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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: PLT9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00697

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245593**

2.STATE VENDOR OR MEDICAID NO.
(L2) **713343000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - ST JAMES**
(L4) **1000 SOUTH SECOND STREET**
(L5) **ST JAMES, MN** (L6) **56081**

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 **12/06/2012** (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 IMR**	**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 **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	55			
(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):
At the time of the December 6, 2012 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Mary Whitlock, HFE NEII 01/23/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 02/06/2013 (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
01/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 8953 7334

December 27, 2012

Mr. Timothy Swoboda, Administrator Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

RE: Project Number S5593023

Dear Mr. Swoboda:

Please note that the health and the life safety code surveys are being processed using separate enforcement tracks. The Life Safety Code survey will be processed later.

On December 6, 2012, a standard survey was completed at your facility by the Minnesota Department of Health 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

attained at the time of a revisit;

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:

Maria King, Unit Supervisor
Minnesota Department of Health
12 Civic Center, Plaza Suite #2105
Mankato, Minnesota 56001

Telephone: (507)344-2716 Fax: (507)344-2723

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 January 15, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

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

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 6, 2013 (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 June 6, 2013 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

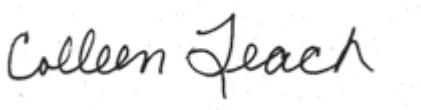
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING _____ B. WING _____	12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow their procedure for locating missing personal items for 1 of 1 resident (R7) who was reviewed for missing items. Findings include: R7 was missing a housecoat and had no resolution of the missing item. During interview on 12/3/12 at 4:02 p.m., R7 stated that she was missing a cotton stripped pink house coat. R7 further added that she had noticed it was missing in the past 2 weeks and verified that she had notified the nurse on duty	F 166	Approved POC mtg 2d 1/10/13	

RECEIVED
JAN 10 2013
Minnesota Dept of Health
Mankato

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tim Swarde	Administrator	1/9/13

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

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F 166	Continued From page 1 when she'd noticed it was missing. She added that the nurse had looked thru her closet and the closets of other residents in an attempt to locate it. R7 stated that the item was still missing and that no staff had followed up with her on resolution of the missing item. The Minimum Data Set (MDS) dated 9/26/12 identified R7 as having no cognitive impairment. Her Brief Interview for Mental Status (BIMS) score was 15/15. During interview with the Licensed Social Worker (LSW) on 12/4/12 at 2:56 p.m., the LSW stated that the facility's missing items procedure was to inform the LSW of items that were missing. The LSW stated she had not been informed that R7 was missing a housecoat. The LSW also stated that a copy of the recently revised Missing Items Procedure had been put into every communication book with a new form that indicated staff were to notify the LSW of missing items. The LSW stated the communication books were required to be read by each staff member. Review of the Resident Council Minutes dated 8/25/12 noted that the LSW had spoken with the residents about the facility's investigative procedure when an item was reported missing. Review of the Missing Item Procedure identified under # 5, "If the item is not found, search other probable center areas, complete Record Of Lost And Found Articles located at each nurses' station." During interview with the LSW on 12/4/12 at 2:58	F 166	The resident who reported a missing item was interviewed by the Social Worker. The item, which had not been found, was replaced by the facility. The Social Worker reviewed the missing items log to determine if any other residents had missing items that were not located. The policy and procedure for missing items was reviewed. An additional clip board with a missing items log was placed in Shepherds Circle. A communication was placed in the communication books at all three Nursing Stations regarding using the procedure for missing items. All staff will receive written education regarding this procedure on 1-9-13 with follow-up education at the January inservices. Audits to ensure compliance with this procedure will be done by the Social Worker weekly for four weeks then monthly for two months, with results forwarded to the Quality Committee for review.	1/9/13

