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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OMMG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00078

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/02/2016** (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 **43** (L18)
13.Total Certified Beds **43** (L17)

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

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
	43			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor — 06/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 07/12/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/12/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245523

July 12, 2016

Mr. Gordon Hormann, Administrator
Good Samaritan Society - Clearbrook
305 3rd Avenue Southwest
Clearbrook, Minnesota 56634

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 May 31, 2016 the above facility is certified for:

43 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 6, 2016

Mr. Gordon Hormann, Administrator
Good Samaritan Society - Clearbrook
305 3rd Avenue Southwest
Clearbrook, Minnesota 56634

RE: Project Number

Dear Mr. Hormann:

On May 3, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 21, 2016. 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 June 2, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 6, 2016 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 April 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 31, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 21, 2016, effective May 31, 2016 and therefore remedies outlined in our letter to you dated May 3, 2016, will not be imposed.

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

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
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245523 Y1	A. Building B. Wing Y2	6/2/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0221	Correction	ID Prefix F0272	Correction	ID Prefix F0279	Correction
Reg. # 483.13(a)	Completed	Reg. # 483.20(b)(1)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed
LSC	05/31/2016	LSC	05/31/2016	LSC	05/31/2016
ID Prefix F0282	Correction	ID Prefix F0312	Correction	ID Prefix F0315	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(d)	Completed
LSC	05/31/2016	LSC	05/31/2016	LSC	05/31/2016
ID Prefix F0412	Correction	ID Prefix F0441	Correction	ID Prefix F0456	Correction
Reg. # 483.55(b)	Completed	Reg. # 483.65	Completed	Reg. # 483.70(c)(2)	Completed
LSC	05/31/2016	LSC	05/31/2016	LSC	05/31/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	06/06/2016	28035	06/02/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/21/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245523 Y1	A. Building 01 - 1953 BUILDING WITH ADDITIONS B. Wing Y2	6/6/2016 Y3

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

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0018	05/31/2016	LSC	K0029	05/31/2016	LSC	K0038	05/31/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #		Completed
LSC	K0056	04/22/2016	LSC	K0144	04/26/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TL/mm	06/06/2016	36536	06/06/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/21/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: OMMG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00078

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/21/2016** (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 **43** (L18)

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Jana Bromenshenkel, HFE NE II 05/10//2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 05/11/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 3, 2016

Mr. Gordon Hormann, Administrator
Good Samaritan Society - Clearbrook
305 3rd Avenue Southwest
Clearbrook, Minnesota 56634

RE: Project Number S5523024

Dear Mr. Hormann:

On April 21, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: 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 May 31, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 31, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 21, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 21, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: 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
	245523	A. BUILDING _____ B. WING _____	04/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify a zipped back full body suit as a restraint for 1 of 1 resident (R29) observed wearing a zipped back body suit which prevented normal access to his body. Findings include: R29's Diagnosis Report dated 4/21/16, indicated R29 had diagnoses which included Frontotemporal dementia (progressive nerve cell	F 221	F221: D 1. R29 reassessed with one piece zip back suit used to prevent skin breakdown and self-induced traumatic skin injury. Suits were removed from resident□s closet and are no longer in use. Care plan updated to reflect. 2. All current residents reviewed for criteria to match restraint status and no further restraints identified in facility. 3. All residents will be reviewed on admission and quarterly for restraint use.	5/31/16

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

Electronically Signed | 05/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245523	A. BUILDING _____ B. WING _____	04/21/2016

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F 221	Continued From page 1 loss in the frontal or temporal lobes of the brain causing deterioration in behavior and personality, language disturbances, or alterations in muscle or motor functions), obsessive-compulsive personality disorder (OCD), dementia with behavioral disturbance and dermatitis. R29's quarterly Minimum Data Set (MDS) dated 3/4/16, indicated R29 had severe cognitive impairment, required extensive assistance for dressing, eating, personal hygiene, transfer and toilet use and required supervision for ambulation. R29's MDS assessment for restraint use indicated "not used" for bed rail, trunk restraint, limb restraint and other. R29's Behavioral Symptoms Care Area Assessment dated 9/5/15, indicated R29 had dementia, poor safety awareness, was impulsive and had obsessive-compulsive disorder. The CAA indicated R29 wandered every few days but not every day. The CAA also indicated R29 tended to want to scratch his backside to the point of tearing his skin and staff had applied lotions and he had been treated for yeast as well in the past with no improvement. The CAA further indicated R29 wore one piece clothing to prevent him hurting himself. However, as R29 could not toilet himself this was not considered a restraint. The Physical Restraint Care Area Assessment (CAA) did not trigger for CAA completed 9/5/15. R29's Care Plan dated 3/23/15, indicated R29 had a behavior symptom related to frontotemporal dementia with behavior disturbance, psychosis and OCD. The Care Plan directed staff to monitor for spreading/eating	F 221	If any article restricts ones access to their body it will be deemed a restraint. All restraints will be handled per Policy and Procedure including MD order and will be care planned accordingly. All nursing staff will be educated on 5-18-16 on appropriate use of and definition of restraints along with correct procedure for use and care planning. 4. DNS or designee will complete audits monthly x4 months and then random audits to follow to monitor restraint use and ensure staff are following correct procedure if in use. All findings will be reviewed by QA committee with action taken as needed. 5. Completion date 5-31-16.	

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F 221	Continued From page 2 inappropriate items and to attempt non-pharmacological interventions which included: wear back zip outfit when possible. The Care Plan indicated the back zip outfit was not a restraint as R29 did not toilet self or participate any part of toileting. The Care Plan lacked the required monitoring and a measurable goal related to the rationale for the suit's use. The Order Summary Report dated 4/1/2009-4/30/16, lacked an order for the use of a one piece, back zipping garment. On 4/20/2016, at 8:25 a.m. R29 was observed seated in a wheelchair in the dining room. R29 was dressed in shirt that was tucked into sweat pants and suspenders. -At 9:07 a.m. nursing assistant (NA)-E wheeled R29 from the common area back to his room. NA-E stated R29 wore a back zip up suit at times, but stated he had not been wearing one lately as the zipper was broken. NA-E also stated R29 could wear either type of clothing but indicated they would put the back zip up suit on him when he was due to have a bowel movement as R29 would "dig" in his rectum. On 4/21/2016, at 8:49 a.m. R29 was observed seated in a wheelchair in the common area. R29 was wearing a one piece suit that had a khaki colored top and navy blue bottom with a zipper up the back of the garment. R29 was reaching his right hand behind his back. NA-B encouraged R29 to remove his arm from behind his back and proceeded to wheel him to his room. NA-B was observed to unzip the rear zipper and remove the	F 221		

