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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QFI9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00967

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245317**

2.STATE VENDOR OR MEDICAID NO.
(L2) **692515400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - COMFORCARE**
(L4) **1201 17TH STREET NE**
(L5) **AUSTIN, MN** (L6) **55912**

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 **02/16/2017** (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 **45** (L18)

13.Total Certified Beds **45** (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
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Danette Bakken, HFE NE II 02/24/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 09/11/2017 (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
06/01/1986
(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.
03401
(L31)

30. REMARKS
Posted 09/20/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/02/2017
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5317

On December 15, 2016 a survey was completed at this facility. The most serious deficiency was cited at a S/S level of G. This constituted a NOTC.

As a result of the survey findings State monitoring was imposed effective January 8, 2017. In addition, we recommended to the CMS RO the following remedy for imposition and CMS concurred:

- Civil money penalty for deficiency cited at F314

On January 20, 2017 a Life Safety Code PCR was completed and verified correction of LSC deficiencies. But, lack of verification of the health deficiencies by the 70 day, resulted in this Department recommending to the CMS RO, the following remedy for imposition and CMS concurred:

- Mandatory denial of payment for Medicare and Medicaid admissions effective March 15, 2017

If mandatory denial of payment goes into effect, the facility would be subject to the loss of NATCEP for a two year period beginning March 15, 2017

On February 16, 2017, a health PCR was completed and all health deficiencies were found correct. The facility was found in substantial compliance as of January 24, 2017. As a result of this most recent PCR, we recommended the following to CMS RO and they concurred:

- State monitoring which was imposed effective January 8, 2017, was discontinued effective January 24, 2017
- Civil Money Penalty cited at F314 be imposed
- Mandatory denial of payment for Medicare and Medicaid admissions effective March 15, 2017 was rescinded effective January 24, 2017

Since Mandatory denial of payment did not go ito effect, the facility would not be subject to a loss of NATCEP.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 24-5317 September 11, 2017

Ms. Jennifer Rowinski, Administrator
Good Samaritan Society - Comforcare
1201 17th Street Northeast
Austin, Minnesota 55912

Dear Ms. Rowinski:

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 January 24, 2017 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 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,

Shellae Dietrich

Shellae Dietrich, Certification Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245317

March 27, 2017
By Certified Mail

Good Samaritan Society – Comforcare
Attn: Administrator
1201 17th Street NE
Austin, MN 55912

Dear Administrator:

SUBJECT: SURVEY FINDINGS AND IMPOSITION/DISPOSITION OF REMEDIES
Cycle Start Date: December 15, 2016

SURVEY RESULTS
On December 14, 2016, and December 15, 2016, Life Safety Code (LSC) and health surveys were completed at Good Samaritan Society - Comforcare by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiency at scope and severity (S/S) level G, cited as follows:

- F314 -- S/S: G -- 483.25(b)(1) -- Treatment/Svcs to Prevent/Heal Pressure Sores

The State agency advised you of the deficiency that led to this determination and provided you with a copy of the survey reports (CMS-2567).

SUMMARY OF ENFORCEMENT REMEDIES
As a result of these survey findings, and as authorized by the Centers for Medicare & Medicaid Services (CMS), the MDH notified you on January 3, 2017 and February 17, 2017 of the imposition of the following remedy, as well as you appeal rights:

- State Monitoring effective January 8, 2017
- Mandatory denial of payment for Medicare and Medicaid admissions effective March 15, 2017

Based on the survey findings, the MDH notified you they were recommending that the CMS impose additional remedies as follows:

- Federal Civil Money Penalty effective December 15, 2016
- Mandatory termination of your Medicare and Medicaid provider agreements effective June

The authority for the imposition of remedies is contained in §§ 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR § 488, Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

The State survey agency conducted revisits at your facility on January 20, 2017 and February 16, 2017 and found that your facility was in substantial compliance as of January 24, 2017. As a result of these survey findings, the final status of remedies is as follows:

- State Monitoring, which was imposed effective January 8, 2017, is discontinued effective January 24, 2017
- Mandatory denial of payment for new Medicare and Medicaid admissions, which was to be effective March 15, 2017, is rescinded as of January 24, 2017. **Thus, there should be no interruption in payment for covered services.**
- Mandatory termination of your Medicare and Medicaid provider agreements, which was to be effective June 15, 2017, will not be imposed
- See Federal Civil Money Penalty below

CIVIL MONEY PENALTY

On September 6, 2016 the Department of Health and Human Services (HHS) published an Interim Final Rule in the Federal Register which adjusts for inflation Civil Money Penalty (CMP) amounts authorized under the Social Security Act. ***See*** **45 CFR Part 102.** In determining the amount of the CMP that we are imposing for each day of noncompliance, we have considered your facility's history, including any repeated deficiencies; its financial condition; and the factors specified in the Federal requirement at 42 CFR § 488.404. The ODH recommended imposition of a Federal CMP. We concur that a CMP is warranted. Thus, we are imposing the following CMP:

- Federal Civil Money Penalty of $3,663.00 per instance for the instance of noncompliance at 314 (S/S: G) identified in the CMS-2567 for the survey ending December 15, 2016

If you believe that you have documented evidence that should be considered in establishing the amount of the CMP, the following documents should be submitted to Mrs. Charlotte A. Hodder electronically at Charlotte.hodder@cms.hhs.gov within fifteen (15) days from the receipt of this notice:

- Written, dated request specifying the reason financial hardship is alleged
- List of the supporting documents submitted
- Current balance sheet
- Current income statements
- Current cash flow statements
- Most recent full year audited financial statements prepared by an independent accounting firm, including footnotes
- Most recent full year audited financial statements of the home office and/or related entities, prepared by an independent accounting firm, including footnotes

- Disclosure of expenses and amounts paid/accrued to the home office and/or related entities
- Schedule showing amounts due to/from related companies or individuals included in the balance sheets. The schedule should list the names of related organizations or persons and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes Receivable, etc.)
- If the nursing home requests an extended payment schedule of more than twelve (12) months duration, the provider must submit a letter from a financial institution denying the provider's loan request for the amount of the CMP

The CMP is due and payable and may be placed in escrow account fifteen days after one of the following, whichever occurs first:

- The date on which an Independent IDR process is completed, if applicable or
- The date which is 90 calendar days after the date of the notice of imposition of the civil money penalty.

CMP CASE NUMBER

A CMP case number will be assigned to your case only when the final CMP is due and payable. At that time you will receive a notice from this office with the CMP case number and payment instructions. Prior to the assignment of a CMP case number, you must ensure that your facility's name, CMS Certification Number (CCN), and the enforcement cycle start date appear on any correspondence pertaining to this CMP.

- Your CMS Certification Number (CCN) is 245317.
- The start date for this cycle is December 15, 2016.

CMP PAYMENT

When due, the CMP is payable by check to CMS at the following address:

Centers for Medicare & Medicaid Services
Division of Accounting Operations
Mail Stop C3-11-03
Post Office Box 7520
Baltimore, MD 21207

If you use a delivery service, such as Federal Express, **use the following address only**:

Centers for Medicare & Medicaid Services
Division of Accounting Operations
Mail Stop C3-11-03
7500 Security Boulevard
Baltimore, MD 21244

Note that your check must be sent to one of the above addresses--not to the Chicago Regional Office. However, a **copy** of your check and, if applicable, **your waiver of your right to a hearing must be sent to the attention of Tamika J. Brown at the Chicago Regional**

Office. Failure to do so could result in our office proceeding with collection of the full amount of the CMP.

If the total amount of the CMP is not received by the due date, interest will be assessed in accordance with the regulations at 42 CFR § 488.442 on the unpaid balance of the penalty beginning on the due date. The Federal rate of interest is 9.50%. The CMP, and any interest accrued after the due date, will be deducted from sums owing to you **without any further notification from this office.**

CMP REDUCED IF HEARING WAIVED

If you waive your right to a hearing, **in writing**, within 60 calendar days from receipt of this notice, the amount of your CMP will be reduced by thirty-five percent (35%). To receive this reduction, the written waiver should be sent to the Centers for Medicare & Medicaid Services, Division of Survey and Certification, 233 North Michigan Avenue, Suite 600, Chicago, Illinois 60601-5519. **The failure to request a hearing within 60 calendar days from your receipt of this notice does not constitute a waiver of your right to a hearing for purposes of the 35% reduction.**

APPEAL RIGHTS

This formal notice imposed the following remedy:

- Federal Civil Money Penalty effective December 15, 2016

If you disagree with the findings of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR § 498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB EFile, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB EFile is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for

hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov**.

