#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICALD CERTIFICATION AND TRANSMITTAL	L
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENC	Y

Facility ID: 00697

	171111	TO BE COMIT	DETED DI I	1111 0 171	EBERTETRIGENET	racinty ib. 00097		
(L1) <b>245593</b>	(L1) <b>245593</b> (L				3. NAME AND ADDRESS OF FACILITY (L3) GOOD SAMARITAN SOCIETY - ST JAMES (L4) 1000 SOUTH SECOND STREET			
2.STATE VENDOR OR MEDICAI (L2) <b>713343000</b>	D NO.	(L4) 1000 SOUTI		TREET	(L6) <b>56081</b>	3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE (L9)	OF OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEG	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other  8. Full Survey After Complaint		
6. DATE OF SURVEY 1/8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other		02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31		
11LTC PERIOD OF CERTIFICAT	ION	10.THE FACILITY	IS CERTIFIED	AS:				
From (a): To (b):		_	equirements e Based On:		And/Or Approved Waivers Of2. Technical Personnel3. 24 Hour RN			
12. Total Facility Beds	<b>51</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	· · · <del>-</del>		
13.Total Certified Beds	<b>51</b> (L17)	-	oliance with Progra and/or Applied V		5. Life Safety Code  * Code: A	9. Beds/Room (L12)		
14. LTC CERTIFIED BED BREAK	DOWN				15. FACILITY MEETS			
18 SNF 18/19 SN 51	IF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Lois Boerboom, HFE	E NE II		02/1/2018	(L19)	Kamala Fiske-Downing.	Enforcement Specialist 2/01/2018 (L20)		
I	PART II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	OFFICE OR SINGLE S	TATE AGENCY		
19. DETERMINATION OF ELIGI  1. Facility is Eligible			IPLIANCE WITH HTS ACT:	H CIVIL	<ol> <li>Statement of Financial Solvency (HCFA-2572)</li> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> </ol>			
2. Facility is not Elig	-				3. Both of the Above	:		
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	MENT	26. TERMINATION ACTION	(L30)		
OF PARTICIPATION <b>01/01/1992</b>	BEGINNING	G DATE	ENDING DAT	ГЕ	VOLUNTARY 00 01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	** - *** - ****************************		
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER  07-Provider Status Change  00-Active		
(L27)	B. Rescind St	uspension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	). INTERMEDIARY	/CARRIER NO.		30. REMARKS			
		00140						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAL	DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		



CMS Certification Number (CCN): 245593

February 1, 2018

Ms. Ursula Hagstrand, Administrator Good Samaritan Society - St James 1000 South Second Street St James, MN 56081

Dear Ms. Hagstrand:

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 8, 2018 the above facility is certified for:

51 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 51 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kamala Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us



Electronically delivered

February 1, 2018

Ms. Ursula Hagstrand, Administrator Good Samaritan Society - St James 1000 South Second Street St James, MN 56081

RE: Project Number S5593028

Dear Ms. Hagstrand:

On December 29, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 4, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On January 18, 2018, the Minnesota Department of Health and the Minnesota Department of Public Safety completed Post Certification Revisits (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 4, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 8, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 4, 2017, effective January 8, 2018 and therefore remedies outlined in our letter to you dated December 29, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us



Electronically delivered

February 1, 2018

Ms. Ursula Hagstrand, Administrator Good Samaritan Society - St James 1000 South Second Street St James, MN 56081

Re: Reinspection Results - Project Number S5593027

Dear Ms. Hagstrand:

On January 18, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 4, 2017, with orders received by you on December 29, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