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F 221	Continued From page 3 top portion of the suit to check R29's incontinent brief. NA-B stated R29 wore the one piece zippered outfit because he scratched and dug at his buttocks. NA-B stated R29 liked to put his hands in his pockets or behind his back to scratch or dig and the suit prevented him from gouging his skin. On 4/21/2016, at 9:14 a.m. the director of nursing (DON) stated they did not use restraints in the facility and there were no restraints currently in use in the building. -At 9:38 a.m. the DON stated R29 wore the one piece back zip up suit because he would dig gouges in his bottom. However, she stated he did not wear it all the time. At the same time, registered nurse (RN)-B, also stated R29 did not wear the suits at night nor wear them every day. Both the DON and RN-B verified they had not considered the suit a restraint. RN-B verified she had not identified the suit as a restraint on the MDS assessment. The DON confirmed the suit limited R29's access to his own body. On 4/21/2016, at 9:58 a.m. NA-B verified R29 could not remove the body suit himself. The Physical Restraints procedure dated 9/2012, defined a physical restraint as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily that restricted freedom of movement or normal access to one's own body. The procedure indicated if the device, material or equipment could not be removed easily by the	F 221		

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F 221	Continued From page 4 resident and restricts freedom of movement or normal access to one's own body then this was a restraint and the procedure must be followed. The procedure included but was not limited to: obtaining a physician's order for the appropriate restraint to be used, the times to be used and the medical symptom for use and updating the care plan to include the reason for the restraint, the required monitoring and a measurable goal related to the rationale for its use.	F 221		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;	F 272		5/31/16

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F 272	Continued From page 5 Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to identify the use of a zipped back full body suite as a restraint on the quarterly Minimum Data Set for 1 of 1 resident (R29) observed to wear a zipped back body suit which prevented R29's access to own body. Findings include: R29's quarterly Minimum Data Set (MDS) dated 3/4/16, indicated R29 had severe cognitive impairment, required extensive assistance for dressing, eating, personal hygiene transfer and toilet use and required supervision for ambulation. R29's MDS assessment for restraint use indicated "not used" for bed rail, trunk restraint, limb restraint and other. R29's Behavioral Symptoms Care Area Assessment dated 9/5/15, indicated R29 had dementia, poor safety awareness, was impulsive and had obsessive-compulsive disorder. The	F 272	F 272: D 1. R29 reassessed with one piece zip back suit used to prevent skin breakdown and self-induced traumatic skin injury. Suits were removed from resident□s closet and are no longer in use. Care plan updated to reflect. We are unable to modify previous MDS as we are unaware if suit was used during observation period. 2. All current residents reviewed for criteria to match restraint status and no further restraints identified in facility. 3. All residents will be reviewed on admission and quarterly for restraint use. If any article restricts ones access to their body it will be deemed a restraint. All restraints will be handled according to Policy and Procedure including MD order and care planned accordingly. MDS nurse will review all documentation and complete interviews during observation period to determine if restraint is in use for any residents and code accurately on the MDS. All nursing staff will be educated on	

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F 272	Continued From page 6 CAA indicated R29 tended to want to scratch his backside to the point of tearing his skin and staff had applied lotions and he had been treated for yeast as well in the past with no improvement. The CAA further indicated R29 wore one piece clothing to prevent him hurting himself. However, as R29 could not toilet himself this was not considered a restraint. The Physical Restraint Care Area Assessment (CAA) did not trigger for CAA completed 9/5/15. R29's Care Plan dated 3/23/15, indicated R29 had a behavior symptom related to frontotemporal dementia with behavior disturbance, psychosis and OCD. The Care Plan directed staff to monitor for spreading/eating inappropriate items and to attempt non-pharmacological interventions which included: wear back zip outfit when possible. The Care Plan indicated the back zip outfit was not a restraint as R29 did not toilet self or participate any part of toileting. The Care Plan lacked the required monitoring and a measurable goal related to the rationale for the suit's use. The Order Summary Report dated 4/1/2009-4/30/16, lacked an order for the use of a one piece, back zipping garment. On 4/20/2016, at 8:25 a.m. R29 was observed seated in a wheelchair in the dining room. R29 was dressed in shirt that was tucked into sweat pants and suspenders. -At 9:07 a.m. nursing assistant (NA)-E wheeled R29 from the common area back to his room. NA-E stated R29 wore a back zip up suit at times,	F 272	5-18-16 on appropriate use of and definition of restraints along with correct procedure for use and care planning. MDS nurse was educated 4-21-16 on correct coding of MDS in regards to restraints. 4. DNS or designee will complete audits monthly x4 months and then random audits to follow to monitor restraint use and ensure staff are following correct procedure if in use and that the MDS is accurately coded. All findings will be reviewed by QA committee with action taken as needed. 5. Completion date 5-31-16.	

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F 272	Continued From page 7 but stated he had not been wearing one lately as the zipper was broken. NA-E also stated R29 could wear either type of clothing but indicated they would put the back zip up suit on him when he was due to have a bowel movement as R29 would "dig" in his rectum. On 4/21/2016, at 8:49 a.m. R29 was observed seated in a wheelchair in the common area. R29 was wearing a one piece suit that had a khaki colored top and navy blue bottom with a zipper up the back of the garment. R29 was reaching his right hand behind his back. NA-B encouraged R29 to remove his arm from behind his back and proceeded to wheel him to his room. NA-B was observed to unzip the rear zipper and remove the top portion of the suit to check R29's incontinent brief. NA-B stated R29 wore the one piece zippered outfit because he scratched and dug at his buttocks. NA-B stated R29 liked to put his hands in his pockets or behind his back to scratch or dig and the suit prevented him from gouging his skin. On 4/21/2016, at 9:14 a.m. the director of nursing (DON) stated they did not use restraints in the facility and there were no restraints currently in use in the building. -At 9:38 a.m. the DON stated R29 wore the one piece back zip up suit because he would dig gouges in his bottom. However, she stated he did not wear it all the time. At the same time, registered nurse (RN)-B who was the MDS coordinator, also stated R29 did not wear the suit at night nor wear them every day. Both the DON and RN-B verified they had not considered the suit a restraint. RN-B verified she had not	F 272		

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F 272	Continued From page 8 identified the suit as a restraint on the MDS assessment. The DON confirmed the suit limited R29's access to his own body. On 4/21/2016, at 9:58 a.m. NA-B verified R29 could not remove the body suit himself. According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated last revised on May 2013, the "DEFINITIONS PHYSICAL RESTRAINT" was any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. In addition, the manual provided "Steps for Assessment" and directed staff to: --Review the medical record, including physician orders, nurses notes, and NA notes to determine if physical restraints were used. --Considering the physical restraint definition, observe the resident to determine the effect the restraint has on the resident's normal function. --Evaluate if the resident can easily and voluntarily remove the device, material, or equipment. If the resident cannot easily and voluntarily remove the restraint, continue with the assessment to determine whether the device restricts freedom of movement or the resident's access to his own body.	F 272		
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		5/31/16