Please note that **all** hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Nancy K. Rubenstein, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice. It is important that you send a copy of your request to our Chicago office to the attention of Tamika J. Brown. Failure to do so could result in our office proceeding with collection of the CMP.

INFORMAL DISPUTE RESOLUTION

The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visit. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431, when a civil money penalty subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited

deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, 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 (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to: www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm. This request must be sent within 10 calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

CONTACT INFORMATION

If you have any questions regarding this matter, please contact Tamika J. Brown, Program Representative, at (312) 353-1502 or Mrs. Charlotte A. Hodder, RN, BSN, CRRN, Certification Specialist. Information may also be faxed to (443) 380-6614. All correspondence should be directed to Tamika J. Brown in our Chicago office.

Sincerely,

/s/

Sahana Sanyal
Acting Branch Manager
Long Term Care Certification
& Enforcement Branch

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

February 24, 2017

Ms. Jennifer Rowinski, Administrator
Good Samaritan Society - Comforcare
1201 17th Street Ne
Austin, MN 55912

RE: Project Number S5317028

Dear Ms. Rowinski:

On January 3, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective January 8, 2017. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on December 15, 2016. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 16, 2017, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 15, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 24, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 15, 2016, as of January 24, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 24, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of January 3, 2017:

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245317	A. Building 02 - BUILT IN 2007 B. Wing	1/20/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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 K0222	Correction Completed 12/14/2016	ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 12/20/2016	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 12/14/2016
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

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 2/23/2017	SIGNATURE OF SURVEYOR 32980	DATE 1/20/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/14/2016	☐ 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245317	A. Building 02 - BUILT IN 2007 B. Wing	1/20/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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 K0222	Correction Completed 12/14/2016	ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 12/20/2016	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 12/14/2016
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

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 1/23/2017	SIGNATURE OF SURVEYOR 37008	DATE 1/20/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/14/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00967 Y1	A. Building B. Wing Y2	2/16/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 20625 Reg. # MN Rule 4658.0450 Subp. 1 A-P LSC	Correction Completed 01/24/2017	ID Prefix 20900 Reg. # MN Rule 4658.0525 Subp. 3 LSC	Correction Completed 01/24/2017	ID Prefix 21830 Reg. # MN St. Statute 144.651 Subd. 10 LSC	Correction Completed 01/24/2017
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

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 2/23/2017	SIGNATURE OF SURVEYOR 32980	DATE 2/16/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/15/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QFI9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00967

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245317**

2. STATE VENDOR OR MEDICAID NO. (L2) **692515400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - COMFORCARE**
(L4) **1201 17TH STREET NE**
(L5) **AUSTIN, MN** (L6) **55912**

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 **12/15/2016** (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 **45** (L18)

13.Total Certified Beds **45** (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
	45			
(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 :
Sarah Strenke, HFE NE II 01/18/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/31/2017 (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 **06/01/1986** (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 Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

January 3, 2017

Ms. Katie Davis, Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, MN 55912

RE: Project Number S5317028

Dear Ms. Davis:

On December 15, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

Potential Consequences - the consequences of not attaining substantial compliance 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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of Substandard Quality of Care (SQC) that are not immediate jeopardy and are identified on the current survey. The current 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) whereby corrections are required. Your facility meets the criterion and remedies will be imposed immediately pursuant to a survey completed on September 2, 2016. Therefore, this Department is imposing the following remedy:

- State Monitoring effective January 8, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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 remedy be imposed:

• 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 ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be

discontinued effective the date of the on-site verification. 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.

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 15, 2017 (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 15, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(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 Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R27) was allowed to chose type of bath. Findings include:	F 242	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	1/24/17

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

Electronically Signed | 01/13/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 242	Continued From page 1 R27 was interview on 12/12/16, at 2:16 p.m. R27 she said she had to take a showers as the facility only had one tub, which was in demand. R27 stated she is up at 6:00 a.m., there should not be such a demand at that time of the day for the tub. R27 stated she had asked for tub baths and was told the tub was too busy. R27 stated she would prefer tub baths. R27 was admitted to the facility on 9/2/15, with diagnosis that included heart failure and weakness, according to facility Admission Record. The facility identified R27 on the quarterly Minimum Data Set (MDS), an assessment dated 11/1/16, and annual MDS, an assessment dated 8/9/16, to have moderate cognitive impairment and required one person physical assist for bathing. Neither assessment identified preference for type of bath. Document review of annual MDS dated 8/9/16, revealed section F, choice of bath was somewhat important to R27. Document review of facility Nursing Admit Re-Admit Data Collection form dated 7/20/16, revealed bathing preferences was shower and whirlpool. Document review of facility resident care plan dated 11/10/16 in facility computer program point click care, revealed a focus of self-care deficit. Interventions included required one person assist with bathing. There was no indication of type of bath. Care plan revision dated 12/13/16 revealed R27 requests whirlpool on bath days.	F 242	correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F 242 R27 was interviewed to determine her preference for bathing. R27's care plan was updated on 12/14/2016. All staff providing bathing care for her was informed of her bathing preference on 12-14-16 by the Nurse Manager. All residents bathing preferences were verified with the resident per interviews or record review. Updates to the care plan were made as necessary. All nursing staff will be provided with re-education by the DNS or designee on 1/24/2017 regarding Good Samaritan Society policy and procedure for resident's choice of honoring bathing preferences. Audits will be conducted for R27 and 5 random other residents to ensure their bathing preferences are being honored, weekly X 4, monthly X3, with results being reported to Quality Committee for further recommendations. Completion date: 1-24-17	

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F 242	Continued From page 2	F 242		

Document review of facility Visual/Bedside Kardex Report, print dated 12/13/16-revealed R27 required one staff participation with bathing, resident requests whirlpool on bath days.

Document review of facility Documentation Survey Report identified intervention of bathing (whirlpool) and revealed the following:
9/1-9/30/16 -received 2 showers and 2 whirlpool baths;
10/1/16 - 10/31/16-received 5 showers, no whirlpool baths;
11/1/16-11/30/16-received 3 showers and 1 whirlpool bath.

Document review of facility Follow Up Question report print date of 12/13/16, identified task of bathing (whirlpool), revealed R27 received 2 showers from 12/1/16 to 12/12/16, and no whirlpool baths.

Document review from 9/1/16 to 12/12/16, revealed R27 received weekly baths,a total of 15 baths in that time period. 12 of the 15 baths were showers and only three whirlpool baths in 3 1/2 months.

Document review of facility Lodge/Garden Bath Schedule, undated, revealed R27 was scheduled for whirlpool baths on Monday mornings

During interview on 12/13/16, at 3:20 social services director stated bathing choices was determined by the nursing department.

During interview on 12/13/16, at 3:30 p.m., registered nurse (RN)-A stated not aware R27 requested tub baths. RN-A verified facility Admit Readmit Data Collection dated 7/20/16, identified

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F 242	Continued From page 3	F 242		

type of bath preferred was tub or shower. RN-A stated bathing preferences were reviewed at care conferences. RN-A stated to check with floor nurses about bathing preferences. RN-A verified R27 received a shower on 11/28/16, 12/5/16, and 12/12/16, and a whirlpool tub bath on 11/21/16, by nursing assistant (NA)-B.

During interview on 12/13/16, at 3:40 p.m., RN-B verified facility Visual/Bedside Kardex Report was the only nursing assistant assignment instructions for R27. RN-B verified the instructions included "resident requests whirlpool on bath days."

RN-B stated instructs new employees that the Visual/Bedside Kardex Report was resident care instructions. RN-B verified from 11/14/16 to 12/12/16, R27 received one tub bath and the rest of baths were showers.

