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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: O76Z

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00021

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245600**

2.STATE VENDOR OR MEDICAID NO.
(L2) **336240000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BLACKDUCK**
(L4) **172 SUMMIT AVENUE WEST**
(L5) **BLACKDUCK, MN** (L6) **56630**

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 **06/19/2014** (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 **32** (L18)

13.Total Certified Beds **32** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor — 08/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 09/02/2014 (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
04/01/1992
(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
06/23/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5600

On May 1, 2014 a standard survey was completed at this facility. On May 13, 2014 a Life Safety Code Federal Monitoring (FMS) survey was completed at this facility. The results of this survey lead lead to CMS Region V decision to impose the following remedy:

Mandatory Denial of Payment for New Admissions (MDPNA), effective August 1, 2014

If MDPNA goes into effect, the facility would be subject to a two year loss of NATCEP beginning August 1, 2014.

On June 19, 2014 a Post Certification Revisit by review of the plan of correction was completed for the health deficiencies and on July 30, 2014 a PCR was completed for the FMS and correction was verified effective July 8, 2014. As a result of the PCR the MDPNA was rescinded and the NATCEP prohibition was also rescinded.

Effective July 8, 2014, the facility is certified for 32 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5600

August 21, 2014

Mr. Gordon Hormann, Administrator
Good Samaritan Society - Blackduck
172 Summit Avenue West
Blackduck, Minnesota 56630

Dear Mr. Hormann:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 8, 2014 the above facility is certified for

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

August 21, 2014

Mr. Gordon Hormann, Administrator
Good Samaritan Society - Blackduck
172 Summit Avenue West
Blackduck, Minnesota 56630

RE: Project Number S5242024, F5600025

Dear Mr. Hormann:

On May 8, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 1, 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 May 13, 2013, A surveyor representing the office of the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS). As the surveyor informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found 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 May 27, 2014, CMS notified you of the results of the FMS and revealed that your facility continues to not be in substantial compliance and imposed the following remedy:

- Mandatory Denial of Payment for New Medicare Admissions and Medicaid Admissions, effective August 1, 2014.

In addition, CMS notified you in their letter of May 27, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 1, 2014.

On June 19, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 30, 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 May 1, 2014 and a Federal Monitoring Survey (FMS) completed on May 13, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 8, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 1, 2014 and the FMS completed on May 13, 2014, effective July 8, 2014. As a result of the revisit findings, we recommended to the CMS Region V Office, they concur and have authorized this Department to notify you of the following action related to the imposed remedy in their letter of May 27, 2014:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 1, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 1, 2014, be rescinded. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 1, 2014, be rescinded. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

In thier letter of May 27, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 29, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 8, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245600	A. Building B. Wing	6/19/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **06/10/2014**	ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **06/10/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **06/10/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **06/10/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/10/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **06/10/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **06/10/2014**	ID Prefix **F0466** Reg. # **483.70(h)(1)** LSC	Correction Completed **06/10/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	08/21/2014	28035	06/19/2014
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
5/1/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245600	A. Building B. Wing **01 - MAIN BUILDING 01**	7/30/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **05/28/2014**	ID Prefix	Correction Completed **06/30/2014**	ID Prefix	Correction Completed **06/15/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0025		LSC K0027		LSC K0050	
ID Prefix	Correction Completed **07/07/2014**	ID Prefix	Correction Completed **06/30/2014**	ID Prefix	Correction Completed **06/15/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0052		LSC K0062		LSC K0064	
ID Prefix	Correction Completed **07/08/2014**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0144		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	08/21/2014	27200	07/30/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/13/2014

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245600	A. Building / B. Wing: 02 - ACTIVITIES ADDITION	7/30/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

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 K0050	06/15/2014	ID Prefix: Reg. # NFPA 101 LSC K0052	07/07/2014	ID Prefix: Reg. # NFPA 101 LSC K0144	07/08/2014
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	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	08/21/2014	27200	07/30/2014
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
5/13/2014	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O76Z

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00021

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245600**
2.STATE VENDOR OR MEDICAID NO.
(L2) **336240000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BLACKDUCK**
(L4) **172 SUMMIT AVENUE WEST**
(L5) **BLACKDUCK, MN** (L6) **56630**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/01/2014** (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 **32** (L18)

13.Total Certified Beds **32** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Debra Vincent, HFE NEII 05/20/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/20/2014 (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
04/01/1992
(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

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5600

On May 1, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections are required. The facility has been given an opportunity to correct before remedies would be imposed. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

May 8, 2014

Ms. Angel Normandin, Administrator
Good Samaritan Society - Blackduck
172 Summit Avenue West
Blackduck, Minnesota 56630

RE: Project Number S5600023

Dear Ms. Normandin:

On May 1, 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

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 June 10, 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 June 10, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 1, 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 November 1, 2014 (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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

5600s14epoc.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING _____ B. WING _____	05/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		6/10/14

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

Electronically Signed | 05/19/2014

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.

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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician of a decline in oxygen saturations, elevated temperature and blood pressures in a timely manner and failed to consult the physician for parameters for oxygen administration for 1 of 3 residents (R6) reviewed for notification of changes who experienced falls and an acute illness. Findings include: R6's quarterly Minimum Data Set dated 1/23/14, indicated R6 had moderate cognitive impairment and required extensive staff assistance for all activities of daily living. R6's most recent physician's progress note, dated 4/22/14, indicated an active diagnoses of diabetes, hypertension, chronic pain, depression, hypothyroidism, anemia and chronic kidney disease. R6's nursing progress notes revealed the following information:	F 157	F 157 Notify of Changes 1. DNS had conversation with R6□s physician on 5-5-14 re: res condition and failure to notify her of change in R6□s condition on 4-1-14. At this time resident O2 stats are within normal limits, no O2 order needed at this time however if stats drop below 92% facility staff will contact physician for order. 2. All residents are being monitored for changes in condition and physician is notified when changes occur. 3. Notification of Change in Resident Status has been assigned to all nurses to review. Policy will also be reviewed & education provided for clinical monitoring and follow up for changes in condition. Nurses meeting scheduled on May 22, 2014 4. Random medical record audits will be completed by DNS or designee 2 X per month X3 months for physician notification of resident change in condition. Results of audits will be reported to facility quality assurance	

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F 157	Continued From page 2 -On 3/21/14, at 6:15 p.m. R6 was found on the floor in another resident's room. R6 said she had hit her head during the fall, neuro checks were listed as within normal limits and an initial blood pressure of 179/76, pulse 78. The note indicated R6's physician and family were notified of the fall. Follow up neuro check information, per the neuro check flow sheet after the incident revealed the following information: - At 8:30 p.m. 3/21/14, R6's blood pressure was 192/89 - At 10:30 p.m. on 3/21/14, R6's blood pressure was 259/84 - At 12:30 a.m. on 3/22/14, R6's blood pressure was 239/93 - At 2:30 a.m. on 3/22/14, R6's blood pressure was 190/80 - The final blood pressure recording for R6 on 3/22/14, at 7:00 p.m. was 193/73. The note indicated R6 was alert with normal hand grasps and upper body movement and her pupils were equal in size and reactive to light. -On 3/23/14, at 12:37 a.m. the nursing progress note revealed R6's neuro checks were within normal limits after her fall on 3/21/14. LOC (level of consciousness) and orientation were WNL (within normal limits) as well. Continue to monitor. The medical record lacked evidence that the significantly elevated blood pressures in excess of 200 millimeters of mercury (mm Hg) on the overnight shift were reported to a physician. -On 4/1/14, at 11:25 a.m. the note indicated R6's	F 157	committee. Findings will be presented to Quality assurance committee, committee will make further recommendations for ongoing audits. Ongoing education will be provided to nursing staff. 5. Corrective action will be completed by 6-10-2014	

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F 157	Continued From page 3 vital signs included an elevated blood pressure of 227/97, a temp of 100.0, a pulse of 91 an oxygen saturations of 85-89%. The note also indicated R6 had vomited therefore was kept in her room. At 9:30 a.m. R6's blood pressure was rechecked and was 202/60, temp of 100.8 degrees, pulse of 67 with oxygen saturations dipping to 78-85% and PRN (as needed) oxygen was applied at two liters per minute. R6's temperature was rechecked and was 99.5 degrees, oxygen saturations increased to 96% with the oxygen at 2 liters. The note further indicated R6 was not complaining of pain or discomfort and had stopped vomiting. R6's family was notified of this incident via an email. - The next recorded vital sign information after 4/1/14, was not until 4/5/14, four days later when a routine weekly check revealed a blood pressure recording of 176/58, temperature of 97.1 (tympanic), pulse 51 (regular) and respirations of 16. R6's oxygen saturation was recorded as 94% on room air. -R6's next recorded nursing progress note was dated 4/15/14, and indicated R6 had her ears checked and cleaned. R6's medical record lacked documentation that R6's physician was notified regarding R6's change of condition on 4/1/14, and evidence of any additional assessment of R6 or vital signs being taken to monitor R6's condition. -R6's nursing home visit note dated 4/22/14, indicated R6 was seen by her physician during nursing home rounds. The note also indicated R6's oxygen saturations were recorded at 93% on room air, pulse was 66 and R6's blood pressure recording was 199/74.	F 157		

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F 157	Continued From page 4 During interview on 04/30/14, at 12:34 p.m., nursing assistant (NA)-A said R6 was in a downhill spiral and had "Given up." During interview on 5/1/14, at 10:03 a.m., both registered nurse (RN) -A and licensed practical nurse (LPN)-A stated blood pressure readings over 200 mm Hg would be concerning and would require a recheck of the blood pressure to see if it came down. Both confirmed a blood pressure of 259 after a fall with a potential head injury was definitely concerning. Both LPN-A and RN-A said oxygen saturations in the 70's would also be a concern, both verified they would definitely call or fax the doctor with something like that. During interview on 5/1/14, at 10:20 a.m. the director of nursing (DON) said she thought there had been an intestinal flu going through the facility on 4/1/14, and said she would have "personally called the doctor" with the elevated blood pressures noted on R6's neuro checks from 3/22/14. She thought R6's information may have been reviewed with the attending physician on rounds but was unable to provide documentation to this effect. The DON remembered receiving a call from R6's daughter on the day of her fall wanting to know how she was doing. The DON stated she would expect follow up oxygen saturations and vitals to be taken once a shift if they were noted to be abnormal with symptoms of an illness. The DON identified she may not necessarily expect staff to call a doctor unless temperatures were over 101 degrees, or if a resident had been running a low grade temperature for several days. During further interview on 5/1/14, at 10:50 a.m.	F 157		