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F 279	Continued From page 9 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 observation, interview and document review, the facility failed to develop a care plan and interventions related to palliative care 1 of 1 resident (R33) who was receiving palliative care and services. Findings include: R33's significant change Minimum Data Set (MDS) dated 3/13/15, indicated was diagnosed with Alzheimer's dementia and anxiety, had severe cognitive impairment, received palliative care and services and required extensive to total assistance with all activities of daily living. The Delirium Care Area Assessment (CAA) dated	F 279	F 279: D 1. R33 Care plan was updated to reflect Palliative care services and family wishes. MDS nurse was educated 4-20-16 on completion of accurate and up to date Plan of care that reflects residents needs and desires. 2. All current residents Care Plans reviewed and updated as needed to ensure unstable diagnosis are reflected on Care Plan. Current residents reviewed for Palliative care services and updates made as appropriate to reflect current needs. All licensed nurses will receive education on Care Plan development, updating and completion on 5-18-16. 3. Upon admission of new residents a	

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F 279	Continued From page 10 3/13/16, indicated R33 was on palliative care and utilized morphine for pain management. The Falls CAA dated 3/16/16, also indicated R33 was receiving palliative care. R33's progress note dated 2/28/16, indicated R33 was lethargic and was difficult to arouse at times. R33's intake had declined to a few sips and had refused meals. R33 had not voided in several hours. She was on bed rest and her lung sounds were diminished. R33's progress noted dated 2/29/16, indicated R33 had sustained a decline and R33's son had been informed of R33's condition. R33's son approved R33 to begin comfort cares and was agreeable to discontinue medications and informed him of specifics for comfort care/palliative cares. R33's care plan dated 2/15/16, did not address palliative cares/services. During intermittent observation, on 4/19/16, from 8:00 a.m. to 1:20 p.m. R33 was observed to remain in bed. At 1:40 p.m. nursing assistant (NA)-A and registered nurse (RN)-B assisted R33 into a reclining wheelchair via a full body mechanical lift. R33 was observed to sleep off in on in the reclining chair. On 4/20/16, from 8:00 a.m. to 1:40 p.m. R33 was observed to eat her meals in bed. NA-A stated R33 ate breakfast and lunch in bed and would be	F 279	comprehensive review will be completed along with quarterly and prn for existing residents. Care Plan will reflect current unstable diagnosis, resident needs and interventions appropriate to care as per Care Plan Policy and Procedure. With any changes in resident condition, start of Palliative care, Care Plan will be updated. All care plans will be reviewed and updated as needed quarterly and prn. 4. DNS or designee will complete audits on all Palliative care residents Care plans weekly x4 weeks, then 2x/month x2 months then random audits. All findings will be reviewed by QA committee with action taken as needed. 5. Completion date 5-31-16	

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F 279	Continued From page 11 assisted out of bed in the afternoon. He stated R33 would return to bed for supper. On 4/20/16, at 1:50 a.m. licensed practical nurse (LPN)-A stated R33 ate all of her meals in bed. She stated when R33 was out of bed, she became so fatigued that she did not eat her meal. LPN-A stated R33 was to receive palliative cares, staff were to listen to R33 and if she didn't want to eat, they were not to force her. If she wanted to eat, they were to feed her. On 4/20/16, at 9:50 a.m. the director of nurses (DON) stated R33 was started on palliative cares in February 2016, because R33 had been very ill. She stated R33 was not to be transferred to the hospital, many of her medications were discontinued and the staff were to follow R33's wishes related to eating. She stated the family and physician were in agreement with the decision to allow R33 to direct her own care. On 4/20/16, at 12:08 p.m. RN-A stated R33's palliative cares was directed by R33 and her family. She stated palliative care options were discussed with the family when they thought death was imminent. RN-A stated R33 had greatly improved since that time, but remained on palliative care. RN-A confirmed R33's care plan did not address palliative care and services and stated the care plan was in need of development to ensure all staff members understood what type of care R33 was to receive. The Care of the Dying Resident policy dated	F 279		

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F 279	Continued From page 12 9/2012, directed the staff to offer care to the dying resident without fear, pain or sense of being alone. The policy directed the staff to offer support and care to both the family and the resident, but did not direct the staff to develop a care plan to coordinate the care for the resident.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure incontinence care and services were provided according to the care plan for 1 of 3 residents (R19) observed for timely toileting and failed to provide oral care as directed by the care plan for 1 of 2 residents (R18) who required assistance with oral cares. Findings include: R19 was not provided incontinence care before and after meals as directed by the care plan. R19's care plan dated 3/1/16, indicated R19 had frequent to total bladder incontinence and directed staff to toilet R19 before and after meals, upon rising, before bed and twice during the night. R19 was able to use the toilet with the assistance from one staff member and a sit to stand lift or the bed pan.	F 282	F 282 : D 1. R19 Care Plan reviewed. New updated Bladder and Bowel assessments completed and Care Plan updated to reflect most beneficial toileting plan for resident. Primary caregivers updated on changes to toileting plan on 4-25-16. R18 oral care was completed at 1000 on day of observation. R18 Care Plan updated to reflect spacing out ADL□s when resident gets agitated or staff feels he is going to become aggressive with further care and to come back and complete ADL□s at a later time. Reviewed behavioral interventions on Care Plan and Resisting care were appropriate in r/t agitation with care. 2. All residents Care Plans will be updated quarterly and prn to ensure they are accurate representation of care required and behavioral interventions that	5/31/16

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	245523	A. BUILDING _____ B. WING _____	04/21/2016