During interview on 12/13/16, at 5:15 p.m., director of nursing stated facility was not aware R27 wanted whirlpool baths. Director of nursing verified the Visual/Bedside Kardex Report was nursing assistant resident care instructions and directed R27 wanted whirlpool baths.

During interview on 12/14/16, at 10:20 a.m., nursing assistant (NA)-C stated asked R27 preference for bath. Stated residents have to take turns with whirlpool because the tub was in use. NA-C verified R27's bath day was Monday mornings.

Document review if facility Resident's Rights for Skilled Nursing Facilities dated 11/2016, page 3, (f) directed The resident has the right to and the facility must promote and facilitate resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 242	Continued From page 4 self-determination through support of resident choice. (1) The resident has a right to choose activities, schedules (including sleeping and waking times), healthcare and providers of healthcare services consistent with his or her interests, assessments, and plans of care. (2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 242		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to identify a new pressure ulcer and a scab located on left heel, complete a comprehensive assessment, and provide appropriate care and services for 1 of 2 residents (R78) reviewed with pressure ulcers. Lack of timely assessment and responsive care	F 314	F 314 R78's left heel was immediately assessed on 12/16/2016. The physician was notified and R78's care plan was updated to include treatment for the wound which was initiated immediately.	1/24/17

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F 314	Continued From page 5 resulted in actual harm for R78 who developed a new pressure ulcer and scab, on the left inner heel. Findings include: R78's Admission record form included an admission date of 7/14/16. The Diagnosis information included: Type 2 Diabetes Mellitus, Hemiplegia, and Hemiparesis following cerebral infarction (paralysis after a stroke) affecting left (non-dominant) side and several other health concerns. R78 ' s Nursing admit/readmit data collection - V2 dated 10/6/16, had been completed after R78 had returned from a 9/30/16 to 10/6/16 hospitalization for an urinary tract infection, kidney infection, urinary retention, chronic atrial fibrillation, anemia, myocardial accident (stroke), type 2 diabetes, left side hemiplegia, and bradycardia. On the form under wounds/ulcers there were two identified, one located on left buttock and described as " upper buttock, stage 1, applied transparent ply skin. " Second site located on left heel with a description of " suspected deep tissue injury. " R78 was identified to need two for assistance with activities of daily living (ADLs). R78's Positioning Assessment and Evaluation dated 10/7/16, indicated R78 was a total assist with Hoyer lift, and a corresponding Braden Scale (used to determine risk to have skin breakdown) indicated R78 was at risk for breakdown. The assessments indicated R78 is unable to ambulate and has left sided paralysis related to having had a stroke. In addition, R78 was identified as needing staff assistance to reposition every two hours. An additional assessment dated 10/29/16, indicated R78 was unable to reposition independently, was totally dependent on staff to provide all needs, required continued use of Hoyer (mechanical lift) assist with two staff, and	F 314	Skin observations were completed as of 1-13-17 for those residents at risk of impaired skin integrity and appropriate documentation was completed. Re-education on Good Samaritan Society policy and procedure regarding wound identification, prevention, treatment and documentation with nurses was initiated on 1/6/2017 with an in-service provided by GSS contracted American Medical Technology Wound Care Certified RN. Additional training will be provided by the DNS or designee on 1-24-17. R 78 is now deceased. Audits will be conducted through record review on all residents at risk for skin breakdown. 5 random residents will be audited via observation after review of the record to ensure wounds are being identified, treated, and documented correctly and care planned. This will be weekly x4, monthly x3, with results being reported to Quality Committee for further recommendations. Completion date will be 1/24/2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	12/15/2016

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F 314	Continued From page 6	F 314		

continued need to be repositioned every two hours. An assessment for positioning conducted 11/12/16, identifies no change to the prior assessments/interventions.
On 12/13/16, a Braden Scale for Predicting Pressure Sore Risk was again completed and R78 scored a 12 which indicated R78 was at high risk for skin breakdown.
A quarterly Minimum Data Set (MDS) assessment dated 10/13/16, identified R78 as having a stage one pressure ulcer and one unstageable pressure ulcer suspected deep tissue injury in evolution.
Wound Assessment documentation dated 11/22/16, identified the stage 1 pressure ulcer (assessed on 10/6/16 after return from hospital) located on the upper buttock had deteriorated to a stage 4 pressure ulcer, had a foul odor, tunneling and depth present. Wound bed 25% eschar, with sloughing and minimum serosanguinous drainage, wound edges denuded, macerated undefined.
Wound Assessment documentation from 11/29/16, identified a stage 4 pressure ulcer to coccyx/right buttocks with no healing noted at this time of this assessment from the last assessment completed.
Wound Assessment documentation dated 12/6/16, identified a second stage 2 pressure ulcer developed and located on coccyx/right buttock area with skin surrounding coccyx is pink and macerated.
Skin observation sheet dated 10/24/16, identifies an intact, healing decubitus ulcer to left heel measuring 4.5 cm by 2 cm.
During a continuous observation on 12/13/16, from 3:17 p.m. and ending at 5:29 p.m. nursing assistant (NA)-C entered the room and R78 was observed lying on her right side in bed. Blue boot

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(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 314	Continued From page 7	F 314		

(a soft sided boot that surrounded the lower leg and foot) was on left foot and both feet were placed directly on top of the blue pad (a thick pad used to support leg yet allow ankle area to be floated over edge of pad). The left foot was not floated. R78 was again observed from 8:44 a.m. to 9:00 a.m. on 12/14/16, (a continuous observation.) R78 was eating breakfast in the dining room. At 9:00 a.m. R78 was assisted out of the building for a medical appointment.
Interview on 12/14/16, at 9:12 a.m. with nursing assistant (NA)-C stated he had assisted R78 from her bed to wheelchair at 7:30 a.m. NA- verified R78 had not been repositioned or offloaded (removing pressure to skin areas prone to breakdown) before leaving for the appointment.
Observation on 12/14/16, at 2:02 p.m. R78 was positioned on her back with a body pillow under the left side. R78 had blue boot on left foot. Feet again were placed directly on top of the blue pad in bed. Left foot was not floated.
Observation and interview on 12/14/16, at 3:29 p.m. with registered nurse (RN)-E verified left foot was not floated while in bed. RN-E stated her heels should be floated and they aren't. Asked RN-E to view left heel where it was documented that a pressure ulcer had recently healed. Two surveyors and RN-E observed a red area on left heel and RN-E verified a wound was present on the left inner heel measuring 1 cm by 0.6 cm with a blanchable outer red area with a dark purple area in the middle measuring 0.2 cm by 0.5 cm that was non-blanchable. RN-E also verified there was a scab present on left inner heel measuring 0.7 cm by 1 cm. RN-E stated she wasn't aware there was any wounds to left heel prior to this time. RN-E removed dressing to R78's sacrum/right buttock area where a stage 2 pressure ulcer was located. RN-E described the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	12/15/2016

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GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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F 314	Continued From page 8	F 314		

dressing to have a moderate amount of serosanguinous drainage. RN-E described the wound to have 10% eschar, 50% granulation and 40% slough. RN-E measured the wound with width from redness to redness measuring 10 cm, length 5.5 cm and depth 3.7 cm.
Observation on 12/15/16, at 7:10 a.m. R78 was observed to be asleep in bed, blue boot on left foot, again left heel flat on blue pad and not floated over edge of pad. Interview on 12/15/16, at 7:44 a.m. with nursing assistant (NA)-D verified R78's heel should have been floated over the edge of the blue pad. NA-D verified R78's heel had not been floated.
Interview on 12/15/16 at 7:49 a.m. with nursing assistant (NA)-B stated R78 no longer had any wounds on her left heel. NA-B stated that they had healed. NA-B stated R78 had first developed the pressure area on her sacrum when she had returned from the hospital. NA-B stated it started out small but had kept growing and growing.
Observation of dressing change on 12/15/16, at 8:09 a.m. with RN-C identified the wound to sacrum/upper buttock area to have 35-40% eschar, 50-60% slough and 20-25% granulation. RN-C stated the wound is measured weekly with all documentation entered into the computer, as well as daily assessments being documented. RN-C stated he was unaware that R78 had a new pressure ulcers to her left heel (this was first observed by RN-E and two surveyors the day prior). RN-C identified the wound on left inner heel to be non-blanchable with red outer area measuring 1.2 cm by 1.1 cm and dark purple area in center measuring 0.4 cm by 0.3 cm which deteriorated from the day prior.
Interview on 12/15/16, at 10:11 a.m. with RN-C stated R78's feet should be checked every shift and weekly on bath days with the full skin