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F 157	Continued From page 5 the DON stated R6 did not have a physician's order for oxygen use at the time of the 4/1/14, incident and the facility medical director preferred staff to first apply the oxygen when needed and then were expected to call a doctor for further guidance. The DON stated the facility did not have standing orders for oxygen as this was against corporate policy and also stated R6 had a previous order for as needed oxygen that had been discontinued due to lack of clear parameters for use. During interview on 5/1/14, at 12:48 p.m. R6's physician (MD-C) stated R6's blood pressures were very difficulty to control due to R6's compromised renal function. MD-C also stated she had been working in conjunction with cardiology regarding the treatment of R6's unstable blood pressures. MD-C confirmed the facility definitely should have called and reported R6's temperature and decreased oxygen saturations on 4/1/14, and stated it was "unfortunate" that this did not happen. MD-C said she reviewed R6's vital signs information during facility rounds as the facility provided a printed report as well as personally monitoring and checking R6's blood pressure reading herself during R6's clinic appointments. The facility policy, entitled Notification of Change in Resident Status, revised February 2005, indicated the center will IMMEDIATELY (written in all caps) inform the resident, if appropriate (except in a medical emergency or when resident is incompetent), and consult with the resident's physician and, if known, notify the resident's family or legal representative in the following cases:	F 157		

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F 157	Continued From page 6 -1. Resident accident which results in injury with a potential for requiring physician intervention. -2. Significant change in the resident's physical, mental or psychosocial status. -3. Need to alter treatment significantly. -4. Decision to transfer or discharge the resident from the center. The policy further included a flow chart including ongoing documentation, monitoring and physician notification for a suspected resident illness. The flow chart indicated staff should continue monitoring a resident according to center policy/procedure, but lacked guidelines for frequency of the monitoring or reassessment. Additionally, the policies for vital signs, last revised 11/13, were reviewed and the policy entitled Temperature defined a fever as a single oral temperature of greater than 100 degrees Fahrenheit or a repeated oral temperature of over 99 degrees Fahrenheit.	F 157		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by:	F 167		6/10/14

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F 167	Continued From page 7 Based on observation, interview and document review, the facility failed ensure the most recent Federal survey results were prominently posted and accessible to be read by all residents, family and public visitors without having to ask staff to do so. This had the potential to affect all 31 residents residing in the facility. Findings include: On 4/28/14, at 2:30 p.m. during the initial tour, and again on 4/29/14, at 9:10 a.m. a clear plastic sheath holding the facility's 2013, survey results was observed hanging on a screw next to the bulletin board across from the main office. No sign indicating what was in the sheath or directions as to where the survey results were posted was observed. On 4/29/14, at 9:15 a.m. the director of nursing (DON) verified the survey results hanging on the bulletin board was not accessible to residents who utilized a wheelchair, and confirmed the facility did not have a sign indicating the sheath contained the most recent survey results. In addition, the DON stated she had a resident ask her what was in the plastic sheath in which the DON informed and assisted the resident to access and read the results.	F 167	F167 Right to Survey Results □ Readily Accessible 1. On 4/29/14 the survey results were placed in a white binder and hung at a wheelchair accessible height in the main facility lobby. The white binder was labeled in large font Minnesota Department of Health Survey. 2. Annually the Survey Results binder will be updated to include the most recent survey results and plan of corrections. 3. All current residents will be informed of their right to review the Minnesota Department of Health Survey and the location of the survey information. This information will be shared during large group activities in the main lobby in which the Activity Director will be able to show residents where the binder is located. 4. Quality Coordinator will complete observation audits monthly to ensure that the binder is located according to this plan of care. This will be completed monthly x 3month with results to QA for further recommendations 5. Corrective Action will be completed 6-10-14.	
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	F 279		6/10/14

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F 279	Continued From page 8 comprehensive plan of care. The facility must develop a comprehensive care 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 interview and document review, the facility failed to ensure the written care plan included appropriate interventions for the care of a resident receiving dialysis related to delineation of fluid due to a fluid restriction, persons responsible for monitoring daily fluid intake, where the resident dialyzes and how to contact them, location of the residents fistula, directive on the frequency of monitoring of the fistula, emergency interventions, who to contact in case of an emergency and which medications were held on the days the resident received dialysis for 1 of 1 resident (R5) in the sample who received hemodialysis. Findings include:	F 279	F279 Develop comprehensive care plans 1. Care plan for R5 has been updated to reflect fluid restrictions, medication hold instructions, Dialysis information, type and emergency care of vascular access and monitoring of that device. 2. No other residents currently receiving dialysis. Care plans for all new residents receiving Dialysis will reflect appropriate care and interventions pertaining to each individuals needs. 3. Education and review of individualizing care plans will be provided to all nurses on May 22, 2014. 4. Random audits of care plans will be completed by DNS or designee to ensure	

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F 279	Continued From page 9 R5's care plan dated 4/8/14, indicated R5 received hemodialysis three times a week due to renal failure. The care plan interventions directed staff to not draw blood or take blood pressure readings in the left grafted arm, to monitor and document / report to R5's health care provider as needed and to report signs and symptoms of bleeding, hemorrhage, bacteremia, septic shock, signs and symptoms of infection to the access site such as redness, swelling, warmth or drainage and to monitor for a bruit (the sound blood makes as it moves through arteries). R5's care plan lacked identification of the type of vascular access R5 had (i.e. fistula, Dacron graft, HeRO graft), where 5's vascular access was placed, how often to check the vascular access for a Bruit or feel for a thrill (a vibration that is felt over an artery and caused by turbulent blood flow), the delineation of fluid related to how much fluid nursing and dietary was going to provide and who was responsible for monitoring R5's total daily fluid intake. The care plan also lacked indication of which of R5's medication were held on dialysis days and also lacked indication of where R5 dialyzed, how to contact them and what to do or who to contact in case of a dialysis related emergency (i.e. excess bleeding from accessing R5's newly placed fistula). On 4/30/14, at 11:30 a.m. licensed practical nurse (LPN)-C stated R5 had two blood pressure medications held on dialysis days (metopropolol succinate ER 50 mg (milligrams) and Imdur ER 60 mg). LPN-C confirmed R5's care plan had not identified which medications were not given to R5 on dialysis days. On 4/30/14, at 1:03 p.m. registered nurse (RN)-C	F 279	all residents have care plans that reflect each residents individual needs. Audits will be completed 2 x monthly x3 months. Quality assurance committee will make further recommendations for ongoing audits. Ongoing education will be provided to nursing staff. 5. Corrective action will be completed by 6-10-2014	

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GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

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F 279	Continued From page 10 confirmed R5's written care plan lacked the identified components as listed above.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor and notify the physician of a decline in oxygen saturations, elevated temperature and blood pressures in a timely manner and failed to consult the physician for parameters for oxygen administration for 1 of 3 residents (R6) reviewed for notification of change who experienced falls and an acute illness. Additionally, the facility failed to monitor fluid intake for 1 of 1 resident (R5) who received dialysis and was on a fluid restriction. Findings include: R6's quarterly Minimum Data Set dated 1/23/14, indicated R6 had moderate cognitive impairment and required extensive staff assistance for all activities of daily living. R6's most recent physician's progress note, dated 4/22/14, indicated an active diagnoses of	F 309	F309 Provide Care/Services for highest well being 1. DNS had conversation with Physician on 5-5-14 re: res condition and failure to notify her of change in R6 condition on 4-1 -14. At this time resident O2 stats are within normal limits, no O2 order needed at this time however if stats drop below 92% facility staff will contact physician for order. Fluid intake is being monitored and recorded for R5 during meal times and med pass times. Total daily fluid intake is being documented at the end of each day. 2. All residents are being monitored for changes in condition and physician is notified when changes occur. All residents requiring fluid restrictions are monitored and amount of fluid intake is being recorded with a documented total daily fluid intake at the end of the day. Nursing and dietary staff have coordinated	6/10/14

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F 309	Continued From page 11 diabetes, hypertension, chronic pain, hypothyroidism, anemia and chronic kidney disease. R6's nursing progress notes revealed the following information: -On 3/21/14, at 6:15 p.m. R6 was found on the floor in another resident's room. R6 said she had hit her head during the fall, neuro checks were listed as within normal limits and an initial blood pressure of 179/76, pulse 78. The note indicated R6's physician and family were notified of the fall. Follow up neuro check information, per the neuro check flow sheet after the incident revealed the following information: - At 8:30 p.m. 3/21/14, R6's blood pressure was 192/89 - At 10:30 p.m. on 3/21/14, R6's blood pressure was 259/84 - At 12:30 a.m. on 3/22/14, R6's blood pressure was 239/93 - At 2:30 a.m. on 3/22/14, R6's blood pressure was 190/80 - The final blood pressure recording for R6 on 3/22/14, at 7:00 p.m. was 193/73. The note indicated R6 was alert with normal hand grasps and upper body movement and her pupils were equal in size and reactive to light. -On 3/23/14, at 12:37 a.m. the nursing progress note revealed R6's neuro checks were within normal limits after her fall on 3/21/14. LOC (level of consciousness) and orientation were WNL (within normal limits) as well. Continue to monitor. The medical record lacked evidence that the significantly elevated blood pressures in excess of 200 millimeters of mercury (mm Hg) on	F 309	the amount of fluid each department will give. 3. Notification of Change in Resident Status has been assigned to all nurses to review. Policy will also be reviewed & education provided for clinical monitoring and follow up for changes in condition. Nurses will also be educated on the appropriate documentation of fluid restrictions, monitoring and recording of fluid intake on May 22, 3014. DNS will educate dietary staff on documentation of fluid intake at meals. Documentation of Fluid intake during med pass will be reviewed with nurses. 4. Random medical record audits will be completed by DNS or designee 2 X per month X3 months for physician notification of resident change in condition and fluid intake documentation to ensure residents with restrictions are receiving fluids as ordered. Results of audits will be reported to facility quality assurance committee. Quality assurance committee will make further recommendations for ongoing audits. Ongoing education will be provided to nursing staff. 5. Corrective action will be completed by 6-10-2014	