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F 166	Continued From page 2 p.m., she verified that the missing item procedure related to completing the Record Of Lost and Found Articles had not been followed in this case.	F 166		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care 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 plan of care regarding falls and dental for 1 of 3 residents (R35) reviewed for accidents and dental. Findings include: R35 had 6 falls from 8/23/12 to 12/2/12 There	F 279	The residents care plan was revised on 12-5-12 with regards to falls and dental. Residents with recurring falls were identified and their care plans were reviewed and updated if indicated. Residents who have refused dental care and those having dental issues were identified and their care plans were reviewed and updated as indicated. Verbal education with the facilities Case Managers was done on 1-3-13 with regards to falls and dental care planning. Written education will be given to all licensed staff on 1-9-13 with follow-up education at the January inservices. The Director of Nursing will complete audits of fall related incident reports and the care plans to ensure the cares plan has been updated and is being followed. Care plans of residents with identified dental issues, as well as those refusing	1/3/13

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F 279	Continued From page 3 was no plan of care addressing falls. Review of the medical record indicated R35 had a diagnosis of end stage Alzheimer's disease with behaviors. The annual Minimum Data Set (MDS) and Care Area Assessment (CAA) dated 4/4/12, identified R35 as being at risk for falls due to medications that can cause increased risk for falls, a balance and gait problem, impulsivity or poor safety awareness, dementia with delusions and behaviors and cognitive impairment. The falls data collection tool for 11/21/12 and 12/2/12 score 26 with score of 12 or more high risk for falls. R35 had fallen on 8/23/12 at 5:30 p.m. in the fireside room. According to documentation, R35 had gone to look out the window and had stepped back to sit in his chair and missed. A fall 9/3/12 at 5:15 p.m., was documented as having occurred in R35's room. The documentation indicated it had appeared R35 had been found leaning against his recliner. The resident had said he'd been trying to sit in the recliner. Fall dated 9/19/12 at 4:30 p.m., 11/3/12 at 4:30 p.m., and 11/13/12 at 4:30 p.m., were documented to indicate the resident had slid out of his recliner, or been trying to self transfer from the chair. Finally, documentation indicated R35 had fallen on 12/2/12 at 5 p.m., in his room while attempting to get out of his chair. The resident's care plan dated 9/12/12, did not identify a problem with falls or any interventions to prevent falls. R35 had broken and carious teeth. There was no plan of care addressing dental issues. During an observation of R35 on 12/3/12 at 2:45 p.m., R35 was noted to have foul breath. During an interview with R35's daughter on 12/4/12 at	F 279	further dental services will be audited by the Director of Nursing to ensure the care plan is specific to these issues. The audits will be completed following any fall for the next two months. The dental audits will occur weekly for one month, then monthly for two months with results forwarded to the quality committee for review.	

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F 279	Continued From page 4 8:43 a.m., she stated that R35 had broken and otherwise bad teeth (full of cavities), and that she had checked into getting all of his teeth pulled and dentures for him but after much discussion with the physician and dentist it was decided that it would be too stressful for R35 to learn how to eat with dentures due to dementia. R35's daughter further stated the resident had some difficulty chewing and received an altered diet. According to chart review, the annual CAA dated 4/4/12, included: "his teeth are in poor condition with broken and missing teeth but no pain in his mouth." An oral assessment dated 6/10/10, identified "res (resident) has lots of decayed teeth in mouth." An assessment from 5/11/11 included, "res has lots of cavities and broken teeth. Unable to fully examine mouth. Res offers no complaints of pain but does pick at his teeth often." An oral assessment from 11/21/12 included, "unable to assess as res refused to open mouth." The resident's care plan dated 9/12/12, did not identify any dental problems even though the resident had known broken and carious teeth. During interview with the Director of Nursing (DON) on 12/5/12 at 11:06 a.m., she verified that R35's care plan failed to address the resident's falls or dental issues.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		