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	245317	A. BUILDING _____ B. WING _____	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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F 314	Continued From page 9 assessments. Observation on 12/15/16, at 10:17 a.m. R78 was asleep in bed, positioned on right side, left foot flat on blue pad and not floated. Interview on 12/15/16, at 10:18 a.m. with RN-C verified R78's left heel had not been floated. RN-C then repositioned R78's left foot so that it was floated off the edge of the blue pad on the bed. RN-C- stated the point of the blue pad is to float the heels. Interview on 12/15/16, at 10:27 a.m. with director of nursing (DON) stated she wasn't in charge of wounds and the nurse manager was in charge of them as she was wound certified. DON stated she was unaware that R78 had two new pressure ulcers on her left heel found the day prior with RN-E. DON stated she would expect weekly wound measurements to be included in the documentation for each wound along with any identifying documentation including drainage, what the wound looks like as well as the surrounding tissue. DON was unable to identify when wound training had been provided to the nursing staff to ensure proper documentation and assessments were being completed. Interview on 12/15/16, at 10:48 a.m. with registered nurse (RN)-A a nurse manager, stated she isn't in charge of the wounds, the floor nurse is. RN-A states she does rounds with the wound nurse (from Mayo) when she is at the facility once a month. RN-A stated she monitors the assessments but was unaware the measurements weren't included in the weekly RN assessments. RN-A stated she tries to monitor the measurements weekly. RN-A stated she wasn't aware R78 had two new pressure ulcers to her left heel which were found the day prior as it had not been passed on to the next shift. RN-A stated when a new pressure ulcer is identified the	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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F 314	Continued From page 10 RN is responsible for filling out the wound data collection form and wound assessment and then notifying the provider. RN-A verified there was no documentation from 12/14/16 when the two new pressure ulcers were identified by surveyors and RN-E. RN-A stated the floor nurses should be assessing wound weekly, measuring and describing what the wounds look like, the data wound collection forms should be filled out daily. RN-A stated diabetic foot checks should be completed on bath days. RN-A stated R78's heels are supposed to be floated off the blue pad. RN-A was unaware of when training was last provided to the nursing staff regarding proper assessments of wounds or when last provided to the nursing assistants for proper positioning of the residents. R78's comprehensive care plan last updated on 10/20/16, was reviewed and had not included the stage 4 pressure ulcer located by sacrum/coccyx nor had the two pressure ulcers located on the left heel first observed on 12/14/16 mentioned on care plan or interventions to promote healing and prevent new ulcers from developing. The care plan did indicate a problem area for impairment to skin integrity related to immobility, and diagnosis of stroke with left sided hemiparesis. The care plan also indicated R78 had returned from the hospital on 10/6/16, with an unstageable pressure ulcer located on left heel with intact blister. Interventions for heal ulcer were identified to include: monitor location, size and treatment of skin injury, turn and reposition in bed and chair every 2 hours (watch heels closely) blue boot to left heel. Elevate heels off bed. Provide blue boot to left heel wear at all Facility policy titled, Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements" dated last revised 4/16 identifies, when a pressure ulcer is identified the registered	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	12/15/2016

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GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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F 314	Continued From page 11 nurse should record the type of wound and the degree of tissue damage on the Wound RN Assessment UDA. The licensed nurse records the location of the area, the measurements and the ulcer/wound characteristics. When a pressure ulcer is present, daily monitoring with accompanying documentation should include the following: an evaluation of the status of the dressing, status of the area surrounding the ulcer, presence of possible complications. Pressure ulcer should be assessed at least weekly and documented on the Wound RN Assessment UDA. Documentation should include at least: measurements, characteristics of the ulcer including wound bed, undermining and tunneling, exudate, surrounding skin, etc., presence of pain and current treatments.	F 314		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident;	F 514		1/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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F 514	Continued From page 12 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure accurate and complete documentation was maintained in health records regarding interventions/services provided for 2 of 3 residents (R78, R89) reviewed for acute changes to health status. Findings include: R78's records did not include documented coordination of care related to urology services. The resident's record at the facility did not include physician progress notes from urologist appointments in October and November 2016. As a result, information regarding potential urologic issues including: possibility of acquiring urinary tract infections, sepsis, ultimate renal deterioration, pyelonephritis was not available by facility staff to develop appropriate interventions for care. R78's Diagnosis Report dated 10/6/16, identified	F 514	F 514 R78 records were updated by HIM Director to include physician progress notes for urology appointments in October and November of 2016 on 12/16/16. R89 records were updated by HIM Director to include pulmonary MD notes referring to hospice in August of 2016 on 12/16/16. LPN-A was re-educated on policies and procedures regarding proper documentation on 12/15/2016 by the DNS. All current residents' records will be reviewed by HIM and DNS or designee to ensure the records are complete and accurate in containing interventions and services that have been provided in the past 30 days by 1/16/17. Re-education on GSS policy and	

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F 514	Continued From page 13 a diagnosis of Urinary Retention and Urinary Tract Infection. R78's progress note dated 10/26/16, indicated R78 had been seen by a urologist for urinary retention and recent urinary tract infections. According to the document, R78 had been hospitalized September 30, 2016 for a stroke, and at that time had experienced a combination of incontinence and urinary retention and a Foley catheter had been placed. R78's care plan revised on 10/20/16, indicated R78 had an indwelling catheter, had moderate cognitive impairment, and memory impairment with a BIMS (brief interview for mental status) score of 10 (indicative moderate cognitive impairment). During interview with R78 on 12/12/16, at 5:35 p.m. R78 was unable to answer basic questions. R78's physician Order Summary reports from October 2016 to December 2016 indicated R78 was to have care including: wash catheter daily with water and soap, and to have the catheter changed every 30 days. There was no order to observe for signs or symptoms of urinary tract infection or sepsis. The progress notes from October 2016 to December 15, 2016 were reviewed. The progress notes did not identify urology instructions or updates. The facility's medical chart for R78 was reviewed, and there were no notes found regarding the resident's urology reports/documents from urology appointments. When information was	F 514	procedure for maintaining complete and accurate health records was provided to HIM and Nursing on 1-13-17. Process will be implemented of having all resident appointments scheduled through HIM to ensure timely receipt of documentation from appointments to ensure accurate and complete documentation of health records. R78 and R89 are deceased. Audits will be conducted on 5 random resident records to ensure accurate and complete documentation of the health record weekly x4 and monthly x3, with results being reported to Quality Committee for further recommendations. completed by 1/24/2017.	

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GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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F 514	Continued From page 14	F 514		

requested including any assessments, interventions, etc. related to Foley catheter, the facility had to request the information via fax (facsimile) to the local clinic requesting the last three months' worth of Urology notes as they had none of the information in the resident's record at the facility. The following was provided:

Review of urology note dated 10/26/16, identifies R78 needing to be monitored closely for development of urinary tract infections. "The signs and symptoms associated with cystitis and pyelonephritis were described in detail to the patient and her family."

Urology note dated 11/15/16, identifies a right renal obstruction. "I discussed with the patient that she has right-sided renal obstruction causing hydrocephalous. I explained that this puts her at higher risk for ultimate renal deterioration, I also described that this would put her at greater risk for urinary tract infections including pyelonephritis, which in her situation could be life threatening. It is unclear to me whether she fully understands the situation". This urology note also indicated the provider had contacted R78's power of attorney to discuss the possibility of nephrostomy tube and stent placement. The note identified the power of attorney had subsequently declined those interventions due to the risks of surgery. The note included: "they understand that there is a risk for not intervening. The consequences could be as dire as sepsis, ICU [intensive care unit] admission, and even death."