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

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F 282	Continued From page 13 On 4/19/16, at 12:10 p.m. R19 was observed in her room, seated in a tilt and space wheelchair. Housekeeper (H)-A was in R19's room cleaning the floor with disposable wipes. -At 12:13 p.m. nursing assistant (NA)-C donned a gown and gloves and entered R19's room with R19's lunch in plastic containers. NA-C positioned a folding chair beside R19 and started to feed R19 lunch. NA-C did not check or offer R19 an opportunity to be toileted. -At 12:40 p.m. laundry staff (L)-A entered R19's room and placed R19's recently laundered clothes in R19's closet and dresser. NA-C continued to feed R19 lunch. -At 12:47 p.m. R19 had finished lunch. NA-C tilted R19's wheelchair back, disposed of the plastic dishes and utensils in R19's bathroom, removed her gloves and gown and washed her hands and exited R19's room. NA-C had not checked or offered R19 an opportunity to be toileted prior to exiting R19's room. -At 1:02 p.m. the director of nursing (DON) briefly stopped by R19's room and acknowledged R19. The DON had not offered toileting to R19. -At 1:22 p.m. the activity director (AD) donned a gown and pair of gloves and entered R19's room to spend 1:1 time. -At 1:30 p.m. NA-C donned a gown and pair of gloves and entered R19's room. NA-C and AD transferred R19 from the wheelchair to R19's bed using a mechanical lift. NA-C and NA-D proceeded to change R19's incontinent brief. R19's perineal area was observed to be reddened. NA-C confirmed R19's brief was wet and R19's bottom and perineal area were reddened. NA-C applied barrier cream to R19's bottom and placed a new brief. -At 1:40 p.m. NA-C confirmed she had checked R19's brief at 9:45 a.m. when she had	F 282	are needed. Nursing Staff will be educated on 5-18-16 regarding following Plan of care and notifying Licensed Nurse regarding changes to Care Plan that are needed or interventions that are more appropriate. 3. Upon admission of new residents a comprehensive review will be completed along with quarterly and prn for existing residents. Care Plan will reflect current unstable diagnosis, resident needs and interventions appropriate to care as per Care Plan Policy and Procedure. With any changes in resident condition Care Plan will be updated. All care plans will be reviewed and updated as needed quarterly and prn. Staff will follow Care Plan to ensure needs are met in a timely fashion. 4. DNS or designee will complete observation audits and care plan review 2x/week x 4 weeks, then weekly x 4 weeks then 2x/month x 4 weeks, then random observation audits on personal care including toileting and oral care in relation to Care Plan interventions. All findings will be reviewed by QA committee with action taken as needed. 5. Completion date 5-31-16	

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F 282	Continued From page 14	F 282		

repositioned R19. NA-C stated she had not changed R19's brief at that time because R19's brief had only been a little wet. NA-C confirmed this had been the last time R19's brief had been checked. (three hours and 55 minutes earlier)

On 4/20/16 at 12:51 p.m. the DON verified R19's care plan directed staff to provide incontinence care before and after meals and confirmed it would be her expectation that staff followed R19's care plan.

R18 did not receive oral cares as directed by the care plan.

R18's care plan dated 6/10/15, indicated R18 had three lower decayed teeth and directed staff to assist with oral cares twice a day.

On 4/20/16, at 7:30 a.m. NA-A was observed to assist R18 with morning cares. NA-A was not observed to assist R18 with oral cares.

On 4/20/16, at 7:50 a.m. R18 was observed to talk to NA-A. R18 was observed to have a single tooth in his lower gum along with broken root tips. R18 was then wheeled to the upper level dining room. Oral cares were not offered or provided.

On 4/20/16, at 9:00 a.m. NA-A assisted R18 back to his room and assisted him to use a urinal. When completed, NA-A wheeled R18 to the lower level lobby area. Oral cares were not offered nor provided.

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F 282	Continued From page 15 On 4/20/16, at 9:10 a.m. NA-A confirmed he had not completed oral care for R18 during morning cares or after breakfast. On 4/20/16, at 12:20 p.m. registered nurse (RN)-A stated R18 should have received oral cares as directed by the care plan. Care plan policy dated 9/2012, indicated the care plan emphasized the care and development of the whole person ensuring the resident received appropriate care and services.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately complete a dental assessment which reflected true dental status and failed to provide assistance with oral cares for 1 of 2 residents (R18) in the sample who had missing and decayed teeth, was dependent on staff for oral hygiene and was not provided oral care. Findings include:	F 312	F 312: D 1. R18 had new oral dental assessment completed on 4-20-16. Care Plan updated to reflect oral/dental status. Oral care was completed on resident at 1000 on day of observation. R18 Care Plan updated to reflect spacing out ADL□s when resident gets agitated or staff feels he is going to become aggressive with further care and to come back and complete ADL□s at a later time. Reviewed behavioral	5/31/16

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F 312	Continued From page 16 R18's quarterly Minimum Data Set (MDS) dated 3/14/16, indicated R18 had severe cognitive impairment, had a stroke with one side paralysis (hemiparesis) and required extensive assistance with all activities of daily living and had no concerns with his teeth. R18's admission MDS dated 6/16/16, did not identify any concerns with R18's teeth. R18's Oral/Dental Assessment dated 6/10/15, indicated R18 had his own natural teeth. The assessment did not identify any concerns with R18's teeth. R18's medical record lacked indication R18 had been evaluated by a dentist. R18's care plan dated 6/10/15, indicated R18 had three lower decayed teeth and directed staff to assist with oral care twice a day. On 4/20/16, at 7:30 a.m. nursing assistant (NA)-A was observed to assist R18 with morning cares. NA-A was not observed to assist R18 with oral cares. -At 7:50 a.m. R18 was observed to talk to NA-A. R18 was observed to have a single tooth in his lower gum along with broken root tips. R18 was then wheeled to the upper level dining room. Orals cares were not offered nor provided. -At 9:00 a.m. NA-A assisted R18 back to his room	F 312	interventions on Care Plan and Resisting care were appropriate in r/t agitation with care. 2. All residents oral/dental assessments reviewed for completion in the last quarter. All residents will have updated oral/dental assessments completed quarterly and prn. Nursing Staff will be educated on 5-18-16 regarding following Plan of care, Completion of oral/dental assessment and Oral care Procedure. 3. All new residents will have oral/dental assessment completed on admission with accurate representation of oral/dental status. All new and existing residents will receive care as per Care Plan. All Care Plans will be reviewed quarterly and prn with changes. 4. DNS or designee will complete observation/documentation audits 2x/week x 4 weeks, then weekly x 4 weeks then 2x/month x 4 weeks, then random observation/documentation audits on oral care and oral/dental assessments. All findings will be reviewed by QA committee with action taken as needed. 5. Completion date 5-31-16.	