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F 280	Continued From page 5 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan for 1 of 3 residents (R28) reviewed in the sample for accidents. Findings Include: R28 lacked a revision of the care plan following a fall, to identify new interventions to minimize the risk of further falls. At 10:30 a.m. on 12/05/12, R28 was observed sitting in a recliner in her room. R28 said she needed help getting out of her chair and staff assist her with transferring and care needs. The resident also stated she had attempted to transfer	F 280	The residents care plan was revised on 12-5-12 in regards to falls. Other residents with falls were identified and their care plans were reviewed and revised if indicated. Verbal education was given to the Case Managers on 1-3-13 in regards to care planning for falls. Written education will be given to all licensed staff on 1-9-13 with follow-up education at the January inservices. To ensure compliance in this area, the Director of Nursing will complete audits of incident reports related to falls, ensure that new fall interventions have been identified, and that the care plan has been reviewed and revised if indicated. These audits will be completed following any fall for two months, with results forwarded to the Quality Committee for review.	1/3/13

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	245593	A. BUILDING _____ B. WING _____	12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 6 herself in the past and had fallen. When asked whether staff had ever reminded her to use her call light or further discussed fall preventions with her, R28 could not recall. According to record review, R28 had been admitted to the facility on 10/07/10, with diagnoses including: congestive heart failure, morbid obesity, chronic edema, depression, diabetes, hypertension, and glaucoma. In addition, physician progress notes indicated the resident had some memory difficulties. However, an annual Minimum Data Set (MDS) dated 12/06/12, indicated R28 had no cognitive or memory impairment, and as requiring one to two person assist with all activities of daily living and transfers. The same annual MDS also indicated the resident had no falls during the look back period. The last fall assessment was dated 11/17/12, and indicated the resident had a history of 1-2 falls in the last 90 days, that the resident ambulated without problems while utilizing devices, and as having a problem with balance. The total fall risk score was 17, which identified R28 as being at high risk for falls. The resident had scored a 12 or higher on each of the prior fall assessments. The resident's plan of care dated 11/14/12, identified problem areas including: "Altered mobility r/t (related to) reduced functional activity, chronic edema & morbid obesity m/b (manifested by) needs extens (extensive) assist w (with)/bed mobility, transfers and ambulation." The goal included for R28 to "maintain ability to transfer w/walker in/out of recliner per staff report". The	F 280		

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F 280	Continued From page 7 interventions were identified as: "Bed mobility: 2 assist to turn. 1. Transfers: Extens. using FWW (four wheeled walker); Total lift w/XL (extra large) high back sling in/out of bed prn (as needed). Ambulation in hallway: Extens. assist of 1 using FWW to Bkft (breakfast) and noon meal. Ambulation in room: Extens. assist of 1 using FWW. Chair type: w/c (wheelchair) no foot pedals. The resident's care plan had not been revised to include fall prevention interventions. At 1:00 p.m. on 12/05/2012 the Director of Nursing (DON) was interviewed and verified the care plan had not been revised nor had a short-term care plan been completed for R28 regarding falls prevention. The facility's procedure Fallen or Injured Resident last reviewed 10/12, instructed staff to update the comprehensive care plan and documentation record with any changes/new interventions and/or initiate a Post Fall Short Term Care plan. A document titled, Suggested Care Plan Approaches for Fall Prevention, was attached to the policy. That document included numerous suggested approaches to implement for the resident at risk of falls.	F 280		
F 431 SS=E	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.	F 431		

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F 431	Continued From page 8 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 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 ensure mediations were securely stored on the Sheppard's Circle unit. This had the potential to affect 6 out of 8 residents. In addition, the facility failed to ensure that eye drops were labeled with discard dates after they'd been opened for 5 of 5 residents (R2, R14, R27, R28, and R57) in the sample who received eye drops.	F 431	The TMA who failed to lock the med cart was given verbal education immediately following the incident. All licensed staff will receive written education regarding the med administration policy and procedure on 1-9-13 with follow-up education at the January inservices. The Director of Nursing will complete random observation audits of med carts to ensure they are locked when not in use. These audits will be done at each section of the facility twice weekly for one month then weekly for one month with the results forwarded to the quality committee for review. All bottles of eye drops were inspected and replaced if appropriate. Licensed staff and TMA's were instructed to date eye drop bottles when opened, follow the pharmacy instructions, and continue checking expiration dates as per facility policy. Bi-monthly audits of this process	1/9/13