Urology note dated 12/14/16, identifies continued discussion with R78's power of attorney related to R78 being at increased risk for renal deterioration and for urinary tract infections, with potentially life

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	245317	A. BUILDING _____ B. WING _____	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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F 514	Continued From page 15	F 514		

threatening consequences. Note identifies symptoms to be monitored and reported as soon as possible to be, "urethral pain, suprapubic discomfort, flank pain, fevers, chills, or other signs or symptoms consistent with urinary tract infections".

During interview on 12/15/16, at 12:10 p.m. with registered nurse (RN)-A stated R78 comes back from urology appointments with a clinical referral note, the facility then has to call for the actual notes the physician dictates from the visit. RN-A stated the floor nurses or the HIMS (health information medical specialist) staff was responsible for getting these notes and scanning them into the computer. RN-A stated the facility is only aware of what is sent on the urology referral. RN-A stated she wasn't aware R78's family had declined interventions due to risks, or that R78 was at high risk for complications of sepsis, hospitalization or death. RN-A verified R78 would not be able to alert staff if experiencing any symptoms of urinary tract infections. RN-A stated she had not previously been aware of the urology provider's recommendations for stents, or the risks of not having the stents, because that information was only available in the clinic progress notes, which the facility had not received or requested prior to survey.

During interview with HIMS staff on 12/15/16, at 1:19 p.m. the HIMS staff stated her process for checking medical records was to randomly select a resident, and go through the chart and make sure everything is where it needs to be. The HIMS staff stated she focused on making sure each chart had a discharge summary and an H&P (history and physical). The HIMS staff stated the floor nurses should be getting notes from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	12/15/2016

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GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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F 514	Continued From page 16	F 514		

appointments and if they aren't getting the notes they should be alerting her to request the information because she is not always aware of when residents have appointments. The HIMS staff also stated she doesn't keep track of which charts have or haven't been reviewed for missing documents and has no specific system in place to ensure medical records aren't missing necessary information.

During interview with the director of nursing (DON) on 12/15/16, at 1:23 p.m. the DON stated she knew nothing about the urologist recommendation for R78 to have nephrostomy stents, or the risks related to R78's health if stents weren't placed. The DON stated her expectation is for the nurse manager to be obtaining paperwork from appointments.
The facility policy Maintenance of Active Medical Records dated 10/16, indicated the medical record: "must contain enough information to show the location [facility] knows the status of the resident, has an adequate plan of care and provides sufficient evidence of the effects of the care provided. Documentation should provide a picture of the resident's progress, including response to treatment, change in condition and changes in treatment."

R89's face sheet indicated the resident had been admitted 8/26/16, with diagnosis of chronic pulmonary, kidney disease and lung cancer. R89 had died on 8/31/16. When the survey team requested all information regarding R89's death and nursing interventions done at the time, none was provided as the License Practical Nurse had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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F 514	Continued From page 17	F 514		

not documented any details. The hospice nurse had found the resident without vital signs. The documentation was unclear as to whether vital signs were attempted, any description of the resident's body/color/temperature, whether rigormortis was present, if physician was contacted, if cardio pulmonary resuscitation was attempted, if emergency services had been contacted, was the coroner contacted, was family contacted and their wishes honored, was a room mate present and what counseling/support given, who took personal items, disposition of medications, etc.

During an interview on 12/15/16 at 11:42 a.m. Licensed Practical Nurse (LPN)-A verified she had not documented anything that transpired regarding the death of R89. LPN-A said that she forgot to document the progress and death of resident on her shift. However, a note was not completed from 8/31/16 to the survey date of 12/15/16. On asking LPN-A what had happened the shift she worked when R89 died. LPN-A stated the Hospice nurse went in to evaluate R89 for hospice services and found R89 dead.

The last progress note found in the electronic medical record (EMR) was dated 8/31/16 at 2:12 p.m. and contained R89 was here due to chronic obstructive pulmonary disease (COPD), had no complaints of shortness of breath or pain. Is assist of one with transfers and activities of daily living. R89 had appointment today, family transported. Author of this note had received a call and told R89 was going to be evaluated by hospice at 3:00 p.m. today, and will continue to monitor. No other information following the health status of this resident was provided even though requested by surveyor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE AUSTIN, MN 55912**

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F 514	Continued From page 18 Document review entitled Release of Body to Mortician reads body released by order of on call physician dated 8-31-16 at 3:25 p.m.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING **02 - BUILT IN 2007** B. WING _____	**12/14/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 12-14-16, Good Samaritan Society Comforcare 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 2012 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	K 000	EPOC	

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

Electronically Signed | 01/12/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING **02 - BUILT IN 2007** B. WING _____	**12/14/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto: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 Comforcare, is a 1-story building with no basement. The building was constructed in 2007 and was determined to be of Type II(111) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridors that is monitored for automatic fire department notification. There is smoke alarms in all resident rooms that are monitored by the nurse call system and light outside each resident room. The facility has a capacity of 45 beds and had a	K 000		

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K 000	Continued From page 2 census of 41 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 222 SS=D	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4	K 222		12/14/16

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K 222	Continued From page 3 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Egress Doors DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Findings Include:	K 222	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 this statement of deficiencies. the plan of correction is prepared and or executed solely because it is required by the provision of federal and state laws. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction	

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K 222	Continued From page 4 On facility tour between 08:45 AM and 12:00 PM on 12/14/16, based on observation and interview revealed the following include: That the exit door by room 314 required more than 15 lbs force to open. This deficient practice could affect the safety of all the residents, staff and visitors within this smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 222	constitutes the centers allegation of compliance in accordance with section 7305 of the state operations manual. The door was fixed on the day of the state inspection to ensure it was able to be opened with less than 15 pounds of force. Audits for all egress doors will be completed monthly X 6 with results reported to Quality committee for further recommendations.	
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by:	K 353		12/20/16

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K 353	Continued From page 5 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Findings Include: On facility tour between 08:45 AM and 12:00 PM on 12-14-16, based on documentation review and interview that the following include: Revealed that there were no fire sprinkler quarterly inspection completed for 2016. This deficient practice could affect the safety of all the residents, staff and visitors within the building. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353	The fire sprinkler system was inspected on 12/20/16 with no negative findings. The center has implemented TELs process for ensuring quarterly inspections for fire sprinkler is completed. Quarterly audits will be completed with results reported to the Quality Committee for further recommendations.	
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie	K 372		12/14/16

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K 372	Continued From page 6 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Findings Include: On facility tour between 08:45 AM and 12:00 PM on 12-14-16, based on observation and interview revealed the following include: There were preparations above ceiling in the smoke barrier for Healing Grace and the Lodge wings.	K 372	Penetrations were filled appropriately by Maintenance on 12-14-16. Facility will conduct monthly audits X 6 to check above ceiling tile for any penetrations and results will be communicated to Quality Meeting for further recommendations.	

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K 372	Continued From page 7 This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 372		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
January 3, 2017

Ms. Katie Davis, Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, MN 55912

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5317028

Dear Ms. Davis:

The above facility was surveyed on December 12, 2016 through December 15, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute

after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: _____ B. WING _____	12/15/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On December, 12, 13, 14, & 15, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings;	2 625		1/24/17

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2 625	Continued From page 3 K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure accurate and complete documentation was maintained in health records regarding interventions/services provided for 2 of 3 residents (R78, R89) reviewed for acute changes to health status. Findings include: R78's records did not include documented coordination of care related to urology services. The resident's record at the facility did not include physician progress notes from urologist appointments in October and November 2016. As a result, information regarding potential urologic issues including: possibility of acquiring urinary tract infections, sepsis, ultimate renal deterioration, pyelonephritis was not available by facility staff to develop appropriate interventions for care. R78's Diagnosis Report dated 10/6/16, identified	2 625	Corrected	