DETACTIVENT OF HEADTH A	MEDICA	RE/MEDICAII			AND TRANSMITTAL TE SURVEY AGENCY	DICARE & MED	ID: QLQ6 Facility ID: 00697
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245593 2.STATE VENDOR OR MEDICAID NO. (L2) 713343000		3. NAME AND AD (L3) GOOD SAM (L4) 1000 SOUTH (L5) ST JAMES,	ARITAN SOC H SECOND ST	CIETY - ST	(L6) <b>56081</b>	4. TYPE OF ACT  1. Initial  3. Termination  5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9) 6. DATE OF SURVEY 12/04/201 8. ACCREDITATION STATUS: 0 Unaccredited 1 TIC 2 AOA 3 Other  11. LTC PERIOD OF CERTIFICATION From (a): To (b):		7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF 10.THE FACILITY A. In Complian Program Re	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP TIS CERTIFIED Ance With	09 ESRD 10 NF 11 ICF/IID 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE  And/Or Approved Waivers Of 2. Technical Personne		DING DATE: (L35)
13.Total Certified Beds	51 (L18) 51 (L17)	X B. Not in Com	cceptable POC		3. 24 Hour RN4. 7-Day RN (Rural SI5. Life Safety Code  * Code: <b>B</b> *	7. Medical	Director oom Size
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF  51  (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARKS	S (IF APPLICAE	BLE SHOW LTC CA	NCELLATION I	DATE):			
17. SURVEYOR SIGNATURE  Kathy Hahn, HFF NF II		Date : 0	1/11/2018	(L19)	18. STATE SURVEY AGENCY  Kamala Fiske-Downing		Date: ecialist 01/25/2018 (L20
PART I	I - TO BE C	OMPLETED B	BY HCFA RE	GIONAL	OFFICE OR SINGLE S	STATE AGENCY	
DETERMINATION OF ELIGIBILITY	pate (L21)		PLIANCE WITH	H CIVIL	21. 1. Statement of Fina 2. Ownership/Contr 3. Both of the Abov	rol Interest Disclosure St	
OF PARTICIPATION 01/01/1992 (L24)	LTC AGREEM BEGINNING (L41) ALTERNATIV A. Suspension of B. Rescind Sus	DATE  E SANCTIONS of Admissions:	ENDING DATE (L25)  (L44)  (L45)		26. TERMINATION ACTION  VOLUNTARY  01-Merger, Closure  02-Dissatisfaction W/ Reimburg  03-Risk of Involuntary Terminati  04-Other Reason for Withdrawal	0         INVOL           05-Fail         06-Fail           sement         06-Fail           on         OTHER	vider Status Change
28. TERMINATION DATE:	29.	INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		00140					

(L31)

(L33)

DETERMINATION APPROVAL

 $32.\ \mathsf{DETERMINATION}\ \mathsf{OF}\ \mathsf{APPROVAL}\ \mathsf{DATE}$ 

31. RO RECEIPT OF CMS-1539

(L28)

(L32)



Electronically delivered December 29, 2017

Ms. Ursula Hagstrand, Administrator Good Samaritan Society - St James 1000 South Second Street St James, MN 56081

Re: State Nursing Home Licensing Orders - Project Number S5593028

Dear Ms. Hagstrand:

The above facility was surveyed November 28 through December 4, 2017, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 <u>only a suggestion</u> 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 order 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

Good Samaritan Society - St James December 29, 2017 Page 2

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 Kathryn Serie, Unit Supervisor at (507) 476-4233 or at kathryn.serie@state.mn.us.

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

Minnesota Department of Health

Kumalu Fiske Downing

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

PRINTED: 01/26/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245593	B. WING			12/	04/2017
	PROVIDER OR SUPPLIER	- ST JAMES		100	REET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH SECOND STREET JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
F 000	Emergency Prepare conducted on 11/28 12/1/17 through 12 survey. Good samin compliance with INITIAL COMMENTO On 11/28/17,11/29 12/4/17, a standard facility by the Minner	_	F 0	00			
	requirements of 42 Requirements for L The facility's plan of as your allegation of Department's accepance enrolled in ePOC, year the bottom of the	CFR Part 483, Subpart B, and ong Term Care Facilities.  f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will					
F 656 SS=D	on-site revisit of you validate that substate regulations has been your verification.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with t Comprehensive Care Plan 1)	F 6	56			1/5/18
ABORATORY	§483.21(b)(1) The implement a compression care plan for each resident rights set f §483.10(c)(3), that	chensive Care Plans facility must develop and rehensive person-centered resident, consistent with the forth at §483.10(c)(2) and includes measurable DER/SUPPLIER REPRESENTATIVE'S SIGN	IATLIDE		TITLE		(X6) DATE