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F 309	Continued From page 12 the overnight shift were reported to a physician. -On 4/1/14, at 11:25 a.m. the note indicated R6's vital signs included an elevated blood pressure of 227/97, a temp of 100.0, a pulse of 91 an oxygen saturations of 85-89%. The note also indicated R6 had vomited and was kept in her room. At 9:30 a.m. R6's blood pressure was rechecked and was 202/60, temp of 100.8 degrees, pulse of 67 with oxygen saturations dipping to 78-85% and PRN (as needed) oxygen was applied at two liters per minute. R6's temperature was rechecked and was 99.5 degrees, oxygen saturations increased to 96% with the oxygen at 2 liters. The note further indicated R6 was not complaining of pain or discomfort and had stopped vomiting. R6's family was notified of this incident via an email. - The next recorded vital sign information after 4/1/14, was not until 4/5/14, four days later at a routine weekly check revealed a blood pressure recording of 176/58, temperature of 97.1 (tympanic), pulse 51 (regular) and respirations of 16. R6's oxygen saturation was recorded as 94% on room air. -R6's next recorded nursing progress note was dated 4/15/14, and indicated R6 had her ears checked and cleaned. R6's medical record lacked documentation that R6's physician was notified regarding R6's change of condition on 4/1/14, and evidence of any additional assessment of R6 or vital signs being taken to monitor R6's condition. -R6 was seen on nursing home rounds by her doctor per a physician nursing home visit note dated 4/22/14. R6's oxygen saturations were	F 309		

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F 309	Continued From page 13 recorded at 93% on room air, pulse was 66 and R6's blood pressure recording was 199/74. During interview on 04/30/14, at 12:34 p.m., nursing assistant (NA)-A said R6 was in a downhill spiral and had "Given up." During interview on 5/1/14, at 10:03 a.m., registered nurse (RN)-A and licensed practical nurse (LPN)-A said blood pressure readings over 200 mm Hg would be concerning and would require a recheck of the blood pressure to see if it came down. Both confirmed a blood pressure of 259 after a fall with a potential head injury was definitely concerning. Both LPN-A and RN-A said oxygen saturations in the 70's would also be a concern, both verified they would definitely call or fax the doctor with something like that. During interview on 5/1/14, at 10:20 a.m. the director of nursing (DON) said she thought there had been an intestinal flu going through the facility on 4/1/14, and said she would have "personally called the doctor" with the elevated blood pressures noted on R6's neuro checks from 3/22/14. She thought R6's information may have been reviewed with the attending physician on rounds but was unable to provide documentation to this effect. The DON remembered receiving a call from R6's daughter on the day of her fall wanting to know how she was doing. The DON stated she would expect follow up oxygen saturations and vitals to be taken once a shift if they were noted to be abnormal with symptoms of an illness. The DON identified she may not necessarily expect staff to call a doctor unless temperatures were over 101 degrees, or if a resident had been running a low grade temperature for several days.	F 309		

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F 309	Continued From page 14 On 5/1/14, at approximately 10:30 a.m. R6 was observed resting in her room in a chair. R6 was pale in color and unable to answer basic questions about how she felt or how long she had resided at the facility. During interview on 5/1/14, at 10:50 a.m. the DON stated R6 did not have a physician's order for oxygen use at the time of the 4/1/14, incident and the facility medical director preferred staff to first apply the oxygen and then were expected to call a doctor for further guidance. The DON stated the facility did not have standing orders for oxygen as this was against corporate policy and also stated R6 had a previous order for as needed oxygen that was discontinued due to lack of clear parameters for use. During interview on 5/1/14, at 12:48 p.m. R6's physician (MD-C) stated R6's blood pressures were very difficult to control due to R6's compromised renal function. MD-C also stated she had been working in conjunction with cardiology regarding the treatment of R6's unstable blood pressures. MD-C confirmed the facility definitely should have called and reported R6's temperature and decreased oxygen saturations on 4/1/14, and stated it was "unfortunate" that this did not happen. MD-C said she reviewed resident vital signs information during facility rounds as the facility provided a printed report as well as personally checking R6's blood pressure reading herself during R6's clinic appointments. The facility policy, entitled Notification of Change in Resident Status, revised February 2005, indicated the center will IMMEDIATELY (written in	F 309		

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F 309	Continued From page 15 all caps) inform the resident, if appropriate (except in a medical emergency or when resident is incompetent), and consult with the resident's physician and, if known, notify the resident's family or legal representative in the following cases: -1. Resident accident which results in injury with a potential for requiring physician intervention. -2. Significant change in the resident's physical, mental or psychosocial status. -3. Need to alter treatment significantly. -4. Decision to transfer or discharge the resident from the center. The policy further included a flow chart including ongoing documentation, monitoring and physician notification for a suspected resident illness. The flow chart indicated staff should continue monitoring a resident according to center policy/procedure, but lacked guidelines for frequency of the monitoring or reassessment. Additionally, the policies for vital signs, last revised 11/13 were reviewed and the policy entitled Temperature defined a fever as a single oral temperature of greater than 100 degrees Fahrenheit or a repeated oral temperature of over 99 degrees Fahrenheit. R5 was on a 1200 cubic centimeter (cc) daily fluid restriction and the daily total fluid intake was not monitored, R5's quarterly MDS dated 4/10/14, indicated R5 had intact cognition and was independent with eating. R5's ADMISSION RECORD indicated R5's diagnoses included end stage renal disease	F 309		

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F 309	Continued From page 16 which required hemodialysis and type II diabetes mellitus. On 4/30/14, at 11:24 a.m. RN-B confirmed R5 was on a 1200cc daily fluid restriction which started day R5 had her first dialysis treatment on 9/4/14. R5's physician orders dated 3/19/14, did not include an order for a restricted fluid intake. R5's care plan dated 4/23/14, indicated R5 was on a daily fluid restriction due to renal disease and directed staff to see the charge nurse before giving R5 any fluids between meals and to document all fluids provided. The care plan lacked identification of the amount of the daily fluid restriction amount and did not delineate how much fluid between meals and medication passes R5 was allowed. On 4/30/14, at 11:20 a.m. LPN-C, who was responsible for the care of R5, stated she did not know how much fluid she was allotted to give R5 during the medication pass. LPN-C stated she would give R5 no more than 100 cc of fluid for the med pass during the day shift but there were no directions or care plan interventions which identified how much fluid LPN-C was allotted for the med pass. LPN-C stated R5 would be given no more than 400 cc of fluid for all of the med passes in 24 hours and she did not know who was responsible for monitoring R5's total daily fluid intake to ensure that R5 was staying within the 1200 cc fluid restriction amount. On 4/30/14, at 12:05 p.m. the dietary manager stated R5 was provided 360 cc of fluid during	F 309		

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F 309	Continued From page 17 each meal which was a total of 1080 cc of fluid daily. The dietary manager confirmed R5's care plan did not delineate how much fluid R5 was allotted with meals and how much fluid R5 was allotted during med pass, and who was responsible to monitor R5's total daily fluid intake. The dietary manager verified there was no way to tell how much total fluid intake R5 received daily because the facility's computer system did not account for the amount of fluid R5 was given with each med pass, and nobody was monitoring the residents total fluid intake each day. Review of the facility's fluid intake monitoring sheets from the Dinning Report revealed fluid intake was not consistently recorded for all residents. Many of the entries were identified as "Not Available" and R5's dietary fluid intake was recorded between 240 cc to 1080 cc daily. Review of R5's Medication Administration sheets indicated fluid intake provided during the med passes had not been recorded from 9/4/13, through 4/24/14. On 4/25/14, the MAR identified staff had begun to record R5's fluid intake with each med pass and indicated R5 was provided between 210 cc and 240 cc fluid daily. On 4/30/14, at 1:03 p.m. RN-C confirmed there was no planned delineation for fluids for nursing or dietary to provide R5. RN-C verified R5's total daily fluid intake was not being monitored.	F 309		
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	F 329		6/10/14

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F 329	Continued From page 18 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure low pulse rates were reviewed with the physician in order to address potential concerns with medication adverse reactions and failed to demonstrate elevated blood pressures were reviewed in order to evaluate the effectiveness of multiple antihypertensive medications including a beta-blocker (a class of medications used to treat hypertension that reduces the rate and force of heart muscle contraction) for 1 of 5 residents (R6) reviewed for unnecessary drugs. Findings include: R6's quarterly Minimum Data Set dated 1/23/14,	F 329	F329 Drug regimen is free from unnecessary drugs 1. R6□s Physician is aware of R6 blood pressures and pulses. DNS discussed current medications, pulses and blood pressures with primary physician. Nursing staff are taking R6□s pulse prior to all metoprolol administration. Orders obtained to hold metoprolol for pulse less than 50. R6□s physician has reviewed all medications, will have pharmacy consultant review and all recommendations will be acted upon. 2. All current and future residents□	

