco.
Hydrocodone with Acetaminophen 5/325 mg 1 twice a day (bid) prn (started 8/8/14). The resident received this medication on 9/4, 9/5, 9/10, 9/13, and 9/15. If utilized by the resident as prescribed, the resident would receive 650 mg of acetaminophen a day.
Acetaminophen (Tylenol) 650 mg every 6 hours (q6hrs) prn pain (started 7/14/14). The resident was administered this medication twice on 9/3, once on 9/5, once on 9/12. If utilized by the resident as prescribed the resident would receive 2600 mg of acetaminophen a day.

The physicians orders did not reflect how much acetaminophen the resident could take in a day to alleviate the risk of possible liver damage.

Although the resident did not receive more than 4000 mg of acetaminophen, there was potential for this to happen if the resident utilized all of the acetaminophen prescribed.

On 9/18/14 at 4:20 p.m. the director of nursing

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(DON) indicated she had no specific policy that addressed acetaminophen and the amount to be given. She would expect 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). She would expect that to be addressed on the residents plan of care.

When interviewed on 9/18/14 at 3:55 p.m., pharmacist (P)-A confirmed it would be preferred that parameters for the use of acetaminophen containing medications be established. The consultant pharmacist should recognize the use of medications containing acetaminophen and recommend to the staff to obtain parameters from the physician.

R62 was prescribed anti-anxiety and anti-depressant medications without adequate analysis to justify use, regular monitoring of symptoms and side effects and non-drug interventions.

R62 was observed seated in the dining room on 9/15/14 at 5:30 p.m., no behaviors noted and resident was well groomed. On 9/16/14 at 3:30 p.m., R62 was observed seated in the resident lounge, no behaviors exhibited. On 9/17/14 at 11:30 p.m., resident was sleeping comfortable in his chair, no behaviors noted.

R62 had Physician's Orders dated 9/2/14, Ativan (antianxiety) 20 milligram (mg) as needed and BuSpar (antidepressant) 5 mg daily, which included Sertraline (antidepressant) 75 milligrams (mg) daily,

R62 ' s annual Minimum Data Set (MDS) dated 8/19/14, identified diagnoses which included

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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 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. 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 antidepressant use, antianxiety use, and monitoring of adverse effects.	21535		

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21535	Continued From page 27 On 9/18/14, at 10:15 a.m. the director of nursing (DON) and social service director (SSD) verified the care plan lacked addressing the use of antianxiety and antidepressants medications. It also did not include monitoring the effectiveness or side effects for the use of antianxiety and antidepressant medications, and non-pharmacological interventions had not been developed for R62. The DON stated the medications were used for R62 because he could not sleep The Buspirone Package Insert packaged and distributed by American Health Packaging last revised: 28 May 2013 noted the "Busprione can cause serious side effects. Read this entire Medication Guide for more information about these serious side effects. Common side effects reported in studies of tachycardia, dizziness, drowsiness, nervousness, insomnia, major depressive disorder, lightheadedness, decreased concentration, excitement, anger, confusion, depression, blurred vision, gastrointestinal, nauseas, dry mouth, diarrhea, constipation, vomiting, musculoskeletal, aches/pains, numbness, incoordination, tremor, skin rash, headache, fatigue and weakness" The Sertraline Package Insert and Label Information by Pfizer Inc. last revised on 8/2014, noted the following: "Common possible side effects in people who take Sertraline include: suicidal thoughts, allergic reactions, abnormal bleeding, seizures or convulsions, changes in appetite, visual problems, dizziness, drowsiness, dry mouth, diarrhea, upset stomach and trouble sleeping may occur. " The Ativan Package Insert and Label Information by Biovail Pharmaceuticals last revised on	21535		

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21535	Continued From page 28 7/2008, noted the following: " fatigue, drowsiness, amnesia, confusion, depression, vertigo, headache, slurred speech, change in libido, change in appetite, constipation, skin rash, insomnia, agitation and hallucinations. " The Psychopharmacologic Medication Use policy revised 1/2007, indicated, "To evaluate behavior interventions and alternatives before using psychopharmacological medications and sedatives/hypnotics. To eliminate unnecessary psychopharmacological medications and sedative/hypnotics. " 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' medication regimens are free of unnecessary medications. The IDT or designee could educate all staff on procedures related to unnecessary medications 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	21535		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written	21685		

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21685	Continued From page 29 routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide housekeeping and maintenance services to maintain a sanitary and comfortable environment for 6 of 30 residents(R28, R14, R40, R1, R45, R2) observed and impacted 38 of 38 resident rooms at the facility with paint chipping on the door frames. Findings include: On 9/15/14, at 7:17 p.m. a urine smell was noted and R28 expressed concerns about the cleanliness of the bathroom. On 9/16/14, at 10:19 a.m. R14 expressed concerns about cleanliness in the bathroom. On 9/18/14, at 12:05 p.m. during the environmental tour with the housekeeping and maintainence directors R14's room had paint chipped on the door frame entering the bathroom and black scuff marks on the wall. On 9/16/14, at 11:39 a.m. R40 and R1's room had wrappers, dust, and garbage under the beds. A large dark spot was on the ceiling over R1's bed. Both privacy curtains had multicolor dark spots. A cord near the ceiling blocked the closet door from fully shutting, and paint was peeling from the walls. An interview conducted at the time with R1's family member (F)-A revealed dissatisfaction with overall maintenance and cleanliness of the room and bathroom. F-A shared had reported to the facility numerous times these concerns.	21685		