Electronically Signed 01/08/2018

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 A. BUILDING			E SURVEY MPLETED
		245593	B. WING		12/	04/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP COD 1000 SOUTH SECOND STREET ST JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	medical, nursing, a needs that are identical assessment. The codescribe the following in the services that or maintain the resiphysical, mental, as required under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclutreatment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS rationale in the resident's represent (A) The resident's represent (A) The resident's redesired outcomes. (B) The resident's redesired outcomes. (B) The resident's redesired outcomes. (C) Discharge plans plan, as appropriate requirements set for section.  This REQUIREMED by: Based on observations.	oframes to meet a resident's and mental and psychosocial stified in the comprehensive comprehensive care plan must ang - t are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 33.25 or §483.40 but are not a resident's exercise of rights auding the right to refuse 83.10(c)(6).  Services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. With the resident and the tative(s)-goals for admission and coreference and potential for acilities must document and the sessed and any referrals to be sessed and any referrals to the sessed and	F 6	Preparation and execution of		
		ailed to develop and implement e person centered care plan for		response and plan of correction constitute an admission or agi		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245593	B. WING			12/0	04/2017
NAME OF I	PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/(	74/2017
					000 SOUTH SECOND STREET		
GOOD S	AMARITAN SOCIETY	Y - ST JAMES			T JAMES, MN 56081		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	V	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLÉTION DATE
F 656	Continued From page	age 2	F6	656			
		R11, R36) reviewed for			the provider of the truth of the facts		
		cation and for 1 of 1 resident			alleged or conclusions set forth in t		
		r hearing impairment.			statement of deficiencies. The plan		
	,				correction is prepared and/or execu		
	Findings include:				solely because it is required by the		
					provision of federal and state law.		
		formation obtained in the			purpose of any allegation that the o		
		eluded: Major depressive			is not in substantial compliance wit		
		a with lewy body disease, eneralized anxiety disorder.			federal requirements of participation response and plan of correction	n, this	
	R11 was admitted				constitutes the center s allegation	of	
	Titti was admitted	011 10/10/10.			compliance in accordance with sec		
	During observation	n on 11/28/17, at 7:00 p.m. R11			7305 of the State Operation Manua		
		d pleasant, seated by her room			R 11 □s plan of care was updated		
		aff to assist her into bed. When			-17 to include the use of Ativan. Ta		
		time, R11 indicated feeling			behaviors were identified and put in		
	tired and wanted to	o get into bed.			plan of care, as well as monitoring		
	D	11/00/17 0:00			specific side effects/adverse reacti		
		tres on 11/29/17, at 9:00 a.m.			All residents receiving antianxiety r		
	R11 appeared plea	sking staff repetitive questions			were identified and their plans of care have		
		ted. When interviewed at this			updated as necessary for those ide		
		d she thought staff assisting			The Case Managers and Social Se		
		en talking about her and that			Director will continue to review care		
	she felt bad.	C .			in the monthly med review meeting	as well	
					as with any newly prescribed antiar		
		/17, at 9:00 a.m. with nursing			medication. The Director of Nursin		
		ndicated R11 will become			Designee will complete bi-monthly		
		ess at times, but is usually			plan audits for three months to ens		
	pleasant and coop	erative.			compliance. Results of the audits		
	Review of the sign	ificant change Minimum Data			monitored by the Director of Nursin forwarded to the Quality Committee		
		ment dated 8/30/17, R11 was			review.	, 101	
		g a Brief Interview of Mental			R 92□s hearing aid was reordered	and	
		re of "4" (meaning cognition is			payment offered on 12-1-17. The		
		. The MDS indicated R11			care was updated to include HOH i		
	exhibited moods o	f having trouble falling asleep			ears and use of devices in both ear		
		ıch 12-14 days during the			Other residents using hearing device		
	assessment period	d. The MDS further indicated			were identified, and plans of care		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245593	B. WING		·····	12/0	04/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COODC	AMADITAN COCIETY	CT LAMES		10	000 SOUTH SECOND STREET		
GOOD S	AMARITAN SOCIETY	- SI JAMES		S	T JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 656	R11 exhibited behand Review of R11's cuincluded: Ativan 0.5 daily (QID) and 0.5 (PRN) during the nidisorder). Review of administration reconstractive of PRN prior). The resident orders on 10/18/16 Review of R11's cuinclude the use of monitoring of targe effects/adverse reause.  Interview on 11/30/director of nursing care for R11 did not did it include specified monitoring of targe effect monitoring for During observation 3:09 p.m. R92 and indicated R92 had aide since July 201 visits daily and exphearing aid one evimorning it was mist the missing hearing locate the hearing in the process of put was unsure who for the replacement staff had not offered reconstructions.	aviors of delusions.  arrent physicians orders by milligrams (mg) four times by mg tablet (1) as needed ight (for generalized anxiety of the medication ord (MAR) indicated R11 had Ativan since 10/27/17 (34 days to was admitted with these by the medication ord include any to behaviors or side actions related to the Ativan and interview on 11/29/17, at family member (FM)-B been missing his right hearing to the tate of the tailor of the side of the tailor of the side of the tailor and interview on 11/29/17, at family member (FM)-B been missing his right hearing to FM-B further indicated she lained that R92 had his ening and the following sing. FM-B stated she reported to aide but staff were unable to device. FM-B stated she was urchasing another hearing aid, ether she would have to pay to FM-B revealed the facility and to assist with replacement of	F6	856	reviewed and updated as appropria The Social Services Director review missing items to identify any other concerns. The Social Services Dir will review the missing items log da immediately follow up with resident family regarding missing item concorton ensure compliance, missing item and related suggestion/concern for audits will be completed weekly for months by the Director of Nursing designee. Audit results will be more by the Director of Nursing and forward to the Quality Committee for review R36 social was reviewed. The placare was reviewed and updated to specific target behaviors and interverleted to sexual comments. Diagrand indication for the use of Paxil was reviewed. All residents on antidepressants were identified and of care were reviewed and updated appropriate. The Case Managers Social Services Director will continue review care plans in the monthly mereview meeting as well as with any antidepressant medication. The Dof Nursing or Designee will comple bi-monthly care plans audits for the months to ensure compliance. Rethe audits will be monitored by the Director of Nursing and forwarded Quality Committee for review.	ector aily and its and eerns. ms logs m three or nitored varded v. r the an of identify ventions nosis vas d plans d as and ue to ed new irector ite ee sults of	
	for the replacemen staff had not offere the right hearing ai	t. FM-B revealed the facility					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245593	B. WING _		12	/04/2017	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP C 1000 SOUTH SECOND STREET ST JAMES, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 656	stated he was havin normal conversation aide in the right earling aide in the right earling aide in the right earling aide was moderated of the Auris form dated 6/20/17 and right hearing a Review of the admidentifies R92 as utility and resident has a moderately impaire is usually understood Review of R92's curesident as having related to hard of hearing aide. Intervention and keep in radithough R92 was having hearing imputilizing a hearing aplan of care.  Interview on 11/30/practical nurse (LP in the right and left both ears.  Interview on 11/30/confirmed R92 was and utilized hearing with hearing and confirmed and confirmed R92 was and utilized hearing with hearing and confirmed R92 was and ut	interviewed at this time, R92 ng a difficult time hearing n due to the missing hearing r. FM-B responded it was more icate with R92 since the right	F 6	56			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245593	B. WING			12	/04/2017	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 SOUTH SECOND STREET ST JAMES, MN 56081			12/04/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	/IDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU EFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 656	device should have R36, admitted on 1 including depressiv dementia with beha admitted the physic milligrams daily. Th dated 11/16/17, ind is a good antidepre forgetfulness and n recommend taperin the physician order be decreased for a the medication. The record (MAR) ident (Paxil) 10 mg table related to other "sp  A fax dated 11/21/1 communicated to th documented the fol inappropriate comm since Paxil was dis 10 mg daily? Also worse since meds response included: HS (bedtime) x 1 m 11/22/17.  The plan of care inc cognitive function w identified on the MI depression score ic 11/1/17, was 1/27. dated 11/14/17, rel diagnosis included: interventions, allow plan lacked any inter	been in the plan of care.  0/26/17, with diagnoses e episodes and unspecified avioral disturbance. When sian ordered Paxil 10 e physician progress note icated: [R36] is on Paxil which ssant but in the elderly that of nay make symptoms worse, ng off the Paxil. Subsequently, ed the Paxil 10 mg daily dose week with discontinuation of e medication administration ified that Paroxetine HCI t was administered daily ecified depressive episodes".  7, from facility staff was	F	56				

