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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: OW93
Facility ID: 00131

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245441**

2. STATE VENDOR OR MEDICAID NO. (L2) **418840300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - ALBERT LEA**
(L4) **75507 240TH STREET**
(L5) **ALBERT LEA, MN** (L6) **56007**

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 **4/11/2016** (L34)

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**

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

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

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

12.Total Facility Beds **95** (L18)

13.Total Certified Beds **95** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	95			
(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 :
Kathryn Serie, Unit Supervisor 4/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/05/2016 (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 **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245441

April 12, 2016

Ms. Katie Davis, Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

Dear Ms. Davis:

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 April 1, 2016 the above facility is certified for or recommended for:

95 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 95 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

An equal opportunity employer

Protecting, Maintaining and Improving the Health of all Minnesotans

May 5, 2016

Ms. Katie Davis, Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

Dear Ms. Davis:

On March 11, 2016 we sent out an all corrected letter along with the 2567b's for your facility. The 2567b's for the Public Safety, Life Safety Code were send out with an incorrect date for the correction. We have revised the documents. Please review and save a copy for your records.

Feel free to contact me if you have questions.

Sincerely,
Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 12, 2016

Ms. Katie Davis, Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

RE: Project Number S5441025

Dear Ms. Davis:

On March 11, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 25, 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 April 11, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 28, 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 February 25, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 1, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 25, 2016, effective April 1, 2016 and therefore remedies outlined in our letter to you dated March 11, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112

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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
245441 Y1	A. Building B. Wing Y2	4/11/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

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 F0244 Reg. # 483.15(c)(6) LSC	Correction Completed 04/01/2016	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 04/01/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 04/01/2016
ID Prefix F0412 Reg. # 483.55(b) LSC	Correction Completed 04/01/2016	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 04/01/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KS/kfd	DATE 4/12/2016	SIGNATURE OF SURVEYOR 03048	DATE 4/11/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/25/2016

☐ 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
245441 (Y1)	A. Building 01 - ALBERT LEA GOOD SAMARITAN CENTER B. Wing Revised Copy (Y2)	4/1/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

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 Reg. # NFPA 101 LSC K0038	Correction Completed 04/01/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVISED

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 5/5/2016	SIGNATURE OF SURVEYOR 37008	DATE 4/1/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/24/2016	☐ 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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: OW93
Facility ID: 00131

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2. STATE VENDOR OR MEDICAID NO. (L2) **418840300**

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(L3) **GOOD SAMARITAN SOCIETY - ALBERT LEA**
(L4) **75507 240TH STREET**
(L5) **ALBERT LEA, MN** (L6) **56007**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **02/25/2016** (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 **95** (L18)

13. Total Certified Beds **95** (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
	95			
(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 :
Holly Kranz, HFE NE II 03/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/30/2016 (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
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
March 11, 2016

Ms. Katie Davis, Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

RE: Project Number S5441025

Dear Ms. Davis:

On February 25, 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. In addition, at the time of the February 25, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5441032 that was found to be unsubstantiated.

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

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

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 April 5, 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 April 5, 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 May 25, 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 August 25, 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
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.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET ALBERT LEA, MN 56007**

(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. A standard recertification survey was conducted and a complaint investigation was also completed at the time of the standard survey. An investigation of complaint H5441032 was not substantiated during this survey.	F 000		
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure resident council recommendations related to offering card game activities were acted upon for 1 of 5 residents (R29) reviewed for activities.	F 244	F244: Plan of correction: Director of Therapeutic Recreation completed a new Activity Interest Data Collection Tool for R29 and care plan was updated to reflect current preferences. Director of	4/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 03/21/2016

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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	245441	A. BUILDING ______ B. WING ______	02/25/2016

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F 244	Continued From page 1	F 244		

Findings include:

The resident council meeting minutes dated 4/6/15, indicated R29 had expressed he wished there were more activities going on; however, did not offer any further suggestions as to the type of activity. Additionally, another resident (unidentified) asked about the card clubs and stated he wasn't sure they were happening. The 6/1/15 resident council minutes identified resident concerns of frustration about game night, related to staff not having the time to complete it and/or the games getting canceled because no one was there to organize it. The minutes further indicated that "Many Elders stated that they would like to see more activities-especially small group activities such as board games and card games." The resident council minutes from July 2015 thru February 2016 did not address the concerns expressed related to card games. No follow-up was documented any of the meeting minute notes reviewed.