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21685	Continued From page 30 On 9/18/14, at 12:05 p.m. the housekeeping and maintainence directors verified the room for R40 and R1 had debris under the beds, the curtain dividing the room had dark stains, and there were large yellow water stains on the ceiling above R1's bed. There was also paint chipped and black marks on the walls and doorway to the room. During a follow up interview on 9/18/14, at approximately 2:00 p.m. with F-A, concerns were reiterated about the upkeep of R1's room. During the interview a large red spot was noted on the privacy curtain, scuffs on the floor and dust on the bed frame. The environmental tour was conducted on 9/18/14, at 12:05 p.m. with the housekeeping and maintenance directors. The following areas of concern were reviewed: Paint was chipping or worn on doorways for 38 out of 38 resident rooms. R45's room had paint chipped on the doorway entering the room and black scuff marks. There was also a two inch hole in the wall by the floor near the bed. R2's doorway had a large amount of paint missing the lower level of the doorway and chipped paint on the doorways. There was also black scuff marks on the doors and walls. During the environmental tour on 9/18/14, at 12:05 p.m. the housekeeping director stated resident rooms were cleaned daily, and verified the rooms listed above were not clean. The maintenance director stated they only painted the resident doorways, and walls every six months. The maintenance director verified the chipped paint and black marks on the doorways and walls. The maintenance director also stated was	21685		

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21685	Continued From page 31 unaware of the water stains on R40's ceiling. In addition, the maintenance director reported there was not a log to track/document any repairs made in each room. Review of the undated facility policy titled Purpose of the Housekeeping Department Housekeeping Procedures directed to maintain clean and healthful surrounding for the residents, staff, and visitors. To maintain cleanliness, order and safety, to meet all federal and state regulations regarding housekeeping. Review of the undated facility policy Maintenance Checklists Overview Policy indicated maintenance had the critical task of caring for the grounds, buildings and the equipment in each center. A SUGGESTED METHOD FOR CORRECTION: The director(s) of housekeeping and maintenance or designee could develop and implement policies and procedures to ensure that all areas of the physical plant are in good repair and operation. The director(s) of housekeeping and maintenance could educate all staff on procedures for ensuring all areas of the physical plant are kept in good repair and operation. The facility develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21685		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and	21810		

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21810	Continued From page 32 residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observations, interview, and document review, the facility failed to ensure the call light was in reach for 1 of 1 resident (R27); failed to accommodate 1 of 1 resident (R2) with comfortably fitting incontinence brief and failed to ensure 1 of 2 residents (R18) was accommodated for bathing preferences. Findings include: The facility failed to ensure a call light was in reach for R27. R27 was observed lying in bed on 9/16/14, at 8:20 a.m., and the pressure pad call light was sitting on the bedside nightstand out of reach. R27 was asked if able to reach the call light. R27 attempted to move hand toward the bedside nightstand but was not able to reach the call light and asked the observer to place the call light on. At 8:31 a.m., the assistant director of nursing registered nurse (RN)-A answered call light. Interview with RN-A revealed R27 was able to use the pressure pad call light and confirmed it was not in reach of R27. On 9/18/14, 9:50 a.m. an interview was conducted with the director of nursing (DON)	21810		

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related to R27's call light not being within reach on 9/16/14. The DON stated that the expectation was that all call lights should be in reach of the residents.

R27's care plan last revised on 1/19/13, for communication problem indicated, "ensure/provide a safe environment: pressure pad for call light."

The policy and procedure for call lights last revised on 1/09, indicated, "When resident's call light is observed/heard, go to resident's room promptly. Respond to request as soon as possible. Turn call light off and inquire about resident's request in a friendly manner. When leaving the room, place call light within easy reach of resident if in bed. If out of bed, stretch call light cord across bed so resident is able to reach it. For residents unable to use call light, staff need to make frequent visits or provide an adaptive call light."

The facility failed to ensure R2 had properly fitting incontinence briefs.

On 9/17/14, at 8:20 a.m., NA-A completed R2's peri care and applied a clean incontinence brief while rolling resident back/forth with R2's help using grab bar. R2 moaned and stated, "That hurts. Ow, ow, oh gosh it hurts." R2 asked NA-A to adjust the incontinence brief and stated, "It's too small. It's not comfortable at all."