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F 312	Continued From page 17 and assisted him to use a urinal. When completed, NA-A wheeled R18 to the lower level lobby area. Oral cares were not offered nor provided. -At 9:10 a.m. NA-A confirmed he had not completed oral care for R18 during morning cares or after breakfast. On 4/20/16, at 12:20 p.m. registered nurse (RN)-A stated R18 should have received oral cares as directed by the care plan. She stated R18 had a few natural decayed teeth and confirmed the oral assessment did not accurately reflect his dental status. On 4/21/16, at 9:15 a.m. the director of nurses stated R18 had three natural teeth, one in the front and two further in the back of his mouth that were not easily seen. She stated R18 had several root tips in the gum line that could be seen. She confirmed the oral assessment did not accurately reflect R18's dental concerns and reported NA-A completed oral cares for R18 at 10:00 a.m. on 4/20/16. The Dental/Oral Policy dated 9/2012, directed the staff to ensure an accurate assessment of the residnets' dental needs. The policy did not direct the staff to provide oral cares.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a	F 315		5/31/16

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F 315	Continued From page 18 resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely assistance with toileting had been provided for 1 of 3 residents (R19) who required assistance and was observed to have been incontinent of urine. Findings include: R19's care plan dated 3/1/16, indicated R19 had frequent to total bladder incontinence and directed staff to toilet R19 before and after meals, upon rising, before bed and twice during the night. R19 was able to use the toilet with the assistance from one staff member and a sit to stand lift or the bed pan. R19's quarterly Minimum Data Set (MDS) dated 3/17/16, indicated R19 had severe cognitive impairment, was frequently incontinent of bowel and bladder, and required extensive assist with personal hygiene and toileting. R19's urinary incontinence and indwelling catheter Care Area Assessment (CAA) dated 12/11/15, indicated R19 was frequently incontinent and required extensive assistance with toileting.	F 315	F315: D 1. R19 Care Plan reviewed. New updated Bladder and Bowel assessments completed and Care Plan updated to reflect most beneficial toileting plan for resident. Primary caregivers updated on changes to toileting plan 4-25-16. 2. All residents Care Plans will be updated quarterly and prn to ensure they are accurate representation of care required. New Bowel and Bladder Assessments will be completed annually and with change in condition. Nursing Staff will be educated on 5-18-16 regarding following Plan of care, timely toileting per Care Plan interventions, and notifying Licensed Nurse regarding changes that are needed to interventions that would serve the resident needs more appropriately. 3. Upon admission of new residents a comprehensive review will be completed along with quarterly and prn for existing residents. Care Plan will reflect current unstable diagnosis, resident needs and interventions appropriate to care as per Care Plan Policy and Procedure. With	

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F 315	Continued From page 19 R19's Diagnosis Report printed on 4/21/16, indicated R19 was diagnosed with anemia, enterocolitis (inflammation of both the small intestine and colon) due to clostridium difficile (a bacteria), and Alzheimer's. R19's Positioning Assessment and Evaluation dated 3/25/16, indicated R19 was incontinent of bowel and bladder and utilized a total lift for transfers when weak and a sit to stand lift for all other transfers. R19's Bladder Incontinence Data Collection Tool dated 12/6/15, indicated R19 was incontinent a large amount more than twice per shift. On 4/19/16, at 12:10 p.m. R19 was observed in her room, seated in a tilt and space wheelchair. Housekeeper (H)-A was in R19's room cleaning the floor with disposable wipes. -At 12:13 p.m. nursing assistant (NA)-C donned a gown and gloves and entered R19's room with R19's lunch in plastic containers. NA-C positioned a folding chair beside R19 and started to feed R19 lunch. NA-C did not check nor offer R19 an opportunity to be toileted. -At 12:40 p.m. laundry staff (L)-A entered R19's room and placed R19's recently laundered clothes in R19's closet and dresser. NA-C continued to feed R19 lunch. -At 12:47 p.m. R19 had finished lunch. NA-C tilted R19's wheelchair back, disposed of the plastic dishes and utensils, removed her gloves and gown, washed her hands and exited R19's room. NA-C did not check nor offer R19 an opportunity to be toileted prior to NA-C exiting R19's room. -At 1:02 p.m. the director of nursing (DON) briefly	F 315	any changes in resident condition Care Plan will be updated. All care plans will be reviewed and updated as needed quarterly and prn. Staff will follow Care Plan to ensure needs are met in a timely fashion. 4. DNS or designee will complete observation audits /Care Plan review 2x/week x 4 weeks, then weekly x 4 weeks then 2x/month x 4 weeks, then random observation audits on toileting per Care Plan. All findings will be reviewed by QA committee with action taken as needed. 5. Completion date 5-31-16	

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F 315	Continued From page 20	F 315		

stopped by R19's room and acknowledged R19. The DON did not offered toileting to R19.
-At 1:22 p.m. the activity director (AD) donned a gown and pair of gloves and entered R19's room to spend 1:1 time.
-At 1:30 p.m. NA-C donned a gown and pair of gloves and entered R19's room. NA-C and NA-D transferred R19 from the wheelchair to R19's bed using a mechanical lift. NA-C and NA-D proceeded to change R19's incontinent brief. R19's perineal area was observed to be reddened. NA-C confirmed R19's brief was wet and R19's bottom and perineal area was reddened. NA-C applied barrier cream to R19's bottom and placed a new brief.
-At 1:40 p.m. NA-C confirmed she had checked R19's brief at 9:45 a.m. when she had repositioned R19. NA-C stated she had not changed R19's brief at that time because R19's brief had only been a little wet. NA-C confirmed this had been the last time R19's brief had been checked. (three hours and 55 minutes earlier)

On 4/20/16 at 12:51 p.m. the DON verified R19's care plan directed staff to provide incontinence care before and after meals and confirmed it would be her expectation that staff followed R19's care plan.

Incontinence Products policy dated 2/2016, indicated skin should be as dry and clean as possible. In addition, based on the assessment, products should be changed and skin care provided.

Care plan policy dated 9/2012, indicated the care plan emphasized the care and development of the whole person ensuring the resident received appropriate care and services.

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F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine dental services for 1 of 3 residents (R45) reviewed with dental concerns. Findings include: R45's admission Minimum Data Set (MDS) dated 1/27/16, indicated R45 had severe cognitive impairment and diagnoses which included hemiplegia (paralysis of one side of the body), seizure disorder, and cerebrovascular disease (a group of conditions that affect circulation of blood to the brain). The MDS also indicated R45 required extensive assist of one for bed mobility, locomotion on unit, dressing, toilet use and personal hygiene, required limited assist of one for transfer and ambulation and was independent with eating. The MDS further indicated R45 had no dental concerns which included but was not limited to no natural teeth or tooth fragments,	F 412	F412- D 1. R 45 had new oral/dental assessment completed on 4-25-16. Dental exam was completed on 4-27-16. No problems or cavities found and dentist reported good overall oral health. Resident denies oral pain. 2. All residents reviewed for completion of oral/dental assessment per Policy and Procedure. All residents will have Oral/Dental Assessments completed quarterly and prn with changes/problems. Nursing staff will be educated on 5-18-16 regarding completion of and best practice for Oral/dental Assessments. Residents will be notified in resident council meeting on 5-31-16 regarding Oral care needs and how to notify staff if having pain or concerns regarding oral health and assistance with setting up dental appointments. 3. All new residents will have oral/dental	5/31/16