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F 329	Continued From page 19 indicated R6 had moderate cognitive impairment and required extensive staff assistance for all activities of daily living. R6's most recent physician's progress notes, dated 4/22/14 identified active diagnoses of diabetes, hypertension, chronic pain, hypothyroidism, anemia and chronic kidney disease. R6's most recent physician's order sheets, dated 4/21/14, identified orders for metoprolol succinate (extended release) ER tablet (a beta-blocker) 24 hour give 100 milligrams (mg) by mouth daily for essential hypertension, Cozaar (an antihypertensive medication) give 50 mg orally twice a day for essential hypertension and Cardura (doxazosin mesylate) give two mg orally daily for hypertension. R6's vital sign recordings for the months of March and April 2014 revealed R6's pulse was taken ten times, of those recordings eight of ten were below 60, with a warning notation generated by the electronic medical record "Low of 60.0 exceeded." Review of R6's blood pressure readings for the same time period revealed systolic blood pressures in excess of 180 millimeters of mercury (mm Hg) five out of 11 recordings. Additional blood pressure and pulse information was reviewed for the previous six months and revealed a consistent pattern of documented pulses in the 50's and blood pressures running over 180 mm Hg systolic. R6's most recent physician progress notes, dated 4/22/14, revealed a blood pressure of 199/74. The progress notes revealed that her primary physician (MD)-C made a comment that R6's	F 329	medications will be reviewed for ensuring that appropriate parameters are set for administration. DNS will work with facility pharmacy consultant to developed guidelines for expected normal parameters for pulse and blood pressure. Facility medical director will review guidelines. 3. Nursing staff will be educated on the developed guidelines for expected normal parameters for pulse and blood pressure and following medication parameters on May 22, 2014. 4. Random audits will be completed by DNS or designee 2 x per month x 3 months to ensure that developed guidelines for expected normal parameters for pulse and blood pressure are being followed. Findings will be presented to Quality assurance committee, committee will make further recommendations for ongoing audits. 5. Corrective action will be completed by 6-10-2014	

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F 329	Continued From page 20	F 329		

vitals were reviewed and listed a diagnosis of hypertension. No other evidence was noted on R6's chart which indicated the pattern of elevated blood pressures or decreased pulses was evaluated to determine if the current drug regimen was effective, or if parameters for administration of the metoprolol should be defined.

During interview on 5/01/14, at 9:15 a.m. licensed practical nurse (LPN)-A said she would not give the metoprolol for a pulse below 60 and confirmed staff was not routinely checking R6's pulse prior to the administration R6's metoprolol as this directive was not indicated on R6's electronic medication administration record.

During interview on 5/1/14, at 9:30 a.m. the consultant pharmacist (CP) said he would usually hold metoprolol for a pulse less than 60. The CP was concerned about the consistently low pulses and high blood pressures and stated "holy cow" when R6's blood pressure readings for March and April were reviewed at this time via phone.

On 5/1/14, at approximately 10:30 a.m. R6 was observed resting in her room in a chair. R6 was pale in color and was unable to answer basic questions about how she felt or how long she had resided at the facility.

During interview on 5/1/14, at 12:48 p.m. MD-C stated R6's blood pressures were very difficult to control due to R6's compromised renal function. MD-C also stated she had been working in conjunction with cardiology regarding the treatment of R6's unstable blood pressures. MD-C stated low pulses would be more of a concern if R6 was ambulatory and she was not

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F 329	Continued From page 21 therefore she was not concerned with R6's irregular pulse. MD-C said she reviewed resident vital signs information during facility rounds as the facility provided a printed report as well as personally checking R6's blood pressure reading herself during R6's clinic appointments. The manufacturer's package insert for metoprolol succinate ER from McKesson Packaging Services Business Unit of McKesson, revised 2/2011, revealed bradycardia (slow pulse) was a common side effect of metoprolol and that metoprolol would be contraindicated in a patient with severe bradycardia. The facility policies for vital signs, revised on 11/13, lacked guidelines for expected normal parameters for pulse or blood pressures.	F 329		
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 interview and document review, the consultant pharmacist failed to review blood pressure and pulse ranges to evaluate	F 428	F428 Drug Regimen Review, Report Irregular, Act On 1. R6□s Physician is aware of R6 blood	6/10/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING _____ B. WING _____	05/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

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F 428	Continued From page 22 therapeutic effectiveness and identify potential concerns with low pulse rates for 1 of 5 residents (R6) reviewed for unnecessary drugs who received multiple anti-hypertensive medications. Findings include: R6's most recent physician's progress note, dated 4/22/14, indicated R6's diagnoses included diabetes, hypertension, chronic pain, hypothyroidism, anemia and chronic kidney disease. R6's most recent physician's order sheets, dated 4/21/14, identified orders for metoprolol succinate (extended release) ER tablet (an anti-hypertensive medication that lowers the pulse rate and reduces the force of heart contractions) 24 hour give 100 milligrams (mg) by mouth daily for essential hypertension, Cozaar (an anti-hypertensive medication) give 50 mg orally twice a day for essential hypertension and Cardura (doxazosin mesylate) give two mg orally daily for hypertension. R6's vital sign recordings for the months of March and April 2014, revealed R6's pulse was taken ten times, of these recordings eight of ten were below 60, with a warning notation generated by the electronic medical record "Low of 60.0 exceeded." Review of R6's blood pressure readings for the same time period revealed systolic blood pressures in excess of 180 millimeters of mercury (mm Hg) five out of 11 recordings. Additional blood pressure and pulse information was reviewed for the previous six months and revealed a consistent pattern of documented pulses in the 50's per minute and	F 428	pressures and pulses. DNS discussed current medications, pulses and blood pressures with primary physician. Nursing staff are taking R6□s pulse prior to all metoprolol administration. Orders obtained to hold metoprolol for pulse less than 50. R6□s physician has reviewed all medications, will have pharmacy consultant review and all recommendations will be acted upon. 2. All current and future resident vital signs will be provided to consultant pharmacist upon every facility visit. DNS will work with facility pharmacy consultant to developed guidelines for expected normal parameters for pulse and blood pressure. Facility medical director will review guidelines. 3. Nursing staff will be educated on the necessity of providing proper medical information to resident physicians and consultant pharmacist on an ongoing basis. Training will take place on May 22, 2014. 6. Resident vital signs and consultant pharmacist medication review forms will be audited by DNS or designee 1x monthly x 3months to ensure consultant pharmacist is addressing abnormal vital signs that may be related to medication adverse effects. . Findings will be presented to Quality assurance committee, committee will make further recommendations for ongoing audits. 4. Corrective action will be completed by 6-10-2014	

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F 428	Continued From page 23 blood pressures running over 180 mm Hg systolic. R6's most recent physician progress notes, dated 4/22/14, revealed a blood pressure of 199/74. The progress notes revealed R6's primary physician (MD)-C made a comment that R6's vitals were reviewed and listed a diagnosis of hypertension. No other evidence was noted on R6's chart that the pattern of elevated blood pressures or decreased pulses were evaluated to determine if the current drug regimen was effective, or if parameters for administration of the metoprolol should be defined. R6's pharmacy consultant documentation was reviewed. No irregularities had been identified for the previous 10 month period. During interview on 5/01/14, at 9:15 a.m. licensed practical nurse (LPN) -A said she would not give the metoprolol for a pulse below 60 and confirmed staff were not routinely checking R6's pulse prior to the administration of the metoprolol and confirmed this was not indicated on R6's electronic medication administration record. During interview on 5/1/14, at 9:30 a.m. the consultant pharmacist (CP) said he would usually hold metoprolol for a pulse less than 60. The CP voiced concern about R6's consistently low pulses and high blood pressures and stated "holy cow" when R6's blood pressure readings for March and April were reviewed at this time via phone. The CP stated staff needed to flag elevated blood pressure readings for him to review and stated if staff did not tell him of problems with resident vital signs, he would typically have to ask in order to know if there were concerns. The CP said every once in a while	F 428		

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F 428	Continued From page 24 someone would print a vital sign report for him but up until now had not had access to the computer and had difficulty getting the information he needed for the drug reviews, and confirmed he had not been reviewing R6's blood pressure readings. The CP indicated he just received access to the vital signs portal in resident electronic records and would now be able to review this information. During interview on 5/1/14, at 12:48 p.m. R6's physician (MD-C) stated R6's blood pressures were very difficult to control due to R6's compromised renal function. MD-C also stated she had been working in conjunction with cardiology regarding the treatment of R6's unstable blood pressures. MD-C stated low pulses would be more of a concern if R6 was ambulatory and she is not so she did not feel the low pulses were a concern. MD-C said she reviewed vital signs information at rounds as the facility printed out a report for her and personally took them herself at clinic appointments. MD-C stated she reviewed resident vital signs information during rounds as the facility provided a printed report as well as personally checking R6's blood pressure reading herself during R6's clinic appointments. The facility policies for vital signs, last revised on 11/13, lacked guidelines for expected normal parameters for pulse or blood pressures.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		6/10/14

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F 441	Continued From page 25 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to analyze patterns and trends of infections for both staff and residents. This had	F 441	F 441 Infection Control, prevent spread , linens	