On 9/17/14, at 8:22 a.m. an interview was conducted with R2 (while waiting for NA-A to return with help to transfer R2 out of bed) to see what hurt when was moved. R2 stated again the incontinence brief was too tight and not comfortable.

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9/17/14, at 8:45 a.m. NA-B came to help NA-A to get R2 out of bed. R2 stated to both NA-A and NA-B, "The pad is too small. I need a special size" as NA-A stated, "That's the biggest size we have." The NA's, via mechanical lift, transfered R2 out of bed and into a wheelchair. At 8:56 a.m. NA-A wheeled R2 into the dining room where she visited with tablemates while waiting for breakfast. There was no report to the registered nurse or other nursing staff the incontinence brief was too tight according to R2.

R2's most current care plan for bladder and bowel incontinence last revised on 3/28/14, indicated, "Resident uses incontinent products tENA [sic] Super Stretch L/XL. Long extended TENA product needed both waking/sleeping to maintain skin integrity, dignity, individual care, needed to maintain incontinence."

On 9/18/14, at 9:50 a.m. an interview was conducted with RN-A related to R2's concern related to incontinence brief being too tight, and R2 letting staff know during morning cares on 9/17/14. RN-A stated was not aware of R2's concern and looked to see if a "Tena notification" was filled out or if the floor nurse was notified so a more appropriate size could be provided. Although RN-A did note R2 was recently measured by Tena on 6/10/14, there was no "Tena notification" or report to the floor nurse of R2's concern related to the incontinence brief being too tight.

R18 had bilateral leg amputations and was not provided bathing choices.

R18's annual Minimum Data Set (MDS) dated

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21810	Continued From page 35 12/31/14, revealed the following question, "While you are in this facility how important is it to you to choose between a tub bath, shower, bed bath or sponge bath?" R18's response was "very important". R18's most recent quarterly MDS dated 7/1/14, indicated R18 had moderate cognitive impairment, was totally dependent for bathing and required one person physical assist. R18's most recent Care Area Assessment (CAA) for activities of daily living and rehabilitation dated 12/31/13, noted "He needs extensive assist with bathing, hygiene, dressing, grooming. He is able to participate by moving extremities and washing own face, hands and teeth. Staff completes remainder of cares. All needs anticipated by staff. Requires a total lift for all transfers. Requires 1 assist to turn in bed and 2 to boost. Has w/c (wheelchair) with bilat (bilateral) elevating foot pedals. Is able to self propel short distances and staff propels to final destination. He has had no recent falls, does use seatbelt in w/c for positioning and is able to self release on command. Belt keeps his hips aligned and safe when self propelling w/c." The assessment did not include an interdisciplinary analysis or rationale for R18 not being able to bathe in a tub, instead of receiving only bed baths. R18's care plan for activities of daily living self care deficit dated 3/31/14, indicated R18 had a left below the knee amputation and a right above the knee amputation. "Bathing: Bedbath [sic] every week on Sunday." The 30 day bathing log dated 8/24/14, 8/31/14, and 9/14/14, indicated R18 received only bed baths.	21810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00022	A. BUILDING: ______ B. WING ______	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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21810	Continued From page 36	21810		

On 9/16/14, at 1:31 p.m. and 9/18/14, at 9:30 a.m. R18 shared he wanted two baths each week. On 9/17/14, at 8:30 a.m. R18 clarified would like a tub bath, but instead received bed baths. On 9/18/14, at 9:30 a.m. R18 reconfirmed was receiving bed baths, but wanted two tub baths each week. R18 shared took tub baths at home, but was not given the choice of type of bath at the facility.

On 9/17/14, at 3:00 p.m. a nursing assistant (NA)-D reported R18 was typically bathed during the day. NA-D believed R18 was given bed baths due to safety reasons, as residents were to be allowed choices in how they bathed.

On 9/18/14, at 9:35 a.m. the assistant director of nursing and the MDS nurse reported R18 was unable to use the bath tub because an assessment by occupational therapy (OT) indicated R18 had poor trunk control.

On 9/18/14, at 9:56 a.m. an interview conducted with OT-A revealed R18's ability to bathe in a tub was never assessed.

On 9/18/14, at 1:50 p.m. the director of nursing (DON) reported no assessment was done to determine R18 was unable to bathe in the tub, and reported it would not be something the facility would normally complete.

On 9/18/14, at 2:00 p.m. the director of social services (SS) reviewed R18's most recent Resident Interview and Observation, dated 6/11/14, offering resident bathing choices. R18's response recorded was, "You know more than I do can't get into tub." The SS confirmed R18's response. R18 was not offered bathing choices.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00022	A. BUILDING: ____ B. WING ____	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE	**1301 50TH STREET EAST** **INVER GROVE HEIGHTS, MN 55077**

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21810	Continued From page 37 A SUGGESTED METHOD FOR CORRECTION: An interdisciplinary team [IDT] could review, revise and implement policies and procedures to ensure that residents receive care appropriate to their individualized needs and preferences. The IDT or designee could educate all staff. 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.	21810		