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F 412	Continued From page 22 abnormal mouth tissue, obvious cavity or loose natural teeth, inflamed or bleeding gums, mouth or facial pain, discomfort or difficulty with chewing. Review of the Medicare 5 day MDS dated 3/3/16, and Medicare 14 day MDS dated 3/10/16, revealed the dental sections were left blank. In addition, the Dental Care Area Assessment (CAA) did not trigger for completion. R45's Care Plan dated 1/21/16, identified an activities of daily living (ADL) self care performance deficit related to a previous stroke and new seizure activity and a goal to improve current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene. The care plan directed staff R45 required extensive assist of 1 for bathing, cues for bed mobility or assist of one with weakness, limited assist of one for transfers and dressing and required set up, open packages for eating. On 4/19/2016, at 9:00 a.m. R45 stated she had problems with her teeth and proceeded to open her mouth and point to a back molar on the upper right side. The molar was observed to be black in color. R45 stated she would like to go to the dentist. R45's Nursing Admit Re-Admit Data Collection - V1 dated 1/21/16, was reviewed. The oral section of the physical exam indicated R45 had her own teeth and her tongue, lips and insides of cheeks were moist. A checklist of other oral observations to be assessed included: --broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose)	F 412	assessments completed upon admission and quarterly and prn with existing residents. All new residents will be notified on admission of reporting problems/concerns to nursing staff regarding oral health. Dental appointments will be made for any residents requesting them or with problems that arise. 4. DNS or designee will complete Oral/dental assessments audits for completion following the weekly MDS schedule to ensure assessments are being completed quarterly. This will occur for all MDS scheduled weekly x3 months, then random. All findings will be reviewed by QA committee with action taken as needed. 5. Completion date 5-31-16	

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F 412	Continued From page 23 --No natural teeth or tooth fragment(s) (edentulous) --abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial if one is worn) --obvious or likely cavity or broken natural teeth --inflamed or bleeding gums or loose natural teeth --mouth or facial pain, discomfort or difficulty with chewing --halitosis "None of the above" was indicated for this question. Other unusual observations were described as "missing a few teeth, several fillings, some crowns." The date of last dental exam was indicated as "unknown." On 4/21/2016, at 9:26 a.m. R45 stated she had some pain related to the tooth on the upper right side however, indicated she could still eat her meals. On 4/21/2016, at 9:30 a.m. registered nurse (RN)-B, stated she typically completed an oral assessment upon resident admission and quarterly thereafter. RN-B indicated if a dental problem was identified at the time of assessment the resident's family would be called to determine how they would like to proceed. At the same time, the director of nursing (DON) verified R45's medical record did not include a specific oral/dental assessment other than the physical exam from the Nursing Admit Re-Admit Data Collection. The DON and RN-B both stated they were not aware of any dental complaints from R45 and had not contacted her family or made a referral regarding any dental concerns.	F 412		

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	245523	A. BUILDING _____ B. WING _____	04/21/2016

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F 412	Continued From page 24 On 4/21/2016, at 12:07 p.m. RN-B stated an appointment had been made for R45 to see a dentist. RN-B indicated she had observed R45's tooth and verfied it was black in color and stated it didn't look right. The Oral / Dental Assessment Policy dated 9/2012, directed staff to document the cleanliness of the mouth, any unusual lesions, growths, broken teeth, loose teeth or denture status and need for a dental visit and communicate the need for follow-up to Social Services to coordinate for dental referrals.	F 412		
F 441 SS=D	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 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	F 441		5/31/16

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F 441	Continued From page 25 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 observation, interview and document review, the facility failed to ensure appropriate hand hygiene, personal protective equipment usage and room cleaning procedures were followed for 1 of 1 resident (R19) who was in contact isolation. Findings include: R19's Diagnosis Report printed on 4/21/16, indicated R19 was diagnosed with enterocolitis (inflammation of both the small intestine and colon) due to clostridium difficile (a bacteria). R19's Order Summary Report dated 3/19/16, indicated R19 had been placed on contact isolation precautions due to the diagnosis of	F 441	F441: D 1. All staff were educated on 4-21-16 regarding proper use of PPE for contact precautions along with mandatory hand washing when on precautions during all staff meeting. Contact precautions were reviewed, process for notifying staff of need for precautions reviewed along with risks of not following precautions in place. All staff including but not limited to: housekeeping, laundry, dietary, maintenance, office staff and nursing staff present. On 4-20-16 Ecolab contacted regarding Virasept directions, did send us information regarding dwell time for product. Staff performed deep clean of R19 room and allowed a 10 minute dwell time of product to meet guidelines for CDiff disinfection.	

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F 441	Continued From page 26 clostridium difficile (C. difficile). R19's C. difficile laboratory results dated 3/18/16, confirmed a positive C. difficile result. R19's care plan indicated R19 was on contact isolation precautions. On 4/19/16, at 12:10 p.m. housekeeper (H)-A was observed in R19's room squatted down while wiping the floor with her gloved hands. H-A was not wearing an isolation gown over H-A's uniform. H-A's uniform pants periodically touched the floor while she wiped R19's floor with disposable disinfectant wipes. At 12:12 p.m. H-A entered R19's bathroom, tossed the used disposable wipes in the garbage can, removed her gloves and exited R19's room and walked over the the housekeeping cart which was located across the hallway. H-A lacked washing her hands with soap and water prior to her exit from R19's room. At this time, H-A was interviewed and confirmed she had not washed her hands after she had removed her gloves and prior to exiting R19's room. H-A also stated initially she had donned an isolation gown when she had started to clean R19's room, but had taken it off and had not put on a new one when she re-entered to wash R19's floor. H-A and H-B were unable to articulate the type of isolation precautions R19 was on. On 4/19/16 at 12:40 p.m. laundry (L)-A staff member was observed to enter R19's room without donning any personal protective equipment (PPE) and placed R19's cleaned clothes in R19's dresser and closet. Following this observation, L-A was interviewed and stated she knew R19 was in isolation however, was unaware of R19's type of isolation precautions	F 441	2. No other residents under precautions at this time. With any infections that arise we will follow Policy and Procedure regarding Precautions. Proper disinfection will be completed with the appropriate product and dwell time will be noted prior to use. 3. The Environmental Services director will ensure products used are researched and have correct guidelines prior to use which will include dwell time. All staff have been educated on 4-21-16 and new staff will be educated on hire regarding proper hand washing, use of PPE for various precautions and procedure for various precautions. Staff will also be educated on hire on facility process for notification of residents requiring precautions which includes sign on door to direct them to nurses station prior to entering room, department directors will be notified immediately and will inform their departments along with precaution cart outside of room. Information will also be available in the Care Plan. Staff currently completes infection control training online annually along with PPE training online. 4. Environmental Services Director, DNS or designee will complete audits weekly x4 weeks, then biweekly x4 weeks then monthly x4 weeks then random with staff to ensure knowledge of precautions used, correct procedures, proper PPE, and use of disinfectants. 5. Completion date 5-31-16	