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245593	B. WING		12/	04/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 SOUTH SECOND STREET ST JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 656	since admission or documentation idea inappropriate sexual 11/19, 11/20 (twice 11/29/17.  When interviewed clinical manager (Corestarted due to an made by R36 to fer When interviewed NA-B indicated that inappropriate comments about providing care comments.  During interview with at 10:13 a.m. it was inappropriate with the "girls" don't put when interviewed licensed social wor administrator were rationale for the adfor depressive epis inappropriate behalf	during cares.  ood/behavior documentation in 10/26/17, nursing natified that R36 made all comments to female staff on in 11/22 (twice), 11/24 and in 11/22 (twice), 11/24 and in 11/30/17, at 8:00 a.m. cm). Be explained that Paxil was increase in sexual comments male staff.  on 12/1/17, at 10:06 a.m. it R36 usually made ments in the evening but it can the day. NA-B also stated that ents that one does not want to fif are scared of R36 and worry redue to the sexual in the sexua	F 650			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245593	B. WING		12/04	4/2017
	PROVIDER OR SUPPLIER	- ST JAMES	1	STREET ADDRESS, CITY, STATE, ZIP CODE 000 SOUTH SECOND STREET ST JAMES, MN 56081		
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F 656	2 staff) but confirmed interventions on the verified she had just plan today 12/1/17, Resident displays/h sexual advances to cognitive impairment comments-initiated Contact health care behavior and seek in SEXUALLY INAPPI non-pharmacologic questioned further interventions to impromunicated. Quality of Care CFR(s): 483.25  § 483.25 Quality of Quality of Quality of care is a applies to all treatmer facility residents. Be assessment of a residents receivance with propractice, the compromunication and the residents receivance of the compromise plan, and the residents receivance plan and the receivan	ed she not identified specific plan of care. The LSW t made a revision to the care which included the following: as displayed inappropriate ward staff R/T [related to] at E/B [evidenced by] sexual 12/1/17 -Interventions were: provider to report new input (dated initiated 12/1/17) ROPRIATE- attempt al interventions. When related to how staff know what element, a response was not care fundamental principle that tent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered	F 684		g the cility	/2/18
		nge Minimum Data Set (MDS) 9/28/17, indicated R18 was		scheduled, and to contact the Hosp agency if a visit has not occurred.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245593	B. WING		<del></del>	12/0	04/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- ST IAMES		10	000 SOUTH SECOND STREET		
GOOD 3	AWANITAN SOCIETT	- 31 UAINES		S	T JAMES, MN 56081		
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F 684	locomotion on/off ti staff assistance with personal hygiene, at R18's Compassion dated 10/25/17, incompassion dated 10/25/17, indicated the 11/10/17 and 11/15 reflect the RN schemonth.  When interviewed hospice aide (HA)-facility 5 days a we HA-A stated she ty help get R18 up for cares. HA-A added each day to inform submitted R18's higher than the schemospice RN. HA-A times/week dependent of the condition. HA-A concalendar did not included agency was att HA-A further added the resolution of the agency was att HA-A further added the resolution of the agency was att HA-A further added the resolution of the agency was att HA-A further added the resolution of the agency was att HA-A further added the resolution of the agency was att HA-A further added the resolution of the agency was att HA-A further added the resolution of the agency was att HA-A further added the resolution of the agency was att HA-A further added the resolution of	an staff for bed mobility and the unit, and required extensive th transfer, dressing, eating, and toilet use.  The Care Hospice care plan dicated the registered nurse in the analysis to the second of the extensive was to visit 5.  The calendar dated November in RN had visited with R18 on the extension of the ex	Fé	584	Licensed nursing staff received wri instruction regarding assessing and documenting the physical status of on Hospice and immediately report changes in condition to Hospice. Further thanks of the completed at the standard Nurse meeting, and include facility contracted Hospice agencies. Director of Nursing or designee will complete Hospice visit audits week three months to ensure compliance. Results of the audits will be monitod the Director of Nursing and forward the Quality Committee for review.	those ting follow he le s. The le kly for e. red by	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 684	nursing assistant (I checks in with staff call the facility arou arrival. NA-B further checks in with the cresident visit.  When interviewed trained medication hospice nurse wou arrival and prior to staff any changes a again that week for the case manager schedule but was under the wisit R18 but was under thought that Cohad a form to commischeduled RN visit.  When interviewed case manager (CM and still in training. notified when the hist R18 but was under thought that Cohad a form to commischeduled RN visit.  When interviewed CM-A stated the hosp cometimes the hosp sometimes the tought facility last week to	on 11/30/17, at 1:39 p.m. NA)-B stated the hospice aide in upon arrival and also would and 4:30 a.m. to verify time of er stated the hospice RN charge nurse before and the charge nurse with staff upon leaving to communicate with and whether they be returning another visit. TMA-A thought was notified of the RN's unsure.  On 12/1/17, at 10:27 a.m. RN l)-B shared being newly hired CM-B stated she was not ospice RN would be arriving to nsure whether another staff and compassionate Care Hospice municate with staff the	F 68				