The monthly activity calendar dated May 2015, included three (3) card group activities scheduled for the month. However, after 5/15/2015, no further card groups were indicated on the 2016 activity calendar.

During interview on 2/25/16, at 9:31 a.m. the activities director (A)-A stated another one of her staff (A)-B was the individual responsible for attending resident council. A-A had heard a complaint that residents wanted to have cards, and stated it was up to the residents on game nights to decide what they wanted. The game night could include a board game or cards, no card activities were specifically scheduled. A-A

Therapeutic Recreation will review each residents Activity Interest Data Collection Tool at the time of their quarterly review and update the care plan as needed. A new assessment will be completed annually. Facility suggestion/concern forms will be completed for each grievance that is brought forward at resident council meetings. These grievances will be investigated, followed up on, and reviewed at the following month s resident council meeting with the group. Review of suggestion/concern forms will be added to the monthly QAPI meeting to allow the group the opportunity to ensure all concerns have been properly followed up on. Social services will review the previous 12 months of resident council minutes to ensure all grievances have been properly addressed and followed up on. All staff will be educated on the facilities protocol for addressing resident s suggestion/concern s via nurses meetings and handouts for other disciplines. Corrective action will be completed by 4/1/16. Audits will be completed weekly x 4 and monthly x 3 to ensure the facility is compliant with this regulation. Audits will be referred to the QAPI committee for further recommendations.

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F 244	Continued From page 2	F 244		

stated they had some turnover of staff last summer which was intentional to improve the programming and that card games were a hard activity to provide due to the changing population. In addition, A-A stated activities attendance was tracked in the electronic health record; however, there was not an item code to specifically monitor whether someone attended cards.

During interview on 2/25/16, at 10:49 a.m. A-B stated she was aware residents would like a card group; however, had not put one on the schedule nor formally organized a group since she started working with activities in June 2015. A-B stated a card group was not formed because not all the residents got along or worked well with one another. She indicated she could "sure put it on the calendar." A-B was unaware R29 enjoyed cards per his activities of interest assessment, and stated "I will have to look at those."

During interview on 2/25/16, at 3:58 p.m. A-A stated she was unaware of any recurrent concerns with activities in resident council, and that typically if someone was bored there should be a suggestion/concern form implemented but couldn't recall seeing one for R29.

R29's admission Minimum Data Set (MDS) assessment dated 3/17/15, identified it was somewhat important for him to do activities of interest and to do things with others. No care area assessment (CAA) triggered for activities.

R29's quarterly MDS assessment dated 12/18/15, revealed a Brief Interview for Mental Status (BIMS) score of 15/15 (cognitively intact). R29's activities of interest assessment dated 3/17/15, indicated R29 had played cards in the past.

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F 244	Continued From page 3 During interview on 2/23/15, at 8:46 a.m. R29 stated he did not feel there were enough activities provided to meet his interests, and would like to see more card games being played. R29 stated he could not understand why there was "nothing going on." The facility policy entitled Activity Program, last revised 1/15 indicated the center will provide for an ongoing activities program designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident.	F 244		
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 follow the plan of care which required skin conditions be reported and monitored for 1 of 3 residents (R71) reviewed for non pressure related skin conditions. Findings include: R71 was admitted to the facility with diagnoses including heart failure, congestive heart failure and dementia.	F 282	F282: Plan of Correction: A complete skin observation was completed for R71 on 3/1/16 to ensure any skin conditions present had been documented and reported. All residents in the facility will have skin checks completed weekly. All nursing staff will be educated on the facilities policies and procedures related to reporting of skin conditions and the policy SKIN ASSESSMENT, PRESSURE ULCER PREVENTION, AND DOCUMENTATION REQUIREMENTS	4/1/16