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F 431	Continued From page 9 The findings include: On 12/6/12 at 7:15 a.m., trained medication aid (TMA)-A was observed to have parked the medication cart in the nursing station area of the Sheppard's Circle unit. TMA-A was observed at that time to have walked out of the nursing station and into room 301 to assist a resident. TMA-A was observed to take the resident from room 301 to the main dining room which was outside the Sheppard's Circle unit. During that time, the medication cart was observed to have been left unlocked and the door to the nursing station was open. TMA-A returned to the nursing station in Sheppard's Circle at 7:25 a.m., and began preparing medications for another resident. At 7:35 a.m., TMA-A again left the unlocked medication cart in the nursing station, with the door to the station open, to deliver medications to another resident. At 7:37 a.m., Housekeeper-A walked past the open nursing station. At 7:39 a.m., TMA-A walked past the open nursing station and assisted R46 to the dining room. TMA-A returned to the nursing station at 7:41 a.m. At 7:43 a.m., TMA-A again left the nursing station and the medication cart remained unlocked and the door to the nursing station open. At 7:45 a.m., registered nurse (RN)-B and RN-C entered the nursing station to retrieve supplies. Neither RN was observed to identify the medication cart as unlocked. At 7:46 a.m. TMA-A returned to the nursing station and began signing out medications on the medication administration sheet (MAR). Both RNs had left the nursing station by 7:47 a.m.. RN-B returned to the nursing station at 7:48 a.m. She was observed to remove an insulin syringe and insulin pen from the unlocked medication cart. At 7:52 a.m., RN-B	F 431	began on 12-12-13 during the med-exchange process (completed by Nurse/TMA) and will continue indefinitely. All licensed staff will receive written education regarding this process on 1-9-13 with follow-up education at the January inservices. Results will be forwarded to the Quality Committee for review.	

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F 431	Continued From page 10 locked the medication cart, closed the door to the nursing station, and left the room. During interview with TMA-A on 12/6/12 at 7:53 a.m., verified the above information to be accurate to the best of her knowledge. TMA-A also stated that she'd left the medication cart unlocked and the nursing station door open because she knew the other nurses would need to get into the medication cart. During interview with RN-B on 12/6/12 at 8:00 a.m., she verified that if the medication cart is out of the line of vision of the person dispensing medications, it should be locked. The facility's policy titled: Acquisition, Receiving, Dispensing and Storage of Medications reviewed 1/12, identified the following under the Procedure section of # 4: Medications will be stored in a locked medication room and/or medication cart. Only authorized personnel will be permitted to have access to the keys and medication room. During interview with the director of nursing (DON) on 12/6/12 at 8:50 a.m., she verified that 6 of the 8 resident's residing on the Shepherd's Circle unit were mobile. The DON also confirmed that the above described practice was not acceptable. During review of the medication storage areas, it was noted that six bottles of eye drops, belonging to 5 different residents, were observed to be open and in use, with no indication of when they'd been opened. The medicated eye drops included: latanoprost, tobramycin and ciprofloxacin. On 12/6/12 at 10:42 a.m., the section 2	F 431		

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F 431	Continued From page 11 medication cart was observed with licensed practical nurse (LPN)-A. During the observation, it was noted that one bottle of opened eye drops was stored in the cart without having been dated when the bottle was opened. LPN-A confirmed the eye drop bottle was not dated when opened. Subsequent inspection of the section 1 medication cart with trained medication aid (TMA) -C, revealed five opened bottles of eye drops without any indication of when the bottles had been opened. TMA-C confirmed that the eye drop bottles had not been dated when opened. Review of the package inserts for disposal of eye drops were as follows: Tobramycin disposal - "Write the date on the bottle when you open the eye drops and throw out any remaining drops after four weeks." Latanoprost disposal - "Opened bottle may be stored at room temperature up to 25 degrees Celsius (77 degrees Fahrenheit) for up to 6 weeks". Ciprofloxacin - "Write the date on the bottle when you open the eye drops and throw out any remaining solution after four weeks." During interview with the DON on 12/6/12, she confirmed there was no facility policy in place to indicate when to discard eye drop medications once they were opened.	F 431		