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F 441	Continued From page 26 the potential to affect all 32 residents who resided in the facility. Findings include: Review of the facility's infection control program revealed a system which lacked a surveillance program with ongoing analysis and interpretation of infections and infection risks. The Monthly Report of Resident Infections in Center for 01/14, 02/14, 03/14, and 04/14, revealed only infections with prescribed antibiotics were tracked. The facility's tracking system lacked trending of infections without antibiotics. In addition, a tracking system for employee infections and comparison surveillance between resident and employee illnesses had not been established. On 5/1/14, at 11:42 a.m. the facility infection control program was reviewed with the director of nursing (DON). DON indicated all residents who were prescribed an antibiotic were entered onto a surveillance report by the floor nurse. Upon completion, the surveillance reports were sent to DON who compiled the information onto the Monthly Report of Resident Infections in Center. Information included on the Monthly Report of Resident Infections in Center included: resident name, date admitted, site of infection, culture taken, causative agent, antibiotic treatment, cautionary measures, isolation and if center acquired. DON also stated she was notified by nursing staff of resident infections not requiring an antibiotic which she reviewed monthly but did not include on the monthly report. DON indicated she reported directly from the monthly reports at the Quality Assurance and Assessment (QAA) committee which met quarterly. In addition, DON stated she had previously created similar monthly	F 441	1. Aprils Staff absences related to illness have been recorded on monthly infection surveillance reports. Resident monthly infection surveillance reports were reviewed and compared to employee monthly infection surveillance reports. Written report has been completed by tabulating and assessing data collected. Rates were calculated and trends were established, results will be reported to QA committee. 2. Reports found in infection control manual, monthly Report of Resident Infections in Center, Monthly Report of Staff Infections in Center, Infection Surveilance Report, Montly Infection Control Report are all being utilized per infection control policy/procedure. 3. DNS to provide education at nurses meeting on 5-22-14 on providing infection surveillance reports on all resident illnesses with and without need for antibiotics. All facility supervisors have been educated on the proper procedure for report their employee illnesses, education conducted on 5-21-14. 4. Infection control reports to be audited by Quality Coordinator or designees 1x per month for 3 months. . Findings will be presented to Quality assurance committee, committee will make further recommendations for ongoing audits. 5. Corrective action will be completed by 6-10-2014	

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F 441	Continued From page 27 reports of employee infections but no longer did this. The DON indicated she retained each employee call in sheet and reviewed them. DON stated the last completed monthly report of employee illnesses/infections available was dated March 2013. On 5/1/14, at 12:05 p.m. DON confirmed no analysis of resident infection trends with comparison to employee infections/illnesses was documented. The Infection Control Nurse Procedure dated July 2003, directs the infection control nurse to investigate and assist with employee health activities, including recording employee infection reports and information. The Disease Surveillance procedure dated July 2003, identified the procedure for disease surveillance to include: "4. Tabulate and assess the data and: a. calculate rates, b. establish trends. 5. Report results" The Infection Control Policies/Procedures manual contained the following disease surveillance forms, as referenced in the Table of Contents dated July 2003: "Monthly Report of Resident Infections in Center, Monthly Report of Staff Infections in Center, Infection Surveillance Report, Monthly Infection Control Report."	F 441		
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.	F 466		6/10/14

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F 466	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility emergency water policy failed to ensure the estimated water needs for dietary and staff use was established and failed to ensure the method for storage and distribution of non-potable water had been identified. This had the potential to affect all 32 residents residing in the facility. Findings include: The facility's EMERGENCY WATER POLICY AND PROCEDURE reviewed 2/4/10, indicated store bottled water in the amount of 2 gallons would be provided for the facility staff. The policy lacked indication of how the 2 gallons of water was allocated to the employees per shift or if the 2 gallons of water was for a 24 hour period for all shift employees. The policy also lacked indication of the average amount of employee's that worked each day to determine if the amount of 2 gallons of water covered the needs for the average amount of staff per day, how much water would be allocated for the dietary department to provide for meals or a method for storage and distribution of the water to meet the needs for employee hand hygiene. The policy indicated water for essential sanitary services would be obtained from a Well Drilling company in Blackduck (bulk water supplier) on a daily basis until the facility's normal supply was reestablished. The policy had not identified the method for storage or distribution of the water and the estimated calculated water needs for sanitation.	F 466	F 466 Procedures to Ensure Water Availability 1. Facility procedure for Emergency Water has been revised to state that 2 gallons of water will be allocated to each employee per 8 hour shift (2 quarts for drinking and food preparation, 2 quarts and 1 gallon for employee sanitation and hand hygiene). Procedure also reads that jugs of water will be transported to both the Dietary & Nursing departments by the Maintenance Director or designee to be distributed by department designee. A 3 gallon jug of water with a hand pump will be placed in each utility room and facility kitchen for employee hand hygiene. The hand hygiene jugs will be replaced as necessary. 2. All employees have reviewed the revised procedure 3. This procedure will be reviewed and updated as determined necessary on an annual basis. 4. Corrective action will be completed by 6-10-2014	

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F 466	Continued From page 29 The director of environmental services was interviewed on 5/1/14, at 11:15 p.m. and confirmed there were area's of the facility emergency water policy that needed clarification.	F 466		

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	245600	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/29/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building 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 Blackduck 01 Main Building was found 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. Good Samaritan Society Blackduck is a 1-story building built at three different times. The first and major portion of the building was built in 1970, is 1-story with a basement and was determined to be Type I(332) construction. In 1996 a dining room/ PT addition was constructed to the north of the original building. This addition is 1-story, with a basement and was determined to be type II (111) construction. In 2009 a connecting link and activities addition was constructed to the north of the dining room. It is separated with a 2-hour fire barrier, 1-story, no basement , Type V(111) construction facility is divided into 3 smoke zones with 30-minute fire barriers. The facility has a complete automatic fire sprinkler system with quick response heads, installed in accordance with NFPA 13 The Standard for Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system which includes smoke detection throughout the corridor system and in all common areas, which is installed in accordance with NFPA 72 "The	K 000		

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

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

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K 000	Continued From page 1 National Fire Alarm Code" 1999 edition. All sleeping rooms have single station battery operated smoke detectors and hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 32 beds had a census of 31 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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	245600	A. BUILDING **02 - ACTIVITIES ADDITION** B. WING _____	**04/29/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY 02 Connecting Link/ Activities 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 Blackduck 01 Main Building was found 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. Good Samaritan Society Blackduck is a 1-story building built at three different times. The first and major portion of the building was built in 1970, is 1-story with a basement and was determined to be Type I(332) construction. In 1996 a dining room/ PT addition was constructed to the north of the original building. This addition is 1-story, with a basement and was determined to be type II (111) construction. In 2009 a connecting link and activities addition was constructed to the north of the dining room. It is separated with a 2-hour fire barrier, 1-story, no basement , Type V(111) construction facility is divided into 3 smoke zones with 30-minute fire barriers. The facility has a complete automatic fire sprinkler system with quick response heads, installed in accordance with NFPA 13 The Standard for Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system which includes smoke detection throughout the corridor system and in all common areas, which is installed in accordance with NFPA 72 "The	K 000		

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

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

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K 000	Continued From page 1 National Fire Alarm Code" 1999 edition. All sleeping rooms have single station battery operated smoke detectors and hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 32 beds had a census of 31 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
May 8, 2014

Ms. Angel Normandin, Administrator Administrator
Good Samaritan Society - Blackduck
172 Summit Avenue West
Blackduck, Minnesota 56630

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5600023

Dear Ms. Normandin:

The above facility was surveyed on April 28, 2014 through May 1, 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.

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact **Lyla Burkman by email: lyla.burkman@state.mn.us, or phone: (218) 308-2104.**

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00021	A. BUILDING: _____ B. WING _____	05/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 4/28/14, 4/29/14, 4/30/14, and 5 /1/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		5/20/14

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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician of a decline in oxygen saturations, elevated temperature and blood pressures in a timely manner and failed to consult the physician for parameters for oxygen administration for 1 of 3 residents (R6) reviewed for notification of changes who experienced falls and an acute illness. Findings include: R6's quarterly Minimum Data Set dated 1/23/14, indicated R6 had moderate cognitive impairment and required extensive staff assistance for all activities of daily living. R6's most recent physician's progress note, dated 4/22/14, indicated an active diagnoses of diabetes, hypertension, chronic pain, depression, hypothyroidism, anemia and chronic kidney disease. R6's nursing progress notes revealed the following information: -On 3/21/14, at 6:15 p.m. R6 was found on the floor in another resident's room. R6 said she had hit her head during the fall, neuro checks were listed as within normal limits and an initial blood pressure of 179/76, pulse 78. The note indicated R6's physician and family were notified of the fall. Follow up neuro check information, per the neuro check flow sheet after the incident revealed the	2 265	Corrected	

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2 265	Continued From page 4 following information: - At 8:30 p.m. 3/21/14, R6's blood pressure was 192/89 - At 10:30 p.m. on 3/21/14, R6's blood pressure was 259/84 - At 12:30 a.m. on 3/22/14, R6's blood pressure was 239/93 - At 2:30 a.m. on 3/22/14, R6's blood pressure was 190/80 - The final blood pressure recording for R6 on 3/22/14, at 7:00 p.m. was 193/73. The note indicated R6 was alert with normal hand grasps and upper body movement and her pupils were equal in size and reactive to light. -On 3/23/14, at 12:37 a.m. the nursing progress note revealed R6's neuro checks were within normal limits after her fall on 3/21/14. LOC (level of consciousness) and orientation were WNL (within normal limits) as well. Continue to monitor. The medical record lacked evidence that the significantly elevated blood pressures in excess of 200 millimeters of mercury (mm Hg) on the overnight shift were reported to a physician. -On 4/1/14, at 11:25 a.m. the note indicated R6's vital signs included an elevated blood pressure of 227/97, a temp of 100.0, a pulse of 91 an oxygen saturations of 85-89%. The note also indicated R6 had vomited therefore was kept in her room. At 9:30 a.m. R6's blood pressure was rechecked and was 202/60, temp of 100.8 degrees, pulse of 67 with oxygen saturations dipping to 78-85% and PRN (as needed) oxygen was applied at two liters per minute. R6's temperature was rechecked	2 265		

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2 265	Continued From page 5 and was 99.5 degrees, oxygen saturations increased to 96% with the oxygen at 2 liters. The note further indicated R6 was not complaining of pain or discomfort and had stopped vomiting. R6's family was notified of this incident via an email. - The next recorded vital sign information after 4/1/14, was not until 4/5/14, four days later when a routine weekly check revealed a blood pressure recording of 176/58, temperature of 97.1 (tympanic), pulse 51 (regular) and respirations of 16. R6's oxygen saturation was recorded as 94% on room air. -R6's next recorded nursing progress note was dated 4/15/14, and indicated R6 had her ears checked and cleaned. R6's medical record lacked documentation that R6's physician was notified regarding R6's change of condition on 4/1/14, and evidence of any additional assessment of R6 or vital signs being taken to monitor R6's condition. -R6's nursing home visit note dated 4/22/14, indicated R6 was seen by her physician during nursing home rounds. The note also indicated R6's oxygen saturations were recorded at 93% on room air, pulse was 66 and R6's blood pressure recording was 199/74. During interview on 04/30/14, at 12:34 p.m., nursing assistant (NA)-A said R6 was in a downhill spiral and had "Given up." During interview on 5/1/14, at 10:03 a.m., both registered nurse (RN) -A and licensed practical nurse (LPN)-A stated blood pressure readings over 200 mm Hg would be concerning and would require a recheck of the blood pressure to see if it	2 265		