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F 282	Continued From page 4 During an observation on 2/23/16, at 8:48 a.m. a one (1) inch by 0.5 inch dark purple bruise was noted on residents left wrist below his watch band. The bruise was clearly visible; the watch band was not covering the bruise. Resident's watch band was noted to be quite tight. R71 was unable to state how he got the bruise. The care plan revised 10/12/15, identified the problem: "chronic impairment to skin integrity and at risk for pressure ulcers related to fragile skin and decreased mobility, use of oxygen and indwelling catheter as evidenced by chronic blisters in the groin area and bruises easily." The interventions included: monitor location, size and treatment of skin injury, report abnormalities, failure to heal, signs symptoms of infection, maceration, etc. Review of the medical record did not identify the noted bruise on R71's left wrist. The facility weekly skin observation dated 2/23/16, at 7:50 a.m. did not identify the bruise. During interview on 2/25/16, at 11:24 a.m. nursing assistant (NA)-A stated she works this wing all the time and had not noticed the bruise when she assisted R71 to get up. She stated it appears like it came from his watch band. During this interview, when the surveyor and NA were located in R71's room, the identified bruise was clearly visible and not covered by his watch. Interview on 2/25/16, at 1:17 p.m. with registered nurse (RN)-A stated she was unaware of any bruising. RN-A indicated the NA should have noted it while doing cares and reported it to the nurse. She also verified R71 did bruise easily as per the plan of care. During interview with the director of nursing on	F 282	during in-services on 3/17 and 3/22. Those who are unable to attend will receive written education on these topics by 4/1/16. To ensure compliance with this regulation, audits will be done weekly x 4 and monthly x 3. Audits will include spot checks on R71 and a random sample of residents on their skin check day to ensure skin conditions are being reported accurately. Another set of audits will include interviews with nursing staff on the process for reporting and action to be taken when new skin concerns are noted. Audits will be reported to the QAPI Committee for further recommendations.	

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F 282	Continued From page 5 2/25/16, at 3:14 p.m. she stated she would have expected staff to follow the care plan and report the bruise. Review of the facility policy titled, SKIN ASSESSMENT, PRESSURE ULCER PREVENTION AND DOCUMENTATION REQUIREMENTS revised 12/2015, identified: "A systematic skin inspection will be made daily by the nursing assistant assigned to those residents at risk for skin breakdown. The nursing assistant responsible for this will report any abnormal findings or signs of skin impairment to the licensed nurse." Assessment and Documentation of Bruises/Contusions/Skin Tears/Abrasions. "If a bruise, contusion, abrasion or skin tear is observed on a resident, this should be reported to the nurse immediately. The bruise/contusion/skin tear/abrasion should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation UDA and on the resident's care plan."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 309	F309: Plan of Correction: A complete skin	4/1/16

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F 309	Continued From page 6 review the facility failed to identify non- pressure skin issues for 2 of 3 residents (R10, R71) reviewed who had a facial lesion and/or bruising. Findings include: R10 was admitted to the facility with diagnosis including heart failure and non traumatic intracranial brain hemorrhage. During interview with R10 on 2/23/16, at 10:13 a.m. a black scabbed area on the left side of his face, beside his nose was observed. R10 stated he had been asking staff for something to dry the area up for quite awhile. R10 indicated he had requested something as he scratches the area at night and it bleeds. R10 stated staff responded with the comment, well then don't scratch it! R10 was again observed the following day on 2/24/16, at 9:00 a.m. and the black scabbed area on his face was still present. When asked whether staff had addressed the area yet, he stated "nope." Review of the quarterly Minimum Data Set (MDS) dated 1/5/16, identified a BIMS score (Brief Interview for Mental Status) score of 13/15 indicating intact cognition. The MDS also identified R10 required extensive assistance of one staff for personal hygiene. No documentation was found in the chart regarding the lesion to R10's face. The facility weekly skin audit sheet dated 2/15/16 did not identify the lesion. R10 was observed again on 2/25/16, at 8:54 a.m. and R10 reiterated the scabbed lesion had been evident at least a month. When questioned whether he informed anyone, R10 responded that he reported it to several staff but no one did	F 309	observation was completed for R10 on 2/29 and R71 on 3/1/16 to ensure any skin conditions present had been documented and reported. All residents in the facility will have skin checks completed weekly. All nursing staff will be educated on the facility s policies and procedures related to reporting of skin conditions and the policy SKIN ASSESSMENT, PRESSURE ULCER PREVENTION, AND DOCUMENTATION REQUIREMENTS during in-services on 3/17 and 3/22. Those who are unable to attend will receive written education on these topics by 4/1/16. To ensure compliance with this regulation, audits will be done weekly x 4 and monthly x 3. Audits will include spot checks of R10 and R71 and a random sample of residents on their skin check day to ensure skin conditions are being reported accurately. Another set of audits will include interviews with nursing staff on the process for reporting and action to be taken when new skin concerns are noted. Audits will be reported to the QAPI Committee for further recommendations.	