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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, on December 31, 2012. At the time of this survey, Good Samaritan Society St. James was found not to be 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 Occupancies. 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 55101-5145, or	K 000	JAN 22 2013 POC ok FB 1-23-13	

DC: 01.15.2013

EXIT: 12.06.2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tim Swanson	Administrator	1/17/13

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: Barbara.Lundberg@state.mn.us, and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This one-story with partial basement facility was determined to be of Type V(000) construction. The original building was constructed in 1963, with additions in 1965, 1993, 1996 and 2002. The facility was fully sprinklered, and had a complete corridor smoke detection system with monitoring for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 52 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each	K 025		

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K 025	Continued From page 2 floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation, the facility had a penetration through a smoke barrier wall, and the interstitial space surrounding the penetration was not properly sealed to prevent smoke and/or fire migration between smoke compartments. This arrangement was not in accordance with the requirements at NFPA 101 (2000), Chapter 19, Sections 19.1.6.3. and 19.3.7.3 and Chapter 8, Section 8.2.4. In a fire emergency, smoke and/or fire could migrate between smoke compartments, adversely affecting 18 of 55 residents, staff and visitors. FINDINGS INCLUDE:	K 025		

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K 025	Continued From page 3 On 12/31/2012 at 12:05 PM, observation revealed building wiring penetrating the Section Two-South smoke barrier wall. This penetration occurred in the concealed space above the drop-ceiling assembly, above the double cross-corridor smoke barrier doors. It was further observed that the interstitial space between the wiring and the surrounding smoke barrier wall, was not properly sealed to maintain a minimum 1/2-hour fire resistance rating and to prevent the migration of smoke. This finding was verified with the chief building engineer at the time of discovery.	K 025	The penetration was sealed up on 12/31/12 by the Director of Maintenance. The contractor doing the work had been instructed to seal up penetrations before they leave the site and to verify at the completion of the work with Maintenance staff. Monthly audits are being performed and will be reviewed at the Safety and QA meetings. This will be monitored by the Director of Maintenance.	~~12/31/12~~ 1-2-13
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - If there is an automatic sprinkler system, it is installed in accordance with NFPA 13 (1999), Standard for the Installation of	K 056		

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K 056	Continued From page 4 Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25 (1998), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with water flow and tamper switches which are connected to the fire alarm system, in accordance with NFPA 101 (2000), Chapter 19, Section 19.3.5. and Chapter 9, Section 9.7. Based on observation, the facility failed to install the fire sprinkler system in accordance with the requirements at NFPA 101 (2000) Section 19.3.5 and NFPA 13 (1999) Sections 6-1 and 6-2. In a fire emergency, this deficient practice could adversely affect 25 of 55 residents, staff and visitors. FINDINGS INCLUDE: On 12/31/2012 at 11:50 AM, observation revealed a section of fire sprinkler branch line located in the Boiler Room was used to support non-fire sprinkler system components. Specifically, a building domestic water line was anchored to a fire sprinkler branch line. This arrangement was not in accordance with NFPA 13 (1999) Section 6-1.1.5. This finding was confirmed with the chief building engineer at the time of discovery.	K 056	The mechanical contractor relocated the domestic water line supports in the boiler room on 1/16/13. The work was verified by the Director of Maintenance and the contractor was instructed to assure proper installation of water lines to comply with K 056. Monthly and ongoing checks of the boiler room will be monitored by the Director of Maintenance and work done by outside consultants will be reviewed at the completion of the work to assure compliance. This will be reviewed at the monthly Safety and QA meetings.	1/16/13