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2 265	Continued From page 6 came down. Both confirmed a blood pressure of 259 after a fall with a potential head injury was definitely concerning. Both LPN-A and RN-A said oxygen saturations in the 70's would also be a concern, both verified they would definitely call or fax the doctor with something like that. During interview on 5/1/14, at 10:20 a.m. the director of nursing (DON) said she thought there had been an intestinal flu going through the facility on 4/1/14, and said she would have "personally called the doctor" with the elevated blood pressures noted on R6's neuro checks from 3/22/14. She thought R6's information may have been reviewed with the attending physician on rounds but was unable to provide documentation to this effect. The DON remembered receiving a call from R6's daughter on the day of her fall wanting to know how she was doing. The DON stated she would expect follow up oxygen saturations and vitals to be taken once a shift if they were noted to be abnormal with symptoms of an illness. The DON identified she may not necessarily expect staff to call a doctor unless temperatures were over 101 degrees, or if a resident had been running a low grade temperature for several days. During further interview on 5/1/14, at 10:50 a.m. the DON stated R6 did not have a physician's order for oxygen use at the time of the 4/1/14, incident and the facility medical director preferred staff to first apply the oxygen when needed and then were expected to call a doctor for further guidance. The DON stated the facility did not have standing orders for oxygen as this was against corporate policy and also stated R6 had a previous order for as needed oxygen that had been discontinued due to lack of clear parameters for use.	2 265		

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2 265	Continued From page 7 During interview on 5/1/14, at 12:48 p.m. R6's physician (MD-C) stated R6's blood pressures were very difficulty to control due to R6's compromised renal function. MD-C also stated she had been working in conjunction with cardiology regarding the treatment of R6's unstable blood pressures. MD-C confirmed the facility definitely should have called and reported R6's temperature and decreased oxygen saturations on 4/1/14, and stated it was "unfortunate" that this did not happen. MD-C said she reviewed R6's vital signs information during facility rounds as the facility provided a printed report as well as personally monitoring and checking R6's blood pressure reading herself during R6's clinic appointments. The facility policy, entitled Notification of Change in Resident Status, revised February 2005, indicated the center will IMMEDIATELY (written in all caps) inform the resident, if appropriate (except in a medical emergency or when resident is incompetent), and consult with the resident's physician and, if known, notify the resident's family or legal representative in the following cases: -1. Resident accident which results in injury with a potential for requiring physician intervention. -2. Significant change in the resident's physical, mental or psychosocial status. -3. Need to alter treatment significantly. -4. Decision to transfer or discharge the resident from the center. The policy further included a flow chart including ongoing documentation, monitoring and physician notification for a suspected resident illness. The flow chart indicated staff should continue	2 265		

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2 265	Continued From page 8 monitoring a resident according to center policy/procedure, but lacked guidelines for frequency of the monitoring or reassessment. Additionally, the policies for vital signs, last revised 11/13, were reviewed and the policy entitled Temperature defined a fever as a single oral temperature of greater than 100 degrees Fahrenheit or a repeated oral temperature of over 99 degrees Fahrenheit. Suggested Method of Correction: The director of nursing (DON) or designee could work with the medical director to update policies and procedures for when to notify the physician of changes in the resident and consulting the physican for parameters of resident needs. The DON could then educate staff. The DON or designee could also perform audits of resident records to determine if the physician had been notified as appropriate. Time Period for Correction: Twenty-one (21) days.	2 265		
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).	2 560		5/20/14

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2 560	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the written care plan included appropriate interventions for the care of a resident receiving dialysis related to delineation of fluid due to a fluid restriction, persons responsible for monitoring daily fluid intake, where the resident dialyzes and how to contact them, location of the residents fistula, directive on the frequency of monitoring of the fistula, emergency interventions, who to contact in case of an emergency and which medications were held on the days the resident received dialysis for 1 of 1 resident (R5) in the sample who received hemodialysis. Findings include: R5's care plan dated 4/8/14, indicated R5 received hemodialysis three times a week due to renal failure. The care plan interventions directed staff to not draw blood or take blood pressure readings in the left grafted arm, to monitor and document / report to R5's health care provider as needed and to report signs and symptoms of bleeding, hemorrhage, bacteremia, septic shock, signs and symptoms of infection to the access site such as redness, swelling, warmth or drainage and to monitor for a bruit (the sound blood makes as it moves through arteries). R5's care plan lacked identification of the type of vascular access R5 had (i.e. fistula, Dacron graft, HeRO graft), where 5's vascular access was placed, how often to check the vascular access for a Bruit or feel for a thrill (a vibration that is felt over an artery and caused by turbulent blood flow), the delineation of fluid related to how much fluid nursing and dietary was going to provide and	2 560	Corrected	

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2 560	Continued From page 10 who was responsible for monitoring R5's total daily fluid intake. The care plan also lacked indication of which of R5's medication were held on dialysis days and also lacked indication of where R5 dialyzed, how to contact them and what to do or who to contact in case of a dialysis related emergency (i.e. excess bleeding from accessing R5's newly placed fistula). On 4/30/14, at 11:30 a.m. licensed practical nurse (LPN)-C stated R5 had two blood pressure medications held on dialysis days (metopropolol succinate ER 50 mg (milligrams) and Imdur ER 60 mg). LPN-C confirmed R5's care plan had not identified which medications were not given to R5 on dialysis days. On 4/30/14, at 1:03 p.m. registered nurse (RN)-C confirmed R5's written care plan lacked the identified components as listed above. Suggested Method of Correction: The director of nursing and/or their designee could review policies and procedures related to the development of comprehansive plans of care. These policies could be revised as necessary. All facility nurse's could be re-educated on these policies and procedures. Resident care plans could be audited for content, with the results of these audits being shared with the facility's Quality Assessment and Assurance committee, to ensure on-going compliance. Time Period For Correction: Twenty-one (21) days.	2 560		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		5/20/14

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2 830	Continued From page 11 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor and notify the physician of a decline in oxygen saturations, elevated temperature and blood pressures in a timely manner and failed to consult the physician for parameters for oxygen administration for 1 of 3 residents (R6) reviewed for notification of change who experienced falls and an acute illness. Additionally, the facility failed to monitor fluid intake for 1 of 1 resident (R5) who received dialysis and was on a fluid restriction. Findings include: R6's quarterly Minimum Data Set dated 1/23/14, indicated R6 had moderate cognitive impairment and required extensive staff assistance for all activities of daily living. R6's most recent physician's progress note, dated 4/22/14, indicated an active diagnoses of	2 830	corrected	

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2 830	Continued From page 12 diabetes, hypertension, chronic pain, hypothyroidism, anemia and chronic kidney disease. R6's nursing progress notes revealed the following information: -On 3/21/14, at 6:15 p.m. R6 was found on the floor in another resident's room. R6 said she had hit her head during the fall, neuro checks were listed as within normal limits and an initial blood pressure of 179/76, pulse 78. The note indicated R6's physician and family were notified of the fall. Follow up neuro check information, per the neuro check flow sheet after the incident revealed the following information: - At 8:30 p.m. 3/21/14, R6's blood pressure was 192/89 - At 10:30 p.m. on 3/21/14, R6's blood pressure was 259/84 - At 12:30 a.m. on 3/22/14, R6's blood pressure was 239/93 - At 2:30 a.m. on 3/22/14, R6's blood pressure was 190/80 - The final blood pressure recording for R6 on 3/22/14, at 7:00 p.m. was 193/73. The note indicated R6 was alert with normal hand grasps and upper body movement and her pupils were equal in size and reactive to light. -On 3/23/14, at 12:37 a.m. the nursing progress note revealed R6's neuro checks were within normal limits after her fall on 3/21/14. LOC (level of consciousness) and orientation were WNL (within normal limits) as well. Continue to monitor. The medical record lacked evidence that the significantly elevated blood pressures in excess of 200 millimeters of mercury (mm Hg) on the overnight shift were reported to a physician.	2 830		

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2 830	Continued From page 13 -On 4/1/14, at 11:25 a.m. the note indicated R6's vital signs included an elevated blood pressure of 227/97, a temp of 100.0, a pulse of 91 an oxygen saturations of 85-89%. The note also indicated R6 had vomited and was kept in her room. At 9:30 a.m. R6's blood pressure was rechecked and was 202/60, temp of 100.8 degrees, pulse of 67 with oxygen saturations dipping to 78-85% and PRN (as needed) oxygen was applied at two liters per minute. R6's temperature was rechecked and was 99.5 degrees, oxygen saturations increased to 96% with the oxygen at 2 liters. The note further indicated R6 was not complaining of pain or discomfort and had stopped vomiting. R6's family was notified of this incident via an email. - The next recorded vital sign information after 4/1/14, was not until 4/5/14, four days later at a routine weekly check revealed a blood pressure recording of 176/58, temperature of 97.1 (tympanic), pulse 51 (regular) and respirations of 16. R6's oxygen saturation was recorded as 94% on room air. -R6's next recorded nursing progress note was dated 4/15/14, and indicated R6 had her ears checked and cleaned. R6's medical record lacked documentation that R6's physician was notified regarding R6's change of condition on 4/1/14, and evidence of any additional assessment of R6 or vital signs being taken to monitor R6's condition. -R6 was seen on nursing home rounds by her doctor per a physician nursing home visit note dated 4/22/14. R6's oxygen saturations were recorded at 93% on room air, pulse was 66 and R6's blood pressure recording was 199/74.	2 830		