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F 684	with the change in the frequency of the R18's previous hos them of return date didn't check with st CM-A checked R18 and confirmed it did hospice RN had visit date. CM-A also re R18's medical recorrecent skilled nursi however, document scheduled return dispensable to confirm the CM-A indicated she nurse to confirm the CM-A indicated she nurse was received for Tuesday (11/28, musical program lottime she arrived. To didn't want to disruit informed CM-A via return Friday (12/1/explained to CM-A to inform of the next the facility.  When interviewed director of nursing expect the hospice facility staff a week and inform staff if the stated facility staff is stated facility staff is	uld make weekly visits but now nurse staffing, she was unsure e schedule. CM-A confirmed spice nurse always informed but the new hospice nurse aff prior to leaving the facility. B's hospice calendar schedule do not reflect the last time the sited nor the scheduled return viewed the hospice charting in ord which reflected the most ng visit was dated 11/22/17; station did not indicate the ate. CM-A confirmed it had week since the most recent RN and no date of return. It would contact the hospice e anticipated schedule.  200 a.m. CM-A informed arm call from R18's hospice do and the visit was scheduled (17) but R18 was busy at a potated in the dining room at the The hospice RN explained she pet R18 from the program so the return call she would (17). The hospice RN that since no staff was around at scheduled visit, she just left (DON) stated she would nurse to at least inform the in advance of scheduled visits that changed. The DON further should recognize when not been at the facility as	F 6	34		