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2 625	Continued From page 4 a diagnosis of Urinary Retention and Urinary Tract Infection. R78's progress note dated 10/26/16, indicated R78 had been seen by a urologist for urinary retention and recent urinary tract infections. According to the document, R78 had been hospitalized September 30, 2016 for a stroke, and at that time had experienced a combination of incontinence and urinary retention and a Foley catheter had been placed. R78's care plan revised on 10/20/16, indicated R78 had an indwelling catheter, had moderate cognitive impairment, and memory impairment with a BIMS (brief interview for mental status) score of 10 (indicative moderate cognitive impairment). During interview with R78 on 12/12/16, at 5:35 p.m. R78 was unable to answer basic questions. R78's physician Order Summary reports from October 2016 to December 2016 indicated R78 was to have care including: wash catheter daily with water and soap, and to have the catheter changed every 30 days. There was no order to observe for signs or symptoms of urinary tract infection or sepsis. The progress notes from October 2016 to December 15, 2016 were reviewed. The progress notes did not identify urology instructions or updates. The facility's medical chart for R78 was reviewed, and there were no notes found regarding the resident's urology reports/documents from urology appointments. When information was requested including any assessments,	2 625		

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2 625	Continued From page 5 interventions, etc. related to Foley catheter, the facility had to request the information via fax (facsimile) to the local clinic requesting the last three months' worth of Urology notes as they had none of the information in the resident's record at the facility. The following was provided: Review of urology note dated 10/26/16, identifies R78 needing to be monitored closely for development of urinary tract infections. "The signs and symptoms associated with cystitis and pyelonephritis were described in detail to the patient and her family." Urology note dated 11/15/16, identifies a right renal obstruction. "I discussed with the patient that she has right-sided renal obstruction causing hydrocephalous. I explained that this puts her at higher risk for ultimate renal deterioration, I also described that this would put her at greater risk for urinary tract infections including pyelonephritis, which in her situation could be life threatening. It is unclear to me whether she fully understands the situation". This urology note also indicated the provider had contacted R78's power of attorney to discuss the possibility of nephrostomy tube and stent placement. The note identified the power of attorney had subsequently declined those interventions due to the risks of surgery. The note included: "they understand that there is a risk for not intervening. The consequences could be as dire as sepsis, ICU [intensive care unit] admission, and even death." Urology note dated 12/14/16, identifies continued discussion with R78's power of attorney related to R78 being at increased risk for renal deterioration and for urinary tract infections, with potentially life threatening consequences. Note identifies symptoms to be monitored and reported as soon	2 625		

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2 625	Continued From page 6 as possible to be, "urethral pain, suprapubic discomfort, flank pain, fevers, chills, or other signs or symptoms consistent with urinary tract infections". During interview on 12/15/16, at 12:10 p.m. with registered nurse (RN)-A stated R78 comes back from urology appointments with a clinical referral note, the facility then has to call for the actual notes the physician dictates from the visit. RN-A stated the floor nurses or the HIMS (health information medical specialist) staff was responsible for getting these notes and scanning them into the computer. RN-A stated the facility is only aware of what is sent on the urology referral. RN-A stated she wasn't aware R78's family had declined interventions due to risks, or that R78 was at high risk for complications of sepsis, hospitalization or death. RN-A verified R78 would not be able to alert staff if experiencing any symptoms of urinary tract infections. RN-A stated she had not previously been aware of the urology provider's recommendations for stents, or the risks of not having the stents, because that information was only available in the clinic progress notes, which the facility had not received or requested prior to survey. During interview with HIMS staff on 12/15/16, at 1:19 p.m. the HIMS staff stated her process for checking medical records was to randomly select a resident, and go through the chart and make sure everything is where it needs to be. The HIMS staff stated she focused on making sure each chart had a discharge summary and an H&P (history and physical). The HIMS staff stated the floor nurses should be getting notes from appointments and if they aren't getting the notes they should be alerting her to request the information because she is not always aware of	2 625		

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2 625	Continued From page 7 when residents have appointments. The HIMS staff also stated she doesn't keep track of which charts have or haven't been reviewed for missing documents and has no specific system in place to ensure medical records aren't missing necessary information. During interview with the director of nursing (DON) on 12/15/16, at 1:23 p.m. the DON stated she knew nothing about the urologist recommendation for R78 to have nephrostomy stents, or the risks related to R78's health if stents weren't placed. The DON stated her expectation is for the nurse manager to be obtaining paperwork from appointments. The facility policy Maintenance of Active Medical Records dated 10/16, indicated the medical record: "must contain enough information to show the location [facility] knows the status of the resident, has an adequate plan of care and provides sufficient evidence of the effects of the care provided. Documentation should provide a picture of the resident's progress, including response to treatment, change in condition and changes in treatment." R89's face sheet indicated the resident had been admitted 8/26/16, with diagnosis of chronic pulmonary, kidney disease and lung cancer. R89 had died on 8/31/16. When the survey team requested all information regarding R89's death and nursing interventions done at the time, none was provided as the License Practical Nurse had not documented any details. The hospice nurse had found the resident without vital signs. The documentation was unclear as to whether vital signs were attempted, any description of the resident's body/color/temperature, whether rigormortis was present, if physician was	2 625		

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2 625	Continued From page 8 contacted, if cardio pulmonary resuscitation was attempted, if emergency services had been contacted, was the coroner contacted, was family contacted and their wishes honored, was a room mate present and what counseling/support given, who took personal items, disposition of medications, etc. During an interview on 12/15/16 at 11:42 a.m. Licensed Practical Nurse (LPN)-A verified she had not documented anything that transpired regarding the death of R89. LPN-A said that she forgot to document the progress and death of resident on her shift. However, a note was not completed from 8/31/16 to the survey date of 12/15/16. On asking LPN-A what had happened the shift she worked when R89 died. LPN-A stated the Hospice nurse went in to evaluate R89 for hospice services and found R89 dead. The last progress note found in the electronic medical record (EMR) was dated 8/31/16 at 2:12 p.m. and contained R89 was here due to chronic obstructive pulmonary disease (COPD), had no complaints of shortness of breath or pain. Is assist of one with transfers and activities of daily living. R89 had appointment today, family transported. Author of this note had received a call and told R89 was going to be evaluated by hospice at 3:00 p.m. today, and will continue to monitor. No other information following the health status of this resident was provided even though requested by surveyor. Document review entitled Release of Body to Mortician reads body released by order of on call physician dated 8-31-16 at 3:25 p.m. SUGGESTED METHOD OF CORRECTION: DON or designee could develop a system to	2 625		

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2 625	Continued From page 9 ensure each resident medical record contains all necessary information. DON or designee could develop an audit to ensure continued compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 625		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to identify one new pressure ulcer and a scab located on left heel, complete a comprehensive assessment, and provide appropriate care and services for 1 of 2 residents (R78) reviewed with pressure ulcers. Lack of timely assessment and responsive care resulted in actual harm for R78 who developed a new pressure ulcer and scab, on the left inner	2 900	Corrected.	1/24/17

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2 900	Continued From page 10 heel. Findings include: R78's Admission record form included an admission date of 7/14/16. The Diagnosis information included: Type 2 Diabetes Mellitus, Hemiplegia, and Hemiparesis following cerebral infarction (paralysis after a stroke) affecting left (non-dominant) side and several other health concerns. R78 ' s Nursing admit/readmit data collection - V2 dated 10/6/16, had been completed after R78 had returned from a 9/30/16 to 10/6/16 hospitalization for an urinary tract infection, kidney infection, urinary retention, chronic atrial fibrillation, anemia, myocardial accident (stroke), type 2 diabetes, left side hemiplegia, and bradycardia. On the form under wounds/ulcers there were two identified, one located on left buttock and described as " upper buttock, stage 1, applied transparent ply skin. " Second site located on left heel with a description of " suspected deep tissue injury. " R78 was identified to need two for assistance with activities of daily living (ADLs). R78's Positioning Assessment and Evaluation dated 10/7/16, indicated R78 was a total assist with Hoyer lift, and a corresponding Braden Scale (used to determine risk to have skin breakdown) indicated R78 was at risk for breakdown. The assessments indicated R78 is unable to ambulate and has left sided paralysis related to having had a stroke. In addition, R78 was identified as needing staff assistance to reposition every two hours. An additional assessment dated 10/29/16, indicated R78 was unable to reposition independently, was totally dependent on staff to provide all needs, required continued use of Hoyer (mechanical lift) assist with two staff, and continued need to be repositioned every two hours. An assessment for positioning conducted 11/12/16, identifies no change to the prior	2 900		