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2 830	Continued From page 14 During interview on 04/30/14, at 12:34 p.m., nursing assistant (NA)-A said R6 was in a downhill spiral and had "Given up." During interview on 5/1/14, at 10:03 a.m., registered nurse (RN)-A and licensed practical nurse (LPN)-A said blood pressure readings over 200 mm Hg would be concerning and would require a recheck of the blood pressure to see if it came down. Both confirmed a blood pressure of 259 after a fall with a potential head injury was definitely concerning. Both LPN-A and RN-A said oxygen saturations in the 70's would also be a concern, both verified they would definitely call or fax the doctor with something like that. During interview on 5/1/14, at 10:20 a.m. the director of nursing (DON) said she thought there had been an intestinal flu going through the facility on 4/1/14, and said she would have "personally called the doctor" with the elevated blood pressures noted on R6's neuro checks from 3/22/14. She thought R6's information may have been reviewed with the attending physician on rounds but was unable to provide documentation to this effect. The DON remembered receiving a call from R6's daughter on the day of her fall wanting to know how she was doing. The DON stated she would expect follow up oxygen saturations and vitals to be taken once a shift if they were noted to be abnormal with symptoms of an illness. The DON identified she may not necessarily expect staff to call a doctor unless temperatures were over 101 degrees, or if a resident had been running a low grade temperature for several days. On 5/1/14, at approximately 10:30 a.m. R6 was observed resting in her room in a chair. R6 was	2 830		

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2 830	Continued From page 15 pale in color and unable to answer basic questions about how she felt or how long she had resided at the facility. During interview on 5/1/14, at 10:50 a.m. the DON stated R6 did not have a physician's order for oxygen use at the time of the 4/1/14, incident and the facility medical director preferred staff to first apply the oxygen and then were expected to call a doctor for further guidance. The DON stated the facility did not have standing orders for oxygen as this was against corporate policy and also stated R6 had a previous order for as needed oxygen that was discontinued due to lack of clear parameters for use. During interview on 5/1/14, at 12:48 p.m. R6's physician (MD-C) stated R6's blood pressures were very difficult to control due to R6's compromised renal function. MD-C also stated she had been working in conjunction with cardiology regarding the treatment of R6's unstable blood pressures. MD-C confirmed the facility definitely should have called and reported R6's temperature and decreased oxygen saturations on 4/1/14, and stated it was "unfortunate" that this did not happen. MD-C said she reviewed resident vital signs information during facility rounds as the facility provided a printed report as well as personally checking R6's blood pressure reading herself during R6's clinic appointments. The facility policy, entitled Notification of Change in Resident Status, revised February 2005, indicated the center will IMMEDIATELY (written in all caps) inform the resident, if appropriate (except in a medical emergency or when resident is incompetent), and consult with the resident's physician and, if known, notify the resident's	2 830		

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2 830	Continued From page 16 family or legal representative in the following cases: -1. Resident accident which results in injury with a potential for requiring physician intervention. -2. Significant change in the resident's physical, mental or psychosocial status. -3. Need to alter treatment significantly. -4. Decision to transfer or discharge the resident from the center. The policy further included a flow chart including ongoing documentation, monitoring and physician notification for a suspected resident illness. The flow chart indicated staff should continue monitoring a resident according to center policy/procedure, but lacked guidelines for frequency of the monitoring or reassessment. Additionally, the policies for vital signs, last revised 11/13 were reviewed and the policy entitled Temperature defined a fever as a single oral temperature of greater than 100 degrees Fahrenheit or a repeated oral temperature of over 99 degrees Fahrenheit. R5 was on a 1200 cubic centimeter (cc) daily fluid restriction and the daily total fluid intake was not monitored, R5's quarterly MDS dated 4/10/14, indicated R5 had intact cognition and was independent with eating. R5's ADMISSION RECORD indicated R5's diagnoses included end stage renal disease which required hemodialysis and type II diabetes mellitus. On 4/30/14, at 11:24 a.m. RN-B confirmed R5 was on a 1200cc daily fluid restriction which	2 830		

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2 830	Continued From page 17 started day R5 had her first dialysis treatment on 9/4/14. R5's physician orders dated 3/19/14, did not include an order for a restricted fluid intake. R5's care plan dated 4/23/14, indicated R5 was on a daily fluid restriction due to renal disease and directed staff to see the charge nurse before giving R5 any fluids between meals and to document all fluids provided. The care plan lacked identification of the amount of the daily fluid restriction amount and did not delineate how much fluid between meals and medication passes R5 was allowed. On 4/30/14, at 11:20 a.m. LPN-C, who was responsible for the care of R5, stated she did not know how much fluid she was allotted to give R5 during the medication pass. LPN-C stated she would give R5 no more than 100 cc of fluid for the med pass during the day shift but there were no directions or care plan interventions which identified how much fluid LPN-C was allotted for the med pass. LPN-C stated R5 would be given no more than 400 cc of fluid for all of the med passes in 24 hours and she did not know who was responsible for monitoring R5's total daily fluid intake to ensure that R5 was staying within the 1200 cc fluid restriction amount. On 4/30/14, at 12:05 p.m. the dietary manager stated R5 was provided 360 cc of fluid during each meal which was a total of 1080 cc of fluid daily. The dietary manager confirmed R5's care plan did not delineate how much fluid R5 was allotted with meals and how much fluid R5 was allotted during med pass, and who was responsible to monitor R5's total daily fluid intake. The dietary manager verified there was no	2 830		

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2 830	Continued From page 18 way to tell how much total fluid intake R5 received daily because the facility's computer system did not account for the amount of fluid R5 was given with each med pass, and nobody was monitoring the residents total fluid intake each day. Review of the facility's fluid intake monitoring sheets from the Dinning Report revealed fluid intake was not consistently recorded for all residents. Many of the entries were identified as "Not Available" and R5's dietary fluid intake was recorded between 240 cc to 1080 cc daily. Review of R5's Medication Administration sheets indicated fluid intake provided during the med passes had not been recorded from 9/4/13, through 4/24/14. On 4/25/14, the MAR identified staff had begun to record R5's fluid intake with each med pass and indicated R5 was provided between 210 cc and 240 cc fluid daily. On 4/30/14, at 1:03 p.m. RN-C confirmed there was no planned delineation for fluids for nursing or dietary to provide R5. RN-C verified R5's total daily fluid intake was not being monitored. Suggested Method of Correction: The director of nursing and/or their designee could review and revise policies and procedures related to the identification of the clinical needs of residents and for reporting resident status and obtaining physicians orders. The director of nursing could provide training to involved staff. The director of nursing could establish a monitoring program to assure appropriate care interventions are being implemented. Time Period For Correction: Twenty one- (21) days.	2 830		

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21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to analyze patterns and trends of infections for both staff and residents. This had the potential to affect all 32 residents who resided in the facility. Findings include: Review of the facility's infection control program revealed a system which lacked a surveillance program with ongoing analysis and interpretation of infections and infection risks. The Monthly Report of Resident Infections in Center for 01/14, 02/14, 03/14, and 04/14, revealed only infections with prescribed antibiotics were tracked. The facility's tracking system lacked trending of infections without antibiotics. In addition, a tracking system for employee infections and comparison surveillance between resident and employee illnesses had not been established. On 5/1/14, at 11:42 a.m. the facility infection control program was reviewed with the director of nursing (DON). DON indicated all residents who were prescribed an antibiotic were entered onto a surveillance report by the floor nurse. Upon completion, the surveillance reports were sent to DON who compiled the information onto the	21375	corrected	5/20/14

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21375	Continued From page 20 Monthly Report of Resident Infections in Center. Information included on the Monthly Report of Resident Infections in Center included: resident name, date admitted, site of infection, culture taken, causative agent, antibiotic treatment, cautionary measures, isolation and if center acquired. DON also stated she was notified by nursing staff of resident infections not requiring an antibiotic which she reviewed monthly but did not include on the monthly report. DON indicated she reported directly from the monthly reports at the Quality Assurance and Assessment (QAA) committee which met quarterly. In addition, DON stated she had previously created similar monthly reports of employee infections but no longer did this. The DON indicated she retained each employee call in sheet and reviewed them. DON stated the last completed monthly report of employee illnesses/infections available was dated March 2013. On 5/1/14, at 12:05 p.m. DON confirmed no analysis of resident infection trends with comparison to employee infections/illnesses was documented. The Infection Control Nurse Procedure dated July 2003, directs the infection control nurse to investigate and assist with employee health activities, including recording employee infection reports and information. The Disease Surveillance procedure dated July 2003, identified the procedure for disease surveillance to include: "4. Tabulate and assess the data and: a. calculate rates, b. establish trends. 5. Report results" The Infection Control Policies/Procedures manual contained the following disease surveillance	21375		

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21375	Continued From page 21 forms, as referenced in the Table of Contents dated July 2003: "Monthly Report of Resident Infections in Center, Monthly Report of Staff Infections in Center, Infection Surveillance Report, Monthly Infection Control Report." Suggested Method of Correction: The director of nursing and/or designee could review and revise policies and procedures related to components of the infection control program and develop a system of auditing, to ensure patterns and trends for infections are monitored and analyzed. The quality assurance committee could randomly audit records to ensure compliance. Time Period For Correction: Twenty one- (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.	21426		5/20/14

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21426	Continued From page 22 (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure all health care workers received the required two-step tuberculin skin test (TST) for 3 of 5 employees (nursing assistant (NA)-D, NA-E, and laundry assistant (LA)-A) reviewed, for tuberculin skin testing. This had the potential to affect all 32 residents who resided in the facility. Findings include: Personnel records for nursing assistant NA-D indicated they were hired on 2/22/14, and a tuberculosis (TB) screening was completed on 2/22/14. However, the record lacked documentation for completion of the first and second step TST. Personnel records for NA-E indicated they were hired on 2/20/14, and revealed the first step TST was administered prior to employment on 7/9/13. However, the record lacked documentation indicating a second step was completed. Personnel records for LA-A, indicated they were hired on 2/6/14, and revealed the first step TST was administered on 2/6/14. However, the record lacked documentation indicating a second step was completed.	21426	corrected	