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245593	B. WING _		12	/04/2017
	PROVIDER OR SUPPLIER	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 SOUTH SECOND STREET ST JAMES, MN 56081		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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F 684	expected hospice sand/or document the arrived, had not assigned to the first time facility on Tuesday though had not confirmed she had staff that R18 had reparding of them of the planupdated calendars. failed to document 11/28/17, and did not regarding her planupdated revised 3/2017 comprehensive plandeveloped by the rehospice representation of the brain hospice was dated the time of death (SIA) and dated 9/23/1 nurse identified than nurse (HN)-B received asking whether hospice was dated the time of death (SIA).	y up. DON confirmed she staff to communicate with staff nat last Tuesday (11/28/17) she sessed and would return on isit R18.  on 12/1/17, at 1:11 p.m.  confirmed she had evaluated the on 11/22/17, arrived at the (11/28/17), located R18 aducted an assessment since in a music activity. RN-B not communicated with facility not been assessed as it was a no staff were around to notify to return on Friday with RN-B further confirmed she she had attempted a visit on not leave a communication note ned return visit.  Indicated the procedure titled, Hospice in a Skilled Nursing Facility, included: A coordinated in of care shall be jointly ehab/skilled care location and attive is required.  record (EMR) review identified on 8/10/17, with a diagnosis of Subsequent admission to 8/22/17, and remained until	F 68	34		

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F 684	doing ok. R41's sist breathe." HN-B we Upon entering his per minute (normal short, and labored. physician] to obtain Morphine [controls during the dying proceed for sched (PRN) HN-B admittime. R41's respiral minute and the nurgive morphine if Rabreaths/minute and facility nurse verbal able to open his eycommunicate his recommunication was nursing staff had contacted and the hospid documentation was staff and the hospid documentation reventered between 8 health status and/or Interview on 12/1/1 nurse (HN)-B indic (FM) had contacted R41's shortness of member told HN-B of nursing (DON) amorning had been explained the Morphis in the short of the morphism of the status and contacted R41's shortness of member told HN-B of nursing (DON) amorning had been explained the Morphism of the status and contacted the short of the status and contacted R41's shortness of member told HN-B of nursing (DON) amorning had been explained the Morphism of the status and contacted the short of the short of the status and contacted the short of	or today and asked if he was ster replied to her "No, he can't not to the facility to see R41. The room, his respirations were 44 at a l = 16 to 20), they were rapid, and order to schedule pain and shortness of breath ocess]. A physician order was used Morphine and as needed inistered the first dose at that attions decreased to 35 per using staff was instructed to 41's respirations exceeded 24 d/or if they were labored. The dized understanding. R41 was see but was not able to needs; not restless or anxious.  Is lacking to indicate that facility ontacted and/or communicated urse to report abnormal vitaling death. During the period cospice benefit, limited as documented between facility ce nurse related to R41's care; ealed only 5 nursing notes /22/17 and 9/24/17, related to	F 68	4		