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F 309	Continued From page 7 anything. R10 stated the staff who instructed him not to scratch the lesion was a staff [LPN B]. R10 stated, "yesterday that one came in and asked me about it and said she would get something. It just doesn't seem to go away, it doesn't heal. It is bothersome, it's always there and it's worse than it was before". When interviewed on 2/25/16, at 3:55 p.m. nursing assistant (NA)-B stated she had noticed the scabbed area several days ago and had asked R10 if he was "picking" it. NA-B stated she did not report the skin issue to the nurse. When interviewed on 2/24/16, at 1:14 p.m. registered nurse (RN)-A stated she knew nothing about the area on R10's face. RN-A indicated, "there is nothing on our radar to be watching it." RN-A went to R10's room to observe the area. R10 informed RN-A the identified area was a growth he had for years. RN-A stated R10 may have to see a dermatologist. When interviewed on 2/25/16, at 3:14 p.m. the director of nursing (DON) stated she would have expected staff to report the skin issue noted on R10's face so it could monitored and treated as necessary. R71 was admitted to the facility with diagnoses including heart failure, congestive heart failure and dementia. During an observation on 2/23/16, at 8:48 a.m. a one inch by 0.5 inch dark purple bruise was noted on residents left wrist below his watch band. The bruise was clearly visible, the watch band was not covering the bruise. Resident's watch band was noted to be quite tight. R71 was unable to state	F 309		

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F 309	Continued From page 8 how he got the bruise. Review of the medical record did not identify the bruise to R71's left wrist. The facility weekly skin observation dated 2/23/16, at 7:50 a.m. did not identify the bruise. During interview on 2/25/16, at 11:24 a.m. nursing assistant (NA)-A stated she works this wing all the time and had not noticed the bruise when she assisted R71 to get up. She stated it appears like it came from his watch band. During this interview, when the surveyor and NA were located in R71's room, the identified bruise was clearly visible and not covered by his watch. Interview on 2/25/16, at 1:17 p.m. with registered nurse (RN)-A stated she was unaware of any bruising. RN-A indicated the NA should have noted it while doing cares and reported it to the nurse. She also verified R71 did bruise easily as identified on the plan of care. During interview with the director of nursing on 2/25/16, at 3:14 p.m. she stated she would have expected staff to report the bruise/lesions, investigate where it came from, complete an incident report and monitor the bruise until resolved. Review of the facility policy titled, SKIN ASSESSMENT, PRESSURE ULCER PREVENTION AND DOCUMENTATION REQUIREMENTS revised 12/2015, identified: "A systematic skin inspection will be made daily by the nursing assistant assigned to those residents at risk for skin breakdown. The nursing assistant responsible for this will report any abnormal findings or signs of skin impairment to the	F 309		

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F 309	Continued From page 9 licensed nurse." Assessment and Documentation of Bruises/Contusions/Skin Tears/Abrasions. "If a bruise, contusion, abrasion or skin tear is observed on a resident, this should be reported to the nurse immediately. The bruise/contusion/skin tear/abrasion should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation UDA and on the resident's care plan."	F 309		
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 ensure dental services were offered for 1 of 3 residents (R67) reviewed for dental services and who had oral concerns. Findings include: The facility face sheet identified R67 had diagnosis including dementia and generalized anxiety disorder.	F 412	F412: Plan of Correction: Family of R67 was contacted regarding scheduling a dental appointment. They agreed to an appointment. Facility staff is currently attempting to schedule an appointment for R67 to be seen. Oral/dental assessments will be completed for all long term care residents and dental appointments will be offered/scheduled as needed. Facility staff will continue to complete oral/dental assessments quarterly. Dental	4/1/16

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

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F 412	Continued From page 10 During observation on 2/23/16, at 9:07 a.m. it was noted R67 was missing teeth on the lower right, as well as upper front. It was also noted that an upper tooth on the left was black and decayed. R67 also had strong halitosis (bad breath) noted when talking. R67 was not able to answer interview questions due to severe cognitive impairment and unable to express whether she experienced pain related to the tooth. The quarterly Minimum Data Set (MDS) dated 1/12/16, identified a BIMS (Brief Interview for Mental Status) score of 2/15 indicating severe cognitive impairment. The MDS also identified that R67 required extensive assistance one person physical assistance with personal hygiene which included brushing teeth. The MDS did not identify any dental issues. The oral/dental assessment dated 1/13/16, did not identify any dental issues except the presence of halitosis. The care plan revised on 2/18/14, identified that R67 had her own teeth, upper teeth and a partial plate on the lower; completes oral cares with set up and supervision; R67 to rinse mouth twice a day with mouthwash due to halitosis; and report changes to the nurse. The nursing assistant kardex was the same as the care plan. A review of aides documentation identified that staff did oral care for R67 on 2/18/16. When interviewed on 2/25/16, at 3:55 p.m. nursing assistant (NA)-C stated that staff have to assist R67 with set up for oral care. NA-C indicated staff have to pour the mouthwash in a cup and need to watch her use the mouthwash and at times, staff have to perform the oral care for her, depending on her status that particular day.	F 412	appointments will be offered at least annually and sooner as needed. Offering dental appointments has been added to the social services care conference checklist. Nursing staff will be provided education on the need to provide family members with updates on changes in oral health status. All nursing staff will be also be educated on the need to perform thorough oral assessments and the need for non-licensed staff to report abnormalities noted during oral cares to the nurse during meetings on 3/17 and 3/22. Those not present at meeting will receive written education by 4/1/16. Audits will be completed weekly x 4 and monthly x 3 to ensure compliance with this regulation. Audits will be brought to the QAPI committee for further recommendations.	