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2 900	Continued From page 11 assessments/interventions. On 12/13/16, a Braden Scale for Predicting Pressure Sore Risk was again completed and R78 scored a 12 which indicated R78 was at high risk for skin breakdown. A quarterly Minimum Data Set (MDS) assessment dated 10/13/16, identified R78 as having a stage one pressure ulcer and one unstageable pressure ulcer suspected deep tissue injury in evolution. Wound Assessment documentation dated 11/22/16, identified the stage 1 pressure ulcer (assessed on 10/6/16 after return from hospital) located on the upper buttock had deteriorated to a stage 4 pressure ulcer, had a foul odor, tunneling and depth present. Wound bed 25% eschar, with sloughing and minimum serosanguinous drainage, wound edges denuded, macerated undefined. Wound Assessment documentation from 11/29/16, identified a stage 4 pressure ulcer to coccyx/right buttocks with no healing noted at this time of this assessment from the last assessment completed. Wound Assessment documentation dated 12/6/16, identified a second stage 2 pressure ulcer developed and located on coccyx/right buttock area with skin surrounding coccyx is pink and macerated. Skin observation sheet dated 10/24/16, identifies an intact, healing decubitus ulcer to left heel measuring 4.5 cm by 2 cm. During a continuous observation on 12/13/16, from 3:17 p.m. and ending at 5:29 p.m. nursing assistant (NA)-C entered the room and R78 was observed lying on her right side in bed. Blue boot (a soft sided boot that surrounded the lower leg and foot) was on left foot and both feet were placed directly on top of the blue pad (a thick pad used to support leg yet allow ankle area to be	2 900		

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2 900	Continued From page 12	2 900		

floated over edge of pad). The left foot was not floated. R78 was again observed from 8:44 a.m. to 9:00 a.m. on 12/14/16, (a continuous observation.) R78 was eating breakfast in the dining room. At 9:00 a.m. R78 was assisted out of the building for a medical appointment.
Interview on 12/14/16, at 9:12 a.m. with nursing assistant (NA)-C stated he had assisted R78 from her bed to wheelchair at 7:30 a.m. NA- verified R78 had not been repositioned or offloaded (removing pressure to skin areas prone to breakdown) before leaving for the appointment.
Observation on 12/14/16, at 2:02 p.m. R78 was positioned on her back with a body pillow under the left side. R78 had blue boot on left foot. Feet again were placed directly on top of the blue pad in bed. Left foot was not floated.
Observation and interview on 12/14/16, at 3:29 p.m. with registered nurse (RN)-E verified left foot was not floated while in bed. RN-E stated her heels should be floated and they aren't. Asked RN-E to view left heel where it was documented that a pressure ulcer had recently healed. Two surveyors and RN-E observed a red area on left heel and RN-E verified a wound was present on the left inner heel measuring 1 cm by 0.6 cm with a blanchable outer red area with a dark purple area in the middle measuring 0.2 cm by 0.5 cm that was non-blanchable. RN-E also verified there was a scab present on left inner heel measuring 0.7 cm by 1 cm. RN-E stated she wasn't aware there was any wounds to left heel prior to this time. RN-E removed dressing to R78's sacrum/right buttock area where a stage 2 pressure ulcer was located. RN-E described the dressing to have a moderate amount of serosanguinous drainage. RN-E described the wound to have 10% eschar, 50% granulation and 40% slough. RN-E measured the wound with width from redness to redness measuring 10 cm,

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2 900	Continued From page 13 length 5.5 cm and depth 3.7 cm. Observation on 12/15/16, at 7:10 a.m. R78 was observed to be asleep in bed, blue boot on left foot, again left heel flat on blue pad and not floated over edge of pad. Interview on 12/15/16, at 7:44 a.m. with nursing assistant (NA)-D verified R78's heel should have been floated over the edge of the blue pad. NA-D verified R78's heel had not been floated. Interview on 12/15/16 at 7:49 a.m. with nursing assistant (NA)-B stated R78 no longer had any wounds on her left heel. NA-B stated that they had healed. NA-B stated R78 had first developed the pressure area on her sacrum when she had returned from the hospital. NA-B stated it started out small but had kept growing and growing. Observation of dressing change on 12/15/16, at 8:09 a.m. with RN-C identified the wound to sacrum/upper buttock area to have 35-40% eschar, 50-60% slough and 20-25% granulation. RN-C stated the wound is measured weekly with all documentation entered into the computer, as well as daily assessments being documented. RN-C stated he was unaware that R78 had a new pressure ulcers to her left heel (this was first observed by RN-E and two surveyors the day prior). RN-C identified the wound on left inner heel to be non-blanchable with red outer area measuring 1.2 cm by 1.1 cm and dark purple area in center measuring 0.4 cm by 0.3 cm which deteriorated from the day prior. Interview on 12/15/16, at 10:11 a.m. with RN-C stated R78's feet should be checked every shift and weekly on bath days with the full skin assessments. Observation on 12/15/16, at 10:17 a.m. R78 was asleep in bed, positioned on right side, left foot flat on blue pad and not floated. Interview on 12/15/16, at 10:18 a.m. with RN-C verified R78's left heel had not been floated.	2 900		

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2 900	Continued From page 14 RN-C then repositioned R78's left foot so that it was floated off the edge of the blue pad on the bed. RN-C- stated the point of the blue pad is to float the heels. Interview on 12/15/16, at 10:27 a.m. with director of nursing (DON) stated she wasn't in charge of wounds and the nurse manager was in charge of them as she was wound certified. DON stated she was unaware that R78 had two new pressure ulcers on her left heel found the day prior with RN-E. DON stated she would expect weekly wound measurements to be included in the documentation for each wound along with any identifying documentation including drainage, what the wound looks like as well as the surrounding tissue. DON was unable to identify when wound training had been provided to the nursing staff to ensure proper documentation and assessments were being completed. Interview on 12/15/16, at 10:48 a.m. with registered nurse (RN)-A a nurse manager, stated she isn't in charge of the wounds, the floor nurse is. RN-A states she does rounds with the wound nurse (from Mayo) when she is at the facility once a month. RN-A stated she monitors the assessments but was unaware the measurements weren't included in the weekly RN assessments. RN-A stated she tries to monitor the measurements weekly. RN-A stated she wasn't aware R78 had two new pressure ulcers to her left heel which were found the day prior as it had not been passed on to the next shift. RN-A stated when a new pressure ulcer is identified the RN is responsible for filling out the wound data collection form and wound assessment and then notifying the provider. RN-A verified there was no documentation from 12/14/16 when the two new pressure ulcers were identified by surveyors and RN-E. RN-A stated the floor nurses should be assessing wound weekly, measuring and	2 900		

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2 900	Continued From page 15 describing what the wounds look like, the data wound collection forms should be filled out daily. RN-A stated diabetic foot checks should be completed on bath days. RN-A stated R78's heels are supposed to be floated off the blue pad. RN-A was unaware of when training was last provided to the nursing staff regarding proper assessments of wounds or when last provided to the nursing assistants for proper positioning of the residents. R78's comprehensive care plan last updated on 10/20/16, was reviewed and had not included the stage 4 pressure ulcer located by sacrum/coccyx nor had the two pressure ulcers located on the left heel first observed on 12/14/16 mentioned on care plan or interventions to promote healing and prevent new ulcers from developing. The care plan did indicate a problem area for impairment to skin integrity related to immobility, and diagnosis of stroke with left sided hemiparesis. The care plan also indicated R78 had returned from the hospital on 10/6/16, with an unstageable pressure ulcer located on left heel with intact blister. Interventions for heal ulcer were identified to include: monitor location, size and treatment of skin injury, turn and reposition in bed and chair every 2 hours (watch heels closely) blue boot to left heel. Elevate heels off bed. Provide blue boot to left heel wear at all Facility policy titled, Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements" dated last revised 4/16 identifies, when a pressure ulcer is identified the registered nurse should record the type of wound and the degree of tissue damage on the Wound RN Assessment UDA. The licensed nurse records the location of the area, the measurements and the ulcer/wound characteristics. When a pressure ulcer is present, daily monitoring with accompanying documentation should include the following: an evaluation of the status of the	2 900		