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F 684	at the time of arrival SOB symptoms has stated she underst in charge of contact HN-B explained at nurse only occurred documentation related the EMR on days serview. HN-B confid documentation related prior to death and it whether nursing as performed. HN-B frommunication was and hospice. HN-B medication were not needed as staff as of the dying process relief during the process rel	al and no notification of the d been communicated. HN-B ood from the family they were sting her about R41's condition. Werbal report from the facility d while she was onsite, no ated to status was entered in the was not onsite for her to rmed the EMR lacked ated to resident health status to was difficult to determine assessments had been curther indicated as not good between the staff of stated that PRN doses of the always administered when sume the symptoms were part as and not to provide symptom boxes.  Is nursing progress notes RN Morphine, (initiated 8/22/17 or under the tongue every 2 or pain or SOB) had been to the hospice nurse arriving at 17. Documentation was no assessment of R41's a performed even though is had been administered prior	F 68	34				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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F 684	as part of the plan milliliters (ml)/5 mill sublingual (under the for pain or SOB.  Review of the R41' identified that no P to be given orally on hours as needed for administered prior the facility on 9/23/ lacking that a nursi condition had been routine medications to the hospice nurs.  Interview and recorp.m. with the adminant the events lead she agreed docum cares provided. The staff responsibility agreed there was a between nursing stadministrator commeducation with nurse ensure documenta and timely communication. When interviewed DON indicated she parking lot that day concerns and was contact the hospice should have contact change in condition concurred docume.	dedication ordered on 8/22/17, of care was Morphine, 0.25 ligrams (mg) PRN oral or the tongue) every 2 hours PRN s nursing progress notes RN Morphine, (initiated 8/22/17 r under the tongue every 2 or pain or SOB) had been to the hospice nurse arriving at 17. Documentation was ng assessment of R41's performed even though is had been administered prior	F 68	34			

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F 684	Review of the facilit indicated resident's the necessary care maintain the highes accordance with the Review of the facilit Documentation poli observations, assess comprehensive care medications and co information related aspects will be clean Treatment/Devices CFR(s): 483.25(a)(1) §483.25(a) Vision a To ensure that resident assist the resident-§483.25(a)(1) In maintain the facility of the serior of the s	hospice staff while R41 e benefit.  y's 11/2016 Care Plan policy will receive and be provided and services to attain or t practicable well-being in e comprehensive assessment.  y's September 2012 cy indicated physical health esments, reassessments, e plan, physician's orders, mpletion of orders, and to emotional and mental rly documented. to Maintain Hearing/Vision 1)(2)	F6	84		1/2/18
	and from the office the treatment of visithe office of a profe provision of vision of This REQUIREMEN by: Based on observative review, the facility face ensure hearing aids	of a practitioner specializing in ion or hearing impairment or ssional specializing in the or hearing assistive devices. To is not met as evidenced ion, interview and document ailed to provide assistance to a were available to maintain ation needs for 1 of 1 resident		R 92□s hearing aid was reorder payment offered on 12-1-17. Th care was updated to include HOI use of devices in both ears. The	e plan of I and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245593	B. WING			12/(	04/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		10	TREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH SECOND STREET T JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 685	3:09 p.m. R92 and indicated R92 had aid since July 2017 visits daily and exphearing aid one even morning it was miss the missing hearing locate the hearing of in the process of pubut was unsure who for the replacements that R92 had a hear in the right. When stated he was havin normal conversationaid in the right ear. difficult to communing aid was missed was missed with the right ear. difficult to communing aid was missed was a Brief Interview score of "9" (meaning and understands.  Review of the Nursform dated 6/20/17 and right hearing aid was missed was missed was a Brief Interview score of "9" (meaning has a Brief Interview sco	and interview on 11/29/17, at family member (FM)-B been missing his right hearing. FM-B further indicated she lained that R92 had his ening and the following sing. FM-B stated she reported graid but staff were unable to device. FM-B stated she was urchasing another hearing aid, ether she would have to pay t. FM-B revealed the facility d to assist with replacement of d. It was noted at this time ring aid in the left ear but none interviewed at this time, R92 ng a difficult time hearing n due to the missing hearing FM-B responded it was more icate with R92 since the right	F 6	85	Services Director reviewed missing to identify any other concerns. The Services Director will review the mitems log daily and immediately foll with residents and family regarding missing item concerns. To ensure compliance, missing items logs and related suggestion/concern form as will be completed weekly for three by the Director of Nursing or design Audit results will be monitored by the Director of Nursing and forwarded Quality Committee for review.	e Social issing low up l d udits months nee.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 685	related to hard of he hearing aid. Interve effectiveness of corassistive devices, eplace and keep in radithough R92 was having hearing imputilizing a hearing aplan of care.  Review of the nursi 6/20/17 to 12/4/17, R92's right and left cart each evening, indicated only the letthe medication cart further documentat aid.  R92's treatment record for R92's right and left in the medication cart further documentat aid.  R92's treatment record for R92's right and left in the medication cart for the medication cart for the medication cart for was no documentat hearing aid was no medication cart for When interviewed of clinical manager (Cadmission, R92's ri CM-A confirmed R9 hearing aid since the single devices of the confirmed R9 hearing aid since the single devices of the confirmed R9 hearing aid since the single devices of the confirmed R9 hearing aid since the single devices of the confirmed R9 hearing aid since the co	a communication problem earing (HOH) and needs a ntions listed: monitor munication strategies and ensure left hearing aid is in nedication cart at bedtime. Identified upon admission as airment in the right ear and id, this was not included in the ang notes from admission on indicated the staff stored hearing aids in the medication. The nurses note dated 7/7/17, eft hearing aid was stored in on that date. There was no ion related to the right hearing aid was reviewed. The signed results and August indicated hearing aids had been stored art each night. Review of the cord for September, October icated only the left hearing aid the medication cart. There tion addressing why the right longer being stored on the	F 6	685			