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F 412	Continued From page 11 When interviewed on 2/24/16, at 11:13 a.m. registered nurse (RN)-A observed R67's tooth with the surveyor. RN-A stated she had never noticed the blackened tooth and confirmed it appeared rotten. RN-A further stated she would contact the family for advice. RN-A explained that dental assessments are conducted quarterly for each resident. RN-A indicated in the past when R67's partial plate was broken, the family did not want it fixed. RN-A reiterated the family does not want anything done and the staff does not offer dental appointments due to the families past wishes. RN-A stated R67's "bad breath" was an ongoing issue since resident was admitted. No documentation was evident that the family had been offered dental services and refused. RN-A explained that R67 had teeth extracted after admission and needed a new partial since the old partial plate did not fit once the teeth were pulled. A dental referral dated 12/22/11, identified that 3 teeth were extracted; two on left upper and one on lower left. When interviewed on 2/25/16, at 12:37 p.m. RN-A stated she had requested the social worker contact the family about the dental appointment. RN-A stated the social worker had not mentioned the black/discolored tooth nor had RN-A contacted the family related to this issue. RN-A stated the aides had not reported any oral concerns but have indicated that sometimes R67's gums bleed. When interviewed on 2/25/16, at 8:39 a.m. the family member (FM) stated she was unaware of F67's discolored tooth. The FM stated the social worker had called yesterday and asked whether she wanted an appointment for her mother but said nothing about the bad tooth. The FM stated	F 412		

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	245441	A. BUILDING ______ B. WING ______	02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

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F 412	Continued From page 12 she will discuss with other family members but the tooth will need to be fixed and for sure a dental cleaning is needed for R67. When interviewed on 2/25/16, at 8:39 a.m. the social worker (SW) stated RN-A had informed her there was a question from the surveyors related to dental appointments. SW stated she had not discussed dental appointments when she talked with the FM prior to the last care conference. The SW also confirmed she had contacted the FM after RN-A informed her about the dental appointment question. SW stated she was unaware of the concern with the tooth and only questioned the FM whether they desired a dental appointment be set up for R67.	F 412		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431		4/1/16

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F 431	Continued From page 13 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to dispose of discontinued and/or expired medications and failed to ensure controlled medications were accurately reconciled and properly stored. This has the potential to affect any of the 82 residents who routinely receive narcotics and/or antibiotic medications. Findings include: During an inspection of the medication storage room on station 1 on 2/24/15, at 8:30 a.m. with registered nurse (RN)- B the following discontinued medications were available for use and stored in the refrigerator: Amoxicillin (antibiotic) 400/5 milligrams (mg), give for one week, do not use after 12/14/15; Intravenous (IV) Vancomycin (antibiotic) 1100 mg dated 11/25/15 and 1300 mg dated 11/20/15 (resident discharged on 12/13/15); and IV Ceftriaxone (antibiotic) 2000 mg dated 12/23/15 (resident discharged on 1/20/16).	F 431	F431: Plan of Correction: The bottle of Lorazepam for R36 was disposed of per facility protocol and a new supply was obtained from the pharmacy. The expired medications found in the station 1 medication refrigerator were disposed of per facility protocol. The counts of all controlled substances in the facility have been verified by 2 licensed staff. All storage areas will be inspected to ensure that the area can properly accommodate medications. The disposal of medications from the refrigerator on station 1 will be added to the list of tasks to be completed upon a resident s discharge. Checking for expired medications in the refrigerator on station 1 will be added to the list of duties for the nurse on the weekend. Education has been provided to licensed nursing staff on the proper storage of medications and the procedure Controlled Substances. To	