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F 441	Continued From page 27 required. On 4/20/16, at 9:27 a.m. maintenance director (MD) who oversaw the housekeeping staff confirmed H-A should have definitely washed her hands prior to exiting R19's room. On 4/20/16, at 11:42 a.m. H-A and H-B were observed in the process of deep cleaning R19's room as R19's contact isolation precautions had been discontinued. From 11:42 a.m. to 12:00 noon H-A and H-B were continuously observed deep cleaning R19's room. H-A and H-B were donned in isolation gowns and gloves. H-A and H-B sprayed Virasept (an appropriate sporicidal disinfectant used to combat C. difficile bacteria) directly on the beds, furniture, equipment and walls in R19's room and immediately wiped the Virasept spray off with a rag with no dwell time (the amount of time necessary for a disinfectant to obtain maximum effective disinfection of the contacted area). At 11: 47 a.m. H-B stated the Virasept spray they used did not require for it to sit on the furnishings or walls for any length of time prior to it being wiped off. On 4/20/16, at 12:28 p.m. the director of nursing (DON) confirmed Virasept was a sporicidal disinfectant which combated C. difficile. However, the DON was unsure of the dwell time required for the Virasept product. The DON confirmed all staff members which included laundry and housekeeping staff should have been knowledgeable on R19's contact isolation precautions. The DON also confirmed H-A should have worn a gown when washing R19's floor and H-A should have washed her hands with soap and water prior to exiting R19's room.	F 441		

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F 441	Continued From page 28 On 4/21/16, at 8:36 a.m. The DON and the MD both confirmed the Virasept disinfectant solution had a dwell time of ten minutes. The DON stated once they found this out, the housekeeping staff went back in and conducted another deep clean of R19's room. The MD stated the facility had utilized the Virasept product for over a year and unfortunately the facility had not been sent the product informational pamphlet on Virasept from their supplier of this product. Virasept manufacture guidelines (undated) indicated Virasept was an effective product to combat C. difficile endospores after a ten minute exposure time (dwell time) before it was wiped off. Standard or Light Cleaning policy dated 3/16, directed staff to donne appropriate personal protective equipment before cleaning. Clostridium Difficile policy dated 3/16, indicated residents known or suspected of C. difficile would be placed in contact precautions. In addition, gowns should be worn when entering the resident's room and hand hygiene with soap and water should be completed after removal of gloves. Virasept was listed as an appropriate sporicidal disinfectant to combat C. difficile and was directed to be used according to the manufacture guidelines. Contact Precautions policy dated 3/16, indicated gowns should be worn whenever anticipated that clothing would come in direct contact with the resident or potentially contaminated environmental surfaces. In addition, hand hygiene should be completed before exiting the resident's room.	F 441		

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F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure wheelchairs were maintained in good repair for 5 of 5 residents (R7, R19, R29, R30, R37) who were observed to have wheelchairs with cracked and/or torn vinyl with exposed padding. Findings include: On 4/20/16, at 9:00 a.m. the maintenance director (MD) confirmed the maintenance staff looked at the resident's wheelchairs when requested by the nursing staff if something needed to be fixed, repaired or replaced on them. On 4/20/16, at 12:05 p.m. the director of nursing (DON) stated if a resident's wheelchair had torn or cracked vinyl seats and/or arm rests the nursing staff should record this in the maintenance repair log book. The DON confirmed the night nursing assistant staff were responsible for the cleaning and inspection of the resident wheelchairs and verified each resident's wheelchair was cleaned and inspected weekly. On 4/20/16, from 1:02 p.m. until 1:11 p.m. a tour	F 456	F456: E 1. R7, R19, R29, R30, R37□s wheelchairs assessed and concerns added to maintenance log book and items were either repaired or parts have been ordered to repair them. Staff educated on 4-21-16 at all staff meeting regarding reporting torn/cracked vinyl, items that need repair on wheelchairs. 2. All resident wheelchairs checked for broken, cracked, torn surfaces and any other problems and all issues added to maintenance log book. These items have either been repaired or parts ordered to repair them. 3. Upon admission residents wheelchairs will be assessed for concerns and any issues will be placed in log book for maintenance repair. All staff educated on 4-21-16 at all staff meeting regarding reporting these issues for repair. On 5-18-16 all nursing staff will again be educated on reporting and observing for problem areas on wheelchairs, personal care equipment including, tears, cracks, frays, wearing out of items. Night shift will continue to complete weekly cleaning per schedule and include an inspection of equipment for problems and will report via	5/31/16

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F 456	Continued From page 30 was conducted with the DON. The DON confirmed the following observations: -The vinyl on R7's wheelchair arm rests were torn and exposed the foam/cloth padding underneath -The vinyl on R19's wheelchair arm rests were cracked -The back rest of R29's wheelchair was torn and the right arm rest had cracked vinyl -The vinyl on R30's wheelchair arm rests were cracked -The vinyl on R37's wheelchair arm rests were torn and cracked The weekly night shift task list dated 3/29/15, directed staff to clean wheelchairs. R7, R19, R29, R30 and R37 were all assigned a day of the week to have their wheelchairs cleaned. The maintenance repair log for the last month lacked notification to replace or repair the above noted resident's wheelchairs. No policy related to wheelchair maintenance was provided.	F 456	maintenance log book. 4. DNS or designee will complete audits 2x/week x4weeks then weekly x4 weeks then monthly x4 weeks then random audits on resident wheelchairs for problem areas along with ensuring cleaning and inspection is being completed per schedule and that log book is being checked and repairs completed as necessary. 5. Completion date 5-31-16	

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey Good Samaritan Society Clearbrook was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/09/2016

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

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K 000	Continued From page 1	K 000		

and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

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

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

The Good Samaritan Society Clearbrook is a one story building with a full basement. The main building was built in 1953 and has a wood roof system making this building a Type V (000). The facility has additions built in 1962 and 1966, one to the south and one to the east of the original building, which are one story buildings with basements and are Type II (111) construction. These additions are separated with 2- hour fire barriers. In 1999 a basement laundry addition was added to the west of the north wing and was determined to be Type II(111) construction. The basement level is call 1st floor and the 1st story is called 2nd floor.