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21426	Continued From page 23 On 5/1/13, at 3:10 p.m. the director of nursing (DON) confirmed the facility did not have documentation that tuberculin testing had been completed for NA-D, NA-E or LA-A. She confirmed the facility had ten doses of tuberculin testing fluid available in-house but failed to utilize it for these employees. Additionally, the DON indicated she had access to additional doses of tuberculin testing fluid from the facility's pharmacy, though she had not obtained it. The Tuberculin Skin Testing (TST) Protocol for Screening Health Care Workers dated 9/17/13, identified the prescribed action for pre-employment screening for healthcare workers and directed the administration of the two-step (TST) test per MDH [Minnesota Department of Health] recommendations. Suggested Method of Correction: The director of nursing could review and revise policies and procedures regarding completion of tuberculin skin testing for health care workers and audit the implementation of those policies and procedures to ensure on-going compliance. Nursing staff could be re-educated on the requirements for tuberculin skin testing. Time Period For Correction: Twenty-one (21) days.	21426		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the	21525		5/20/14

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21525	Continued From page 24 provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained. This MN Requirement is not met as evidenced by: Based on interview and document review, the consultant pharmacist failed to review blood pressure and pulse ranges to evaluate therapeutic effectiveness and identify potential concerns with low pulse rates for 1 of 5 residents (R6) reviewed for unnecessary drugs who received multiple anti-hypertensive medications. Findings include: R6's most recent physician's progress note, dated 4/22/14, indicated R6's diagnoses included diabetes, hypertension, chronic pain, hypothyroidism, anemia and chronic kidney disease. R6's most recent physician's order sheets, dated 4/21/14, identified orders for metoprolol succinate (extended release) ER tablet (an anti-hypertensive medication that lowers the pulse rate and reduces the force of heart contractions) 24 hour give 100 milligrams (mg) by mouth daily for essential hypertension, Cozaar (an anti-hypertensive medication) give 50 mg orally twice a day for essential hypertension and Cardura (doxazosin mesylate) give two mg orally daily for hypertension.	21525	corrected	

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21525	Continued From page 25 R6's vital sign recordings for the months of March and April 2014, revealed R6's pulse was taken ten times, of these recordings eight of ten were below 60, with a warning notation generated by the electronic medical record "Low of 60.0 exceeded." Review of R6's blood pressure readings for the same time period revealed systolic blood pressures in excess of 180 millimeters of mercury (mm Hg) five out of 11 recordings. Additional blood pressure and pulse information was reviewed for the previous six months and revealed a consistent pattern of documented pulses in the 50's per minute and blood pressures running over 180 mm Hg systolic. R6's most recent physician progress notes, dated 4/22/14, revealed a blood pressure of 199/74. The progress notes revealed R6's primary physician (MD)-C made a comment that R6's vitals were reviewed and listed a diagnosis of hypertension. No other evidence was noted on R6's chart that the pattern of elevated blood pressures or decreased pulses were evaluated to determine if the current drug regimen was effective, or if parameters for administration of the metoprolol should be defined. R6's pharmacy consultant documentation was reviewed. No irregularities had been identified for the previous 10 month period. During interview on 5/01/14, at 9:15 a.m. licensed practical nurse (LPN) -A said she would not give the metoprolol for a pulse below 60 and confirmed staff were not routinely checking R6's pulse prior to the administration of the metoprolol and confirmed this was not indicated on R6's electronic medication administration record.	21525		

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	00021	A. BUILDING: _____ B. WING _____	05/01/2014

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GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

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21525	Continued From page 26 During interview on 5/1/14, at 9:30 a.m. the consultant pharmacist (CP) said he would usually hold metoprolol for a pulse less than 60. The CP voiced concern about R6's consistently low pulses and high blood pressures and stated "holy cow" when R6's blood pressure readings for March and April were reviewed at this time via phone. The CP stated staff needed to flag elevated blood pressure readings for him to review and stated if staff did not tell him of problems with resident vital signs, he would typically have to ask in order to know if there were concerns. The CP said every once in a while someone would print a vital sign report for him but up until now had not had access to the computer and had difficulty getting the information he needed for the drug reviews, and confirmed he had not been reviewing R6's blood pressure readings. The CP indicated he just received access to the vital signs portal in resident electronic records and would now be able to review this information. During interview on 5/1/14, at 12:48 p.m. R6's physician (MD-C) stated R6's blood pressures were very difficult to control due to R6's compromised renal function. MD-C also stated she had been working in conjunction with cardiology regarding the treatment of R6's unstable blood pressures. MD-C stated low pulses would be more of a concern if R6 was ambulatory and she is not so she did not feel the low pulses were a concern. MD-C said she reviewed vital signs information at rounds as the facility printed out a report for her and personally took them herself at clinic appointments. MD-C stated she reviewed resident vital signs information during rounds as the facility provided a printed report as well as personally checking R6's blood pressure reading herself during R6's	21525		

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21525	Continued From page 27 clinic appointments. The facility policies for vital signs, last revised on 11/13, lacked guidelines for expected normal parameters for pulse or blood pressures. Suggested Method of Correction: The director of nursing (DON) and the Consulting Pharmacist could establish a system to monitor that blood pressures and pulse ranges are reviewed for theraputic ranges and parameters for administration are established. The DON could randomly audit the system to ensure interventions are being addressed and report to the quality assurance committee. Time Period For Correction: Twenty one- (21) days.	21525		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General 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	21535		5/20/14

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21535	Continued From page 28 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 low pulse rates were reviewed with the physician in order to address potential concerns with medication adverse reactions and failed to demonstrate elevated blood pressures were reviewed in order to evaluate the effectiveness of multiple antihypertensive medications including a beta-blocker (a class of medications used to treat hypertension that reduces the rate and force of heart muscle contraction) for 1 of 5 residents (R6) reviewed for unnecessary drugs. Findings include: R6's quarterly Minimum Data Set dated 1/23/14, indicated R6 had moderate cognitive impairment and required extensive staff assistance for all activities of daily living. R6's most recent physician's progress notes, dated 4/22/14 identified active diagnoses of diabetes, hypertension, chronic pain, hypothyroidism, anemia and chronic kidney disease. R6's most recent physician's order sheets, dated 4/21/14, identified orders for metoprolol succinate (extended release) ER tablet (a beta-blocker) 24 hour give 100 milligrams (mg) by mouth daily for	21535	corrected	

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21535	Continued From page 29	21535		

essential hypertension, Cozaar (an antihypertensive medication) give 50 mg orally twice a day for essential hypertension and Cardura (doxazosin mesylate) give two mg orally daily for hypertension.

R6's vital sign recordings for the months of March and April 2014 revealed R6's pulse was taken ten times, of those recordings eight of ten were below 60, with a warning notation generated by the electronic medical record "Low of 60.0 exceeded." Review of R6's blood pressure readings for the same time period revealed systolic blood pressures in excess of 180 millimeters of mercury (mm Hg) five out of 11 recordings. Additional blood pressure and pulse information was reviewed for the previous six months and revealed a consistent pattern of documented pulses in the 50's and blood pressures running over 180 mm Hg systolic.

R6's most recent physician progress notes, dated 4/22/14, revealed a blood pressure of 199/74. The progress notes revealed that her primary physician (MD)-C made a comment that R6's vitals were reviewed and listed a diagnosis of hypertension. No other evidence was noted on R6's chart which indicated the pattern of elevated blood pressures or decreased pulses was evaluated to determine if the current drug regimen was effective, or if parameters for administration of the metoprolol should be defined.

During interview on 5/01/14, at 9:15 a.m. licensed practical nurse (LPN)-A said she would not give the metoprolol for a pulse below 60 and confirmed staff was not routinely checking R6's pulse prior to the administration R6's metoprolol as this directive was not indicated on R6's

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21535	Continued From page 30 electronic medication administration record. During interview on 5/1/14, at 9:30 a.m. the consultant pharmacist (CP) said he would usually hold metoprolol for a pulse less than 60. The CP was concerned about the consistently low pulses and high blood pressures and stated "holy cow" when R6's blood pressure readings for March and April were reviewed at this time via phone. On 5/1/14, at approximately 10:30 a.m. R6 was observed resting in her room in a chair. R6 was pale in color and was unable to answer basic questions about how she felt or how long she had resided at the facility. During interview on 5/1/14, at 12:48 p.m. MD-C stated R6's blood pressures were very difficult to control due to R6's compromised renal function. MD-C also stated she had been working in conjunction with cardiology regarding the treatment of R6's unstable blood pressures. MD-C stated low pulses would be more of a concern if R6 was ambulatory and she was not therefore she was not concerned with R6's irregular pulse. MD-C said she reviewed resident vital signs information during facility rounds as the facility provided a printed report as well as personally checking R6's blood pressure reading herself during R6's clinic appointments. The manufacturer's package insert for metoprolol succinate ER from McKesson Packaging Services Business Unit of McKesson, revised 2/2011, revealed bradycardia (slow pulse) was a common side effect of metoprolol and that metoprolol would be contraindicated in a patient with severe bradycardia. The facility policies for vital signs, revised on	21535		

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21535	Continued From page 31 11/13, lacked guidelines for expected normal parameters for pulse or blood pressures. Suggested Method of Correction: The director of nursing and/or their designee could review and revise policies/procedures related to monitoring medications for adverse effects and medication effectiveness. All nursing staff could be re-educated on these policies and procedures. An auditing tool could be developed, with results being shared with the facility's quality assessment and assurance committee, to ensure ongoing compliance. Time Period For Correction: Twenty-one (21) days.	21535		