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F 431	Continued From page 14 A bottle of liquid Lorazepam (antianxiety medication, controlled substance) 2 mg/ml (millimeter) prescribed twice daily for R36 was found laying on it's side. The bottle was wet and the label was faded from the medication leaking out. There was observed to be 20 ml in the bottle at this time. RN-B verified the above findings and stated the discontinued medications should have been taken out of the refrigerator and been disposed. She also verified the bottle of Lorazepam was wet. On 2/24/16, at 1:35 p.m. RN-A and the surveyor checked the Individual Resident Narcotic Record (GSS form #247) for the Lorazepam which was kept in the resident's room on station 3. The sign-out sheet indicated there was 0.5 ml Lorazepam administered at 6:00 a.m. and 23.25 mls narcotic remaining in the bottle. The surveyor and RN-A then checked the station 1 medication room. RN-A verified there was only 20 mls remaining in the bottle of Lorazepam. RN-A also confirmed the bottle remained wet, appeared to be leaking, the label was faded and difficult to read. At this time RN-A questioned licensed practical nurse (LPN)-A regarding the Lorazepam. LPN-A stated the previous day (2/23/16) the bottle was wet and the count was about 2 ml off when reconciled. LPN-A also stated the bottle was already wet on Monday (2/22/16) when she worked. RN-A stated staff should have checked to make sure the count was correct and as soon as they discovered the bottle was wet, ordered a new supply, an incident should have been filled out and an investigation started. During interview with the consulting pharmacist	F 431	ensure compliance with this regulation, audits will be completed weekly x 4 and monthly x 3. The audits will be reviewed by the QAPI committee for further recommendations.	

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F 431	Continued From page 15 on 2/25/16, at 3:36 p.m. he stated the liquid Lorazepam left in the bottle should have been reconciled on the count sheet and a new bottle ordered. On 2/25/15, at 3:08 p.m. the director of nursing (DON) verified that upon discovery of the leaking bottle and that the count (ml) was not correct, it should have been reported, discontinued and an incident report completed with subsequent investigation. The facility procedure titled CONTROLLED SUBSTANCES revised 6/14, identified: (1.) One nurse unlocks the controlled substances storage unit and counts controlled drugs, per state regulations, on hand for each resident. (2.) The other nurse assists by watching and verifying the count in the Individual Resident Narcotic Record (GSS 247). or alternate Controlled Drugs - Count Record (GSS #247A). (3.) If the record and actual count are in agreement, both nurses need to initial the Individual Resident Narcotic Record (GSS #247). or Controlled Drugs - Count Record (GSS #247A). (4.) If the count is NOT in agreement with the record, the error must be found or an incident report must be completed and signed in PCC (electronic medical record Point Click Care) prior to the end of the shift and reported to the director of nursing services or designee before leaving the building.	F 431		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING **01 - ALBERT LEA GOOD SAMARITAN CENTER** B. WING ___	**02/24/2016**

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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 FORM 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 - State Fire Marshal Division. At the time of this survey, Good Samaritan Society - Albert Lea was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 03/21/2016

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 By email to: Marian.Whitney@state.mn.us 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. Good Samaritan Society - Albert Lea, is a 1-story building. The building was constructed at 6 different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1968, an addition was constructed and was determined to be of Type II(111) construction. In 1975, an addition was constructed and was determined to be of Type II (111) construction. In 1980, an addition was constructed and was determined to be of Type II(111) construction. In 1997, an addition was constructed and was determined to be of Type II(111) construction In 1998, an addition was constructed and was determined to be of Type II(111) construction Because the original building and the 5 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is automatic sprinkler protected. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire	K 000		

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K 000	Continued From page 2 department notification. The facility has a capacity of 95beds and had a census of 81 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=F	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 interview, the facility has failed to provide a proper exit to the outside. This deficient practice could affect the safe and rapid evacuation of all patients and staff in the event of an emergency that may require quick evacuation in accordance with section 7.1. 19.2.1 Findings include: On facility tour between 10:00 AM to 2:00: PM on 02/24/2016 the Exit access used by ambulance personal is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1. This deficient practice was verified by the facility maintained supervisor, at the time of discovery.	K 038	K038: Plan of Correction: Sound & Media Solutions adjusted the ambulance door push bar to open with less than 15 lbs of pressure after 15 seconds on 3/14/16. Audits of push bars on doors will be done weekly for 3 months.	4/1/16