The facility is completely protected by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 43 beds and had a

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K 000	Continued From page 2 census of 27 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 5 resident room doors according to NFPA 101 LSC (00) section 19.3.6.3.1. This deficient practice could affect the safety of 34 of the 43 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 1:00 pm to 4:00 pm	K 018	K018 Resident room doors 1. Maintenance staff will repair doors to rooms 105, 117, 119, 212, 225 so they will latch shut when closed. 2. Maintenance staff will be checking all doors for proper operation monthly. 3. Maintenance staff will have ongoing monitoring on all doors to prevent future occurrences with repairs/replacement as appropriate. Maintenance was educated on 04-22-16 regarding monitor doors and	5/31/16

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K 018	Continued From page 3 on 04/21/2016 observations and staff interview revealed the following resident rooms did not latch. 105, 117, 119, 212, 225. This deficient condition was verified by the the Environmental Maintenance Director and the Assistant Environmental Maintenance Director.	K 018	maintenance concerns. 4. Maintenance Director/designee will monitor doors for proper function monthly x 3 months then random audits. Findings will be reviewed by QA committee with action taken as needed. 5. Completion Date May 31st, 2016.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the corridor and adjacent areas making them untenable, which could negatively affect the exiting capabilities for 18 of the 43 of residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 1:00 pm to 4:00 pm	K 029	K029 Housekeeping and Linen room doors 1. Housekeeping room 2nd floor North wing did not have a closer and clean linen room 1st floor across from nurses station did not latch. A closer will be added to 2nd floor housekeeping door and needed repairs to 1st floor clean linen room will be made by maintenance to ensure door latches. 2. Maintenance staff will audit all housekeeping and maintenance doors to ensure closers are appropriate if needed and all doors latch. 3. Maintenance staff will have an	5/31/16

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	245523	A. BUILDING **01 - 1953 BUILDING WITH ADDITIONS** B. WING _____	**04/21/2016**

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GOOD SAMARITAN SOCIETY - CLEARBROOK	**305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 4 on 04/21/2016 observations and staff interview revealed the housekeeping storage room on the second floor in the North wing did not have a closer and the clean linen room on the first floor across from the nursing station did not latch. This deficient condition was verified by the the Environmental Maintenance Director and the Assistant Environmental Maintenance Director.	K 029	ongoing monitoring of doors to prevent future issues maintenance staff have been educated on 04/22/16 monitoring doors and maintenance concerns. 4. Maintenance Director/Designee will monitor housekeeping and maintenance doors monthly x 3 months. Then random audits to ensure proper functions. Findings will be reviewed by QA committee with action taken as needed. 5. Completion Date May 31st, 2016	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain a means of egress in accordance with the egress requirements of NFPA 101 Life Safety Code (00) section 7.2.1.5.1, 7.1.6.2 and 7.1.10.1. This decficient practice could affect the safe and efficient exiting of 18 of the 43 residents and an undetermined amount of staff and visitors Findings include: On the facility tour between 1:00 pm to 4:00 pm on 04/21/2016 observations and staff interview revealed: 1. Codes were not displayed near the key pads on the second floor North wing exit and on the first floor west wing exit. 2. The concrete pad on the exterior of the east wing south exit was deteriorated to a point which exceeded the limits of flatness and elevation difference.	K 038	K038 Code placement 1. Codes were not displayed near key pads. Codes have been put in place near all key pads on 04/22/16. a) Concrete pad on exterior of East wing, South exit exceeds the limits of flatness and evaluation equality. 2. Maintenance staff will be checking codes near key pads to ensure the codes remain there and can be read easily. Checks will be made weekly and if any noted concerns arise a new code will be put in place. a) Maintenance staff will be monitoring concrete patch monthly x 6 months to ensure concrete patch remains functional. 3. Maintenance staff will have an ongoing monitoring of codes and concrete patch to prevent future occurrences with	5/31/16

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K 038	Continued From page 5 This deficient condition was verified by the the Environmental Maintenance Director and the Assistant Environmental Maintenance Director.	K 038	replacement and repair as appropriate. Maintenance staff was educated on 04-22 -16 regarding patches and codes. a) Maintenance Director/Designee will conduct weekly key pad audits will be recorded x 8 weeks and random after that. Monthly audits will be conducted x 6 months to ensure concrete replacement/repair is within compliance. Maintenance staff educated regarding monitoring concrete/repairs on 4/26/16. All audits findings will be reported to Quality improvement assurance committee. a) Completion date 05/31/16	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain an automatic fire sprinkler system in accordance with NFPA 101 (2000) Chapter 19, Section 19.3.5 and NFPA 13 (1999) Chapter 5, Section 5-5.5.2.1. In a fire emergency, this deficient practice could adversely affect 2 of 43	K 056	K056 I I Cubicle Curtains 1. Cubicle curtains in room 218 and physical therapy found to have to small of openings for water to pass have been replaced with curtains that meet specifications and code this was done on	4/22/16

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K 056	Continued From page 6 residents and an undetermined amount of staff and visitors. FINDINGS INCLUDE: On the facility tour between 1:00 pm to 4:00 pm on 04/21/2016 observations and staff interview revealed cubicle curtains with too small of openings at the top 18 inches in resident room 216 and the physical therapy room on the first floor next to the Environmental Directors office. This deficient condition was verified by the the Environmental Maintenance Director and the Assistant Environmental Maintenance Director.	K 056	04/22/16. 2. A review of remaining supplies in the facility completed to ensure no other small holed curtains were in stock. Environmental staff and director have gone through all reaming supplies to ensure no other small holed curtains were in stock and none where found. 3. All old curtains have been discarded. All remaining or future ordered curtains will meet and do meet code. Staff educated on 4/22/16 regarding proper curtains with appropriate openings.. 4. Environmental staff will conduct random audits monthly for 4 months to ensure that no curtains with the small holes are in use. Findings will be reviewed by QA committee with action taken as needed. 5. Completion was 04/22/16.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 43 residents, staff, and visitors.	K 144	K144 Generator cool down cycle 1. The generator cool down cycle was not recorded on the monthly log. Cool down period was verified by environmental computer and has now been recorded in the log in the cool down section starting 04/26/16.	4/26/16

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K 144	Continued From page 7 Findings include: On the facility tour between 1:00 pm to 4:00 pm on 04/21/2016 record review and staff interview revealed the generator cool down cycle was not recorded on the monthly log. This deficient condition was verified by the the Environmental Maintenance Director and the Assistant Environmental Maintenance Director.	K 144	2. Maintenance staff will log cool down time on generator weekly. 3. A new log with cool down column has been established 04/25/16 and put in to use on 04/26/16. Staff has been educated on use. 4. Maintenance Director/Designee will monitor the new log for proper use and all columns filled in as appropriate for 8 weeks then random audits to ensure proper use. Findings will be reviewed by QA Committee for further recommendations.. 5. Completion date was 04/26/16	