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2 900	Continued From page 16 dressing, status of the area surrounding the ulcer, presence of possible complications. Pressure ulcer should be assessed at least weekly and documented on the Wound RN Assessment UDA. Documentation should include at least: measurements, characteristics of the ulcer including wound bed, undermining and tunneling, exudate, surrounding skin, etc., presence of pain and current treatments. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students,	21426		1/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: _____ B. WING _____	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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21426	Continued From page 17 residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure newly admitted residents received tuberculin skin testing within 72 hours of admission for 1 of 5 residents (R23) and new employees received baseline tuberculosis screening and tuberculin skin testing prior to starting work for 4 of 6 employees (E-1, E-2, E-3 E-4). This has the potential to effect all 40 residents in the facility, staff, and visitors. Findings Include: R23 was admitted to the facility on 9/28/16 according to their face sheet. R23 tuberculin screening was completed on 9/28/16. However, R23 received his first tuberculin skin testing (TST) on 12/14/16 after the surveyor brought this concern to the attention of director of nursing (DON). E-1 started at the facility on 9/29/16 according to employee file. E-1's baseline tuberculosis (TB) screening tool was completed on 9/29/16 with the first TST administered on 9/30/16 which had not been read. The second TST administered on 10/27/16 (past the two to three weeks	21426	Corrected.	

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21426	Continued From page 18 recommended between TST) and read 0 mm (millimeters) and negative. E-2 started at the facility on 11/17/16 according to personal file. E-2's baseline TB screening tool was completed on 11/17/16 with the first TST administered on 11/17/16. Second TST administered on 12/14/16 which was over the recommended 21 day interval. E-3 started at the facility on 08/17/16 according to the employee file. E-3's baseline TB screening tool was completed on 8/17/16 with his first TST administered on 8/17/16. No second TST was administered. E-4 started at the facility on 05/18/16 according to the employee file. There was no information in regards to TST status or TB screening. On 12/13/16 at 3:22 p.m. interview with human resources (HR) stated, that E-4's paperwork showing screening and TST was completed had not been provided when requested. On 10/15/15 at 2:17 p.m. the TB program was reviewed with the DON. The DON stated, "I know it's [TB program] not right." Facility policy, TB Exposure Control Plan dated 3/1/2010, read, "V. Risk Assessment:...i. Healthcare workers (HCW's) will have a pre-placement and annual Tuberculin skin test (TST) to assess for possible conversions....ii. All residents will have a Tuberculin Skin Test (TST) within 72 hours of admission unless contraindicated...VII. Early Detection of TB disease: a. Residents will have a two-step TST upon admission and will be evaluated for symptoms of TB, including cough, fever, night sweats, weight loss, etc..."	21426		

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21426	Continued From page 19 Minnesota Department of Health, Regulations for Tuberculosis Control in Minnesota Health Care Settings, A guide for implementing tuberculosis infection control regulation in your facility, dated July 2013. Page 10, Screening Health Care Workers, General principles, "TST documentation should include the date of the test (i.e. month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative). Baseline TB screening, "An employee may begin working with patients after a negative TB symptom screen and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. Page 23, Screening Residents, General principles, "Screening should be initiated within 72 hours of admission or 90 days prior to admission...TST documentation for residents should include the date (i.e., month, date, year), the number of millimeters of induration (if no induration, document "0" mm), and interpretation (i.e., positive or negative). SUGGESTED METHOD OF CORRECTION: The director of nursing could review tuberculosis policies and procedures to ensure compliance. The director of nursing could educate nursing staff to their policies and procedures for employee and resident tuberculosis skin tests and tuberculosis screens and provide all staff ongoing tuberculosis training. The director of nursing could monitor for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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21830	Continued From page 20	21830		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:	21830		1/24/17

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21830	Continued From page 21 (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or	21830		

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21830	Continued From page 22 designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R27) was allowed to chose type of bath. Findings include: R27 was interview on 12/12/16, at 2:16 p.m. R27 she said she had to take a showers as the facility only had one tub, which was in demand. R27 stated she is up at 6:00 a.m., there should not be such a demand at that time of the day for the tub. R27 stated she had asked for tub baths and was told the tub was too busy. R27 stated she would prefer tub baths. R27 was admitted to the facility on 9/2/15, with diagnosis that included heart failure and weakness, according to facility Admission Record. The facility identified R27 on the quarterly Minimum Data Set (MDS), an assessment dated 11/1/16, and annual MDS, an assessment dated 8/9/16, to have moderate cognitive impairment and required one person physical assist for bathing. Neither assessment identified preference for type of bath.	21830	Corrected.	

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21830	Continued From page 23 Document review of annual MDS dated 8/9/16, revealed section F, choice of bath was somewhat important to R27. Document review of facility Nursing Admit Re-Admit Data Collection form dated 7/20/16, revealed bathing preferences was shower and whirlpool. Document review of facility resident care plan dated 11/10/16 in facility computer program point click care, revealed a focus of self-care deficit. Interventions included required one person assist with bathing. There was no indication of type of bath. Care plan revision dated 12/13/16 revealed R27 requests whirlpool on bath days. Document review of facility Visual/Bedside Kardex Report, print dated 12/13/16-revealed R27 required one staff participation with bathing, resident requests whirlpool on bath days. Document review of facility Documentation Survey Report identified intervention of bathing (whirlpool) and revealed the following: 9/1-9/30/16 -received 2 showers and 2 whirlpool baths; 10/1/16 - 10/31/16-received 5 showers, no whirlpool baths; 11/1/16-11/30/16-received 3 showers and 1 whirlpool bath. Document review of facility Follow Up Question report print date of 12/13/16, identified task of bathing (whirlpool), revealed R27 received 2 showers from 12/1/16 to 12/12/16, and no whirlpool baths. Document review from 9/1/16 to 12/12/16,	21830		

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21830	Continued From page 24	21830		

revealed R27 received weekly baths,a total of 15 baths in that time period. 12 of the 15 baths were showers and only three whirlpool baths in 3 1/2 months.

Document review of facility Lodge/Garden Bath Schedule, undated, revealed R27 was scheduled for whirlpool baths on Monday mornings

During interview on 12/13/16, at 3:20 social services director stated bathing choices was determined by the nursing department.

During interview on 12/13/16, at 3:30 p.m., registered nurse (RN)-A stated not aware R27 requested tub baths. RN-A verified facility Admit Readmit Data Collection dated 7/20/16, identified type of bath preferred was tub or shower. RN-A stated bathing preferences were reviewed at care conferences. RN-A stated to check with floor nurses about bathing preferences. RN-A verified R27 received a shower on 11/28/16, 12/5/16, and 12/12/16, and a whirlpool tub bath on 11/21/16, by nursing assistant (NA)-B.

During interview on 12/13/16, at 3:40 p.m., RN-B verified facility Visual/Bedside Kardex Report was the only nursing assistant assignment instructions for R27. RN-B verified the instructions included "resident requests whirlpool on bath days."

RN-B stated instructs new employees that the Visual/Bedside Kardex Report was resident care instructions. RN-B verified from 11/14/16 to 12/12/16, R27 received one tub bath and the rest of baths were showers.

During interview on 12/13/16, at 5:15 p.m., director of nursing stated facility was not aware

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21830	Continued From page 25 R27 wanted whirlpool baths. Director of nursing verified the Visual/Bedside Kardex Report was nursing assistant resident care instructions and directed R27 wanted whirlpool baths. During interview on 12/14/16, at 10:20 a.m., nursing assistant (NA)-C stated asked R27 preference for bath. Stated residents have to take turns with whirlpool because the tub was in use. NA-C verified R27's bath day was Monday mornings. Document review if facility Resident's Rights for Skilled Nursing Facilities dated 11/2016, page 3, (f) directed The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice. (1) The resident has a right to choose activities, schedules (including sleeping and waking times), healthcare and providers of healthcare services consistent with his or her interests, assessments, and plans of care. (2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise polices and procedures concerning bathing preferences in the facility, educate staff, and audit staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		