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 685	Continued From pa	ge 18	F 68	35		
F 689 SS=D	licensed practical n was aware of R92's confirmed it had be months. LPN-A condifficulty hearing aid.  Interview on 11/30/nursing (DON) confright hearing aid simmissing shortly (7/7 DON verified R92 is hearing aids of which needs. The DON all have investigated the provided assistance learning the hearing Free of Accident Hac CFR(s): 483.25(d) (1) \$483.25(d) (2) Each supervision and assaccidents.  This REQUIREMEN by:  Based on observative review, the facility fassess/reassess the Wanderguard device ensure adequate supervision and estable for the supervision and assaccidents.	ts. sure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced ion, interview, and document	F 68	R 20 was reassessed for elopeme An order for a wanderguard device obtained on 12-19-17. The plan of for elopement risk was reviewed ar updated. Residents with wanderg were identified and reassessed for	nt risk. was care nd	1/8/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY ETED
		245593	B. WING		12/04	1/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 SOUTH SECOND STREET ST JAMES, MN 56081	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 689	Findings include:  R20 had been read 11/9/17, after a brie facility for behavior dementia. Diagnos dementia with behavestlessness and a When interviewed licensed practical rhad recently return after approximately R20's behaviors have cooperative with caprior to hospitalizat hallucinations, new some medications that prior to hospitalizat hallucinations, new some medications that prior to hospitar room to eat and sir had been participated dining room and visual Observations were (1) On 11/28/17, at Wanderguard on home conversation and noom with the use (2) On 11/29/17, at wheelchair enjoying dining room with ot and a Wanderguard (3) On 11/30/17, at a recliner located in her and Wandergu behaviors noted.	dmitted to the facility on ef discharge to a psychiatric s associated with her es included Alzheimer's, avioral disturbances and gitation.  on 11/28/17, at 2:12 p.m. aurse (LPN)-A indicated R20 ed from a psychiatric hospital of 2 weeks. LPN-A stated that ad improved and was ares. LPN-A explained that ion, R20 had experienced of meds had been started and discontinued. LPN-A indicated alization, R20 remained in her note medication adjustments, ting with eating meals in the siting with other residents.  noted as follows: 4:01 p.m. R20 was wearing a er right wrist, was pleasant in noved independently about the	F 689	elopement risk. Verbal education given to the Case Managers regarding and clarifying Physicia Verbal education was also given Case Managers regarding asses residents for elopement risk upon admission. This assessment will prior risk, the admission UDA, ar monitoring each shift for wander elopement risks and elopement at Elopement risk assessment audit done the Director of Nursing or I with each admission and readmit three months. Results of the audit be monitored by the Director of Nand forwarded to the Quality Confor review.	arding ns orders. to the ssing n I include nd ing, attempts. its will be Designee ssion for dits will Nursing	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
		245593	B. WING			12/	04/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		10	TREET ADDRESS, CITY, STATE, ZIP CODE DOO SOUTH SECOND STREET T JAMES, MN 56081	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	her walker beside hattached to the wall  When interviewed of trained medication any resident with a physician order with treatment administrative of R20's TAF documentation to inchecked to ensure TMA-B indicated the checked it's function check the device wR20's walker. It was functional. However eason the device hwrist and placed on Review of the Minimassessment dated psychiatric stay, including the look time. The MDS date 11/16/17, indicated wander.  When interviewed of director of nursing (assessment related was available for reworker was responsinformation to the Nelopement or wand Review of the median elopement from	chair in the dining room with her; Wanderguard was ker and not on her wrist.  In 11/30/17, at 12:40 p.m. aide (TMA)-B explained that Wanderguard, required a nodocumentation on the ration record (TAR). Upon R, TMA-B was unable to locate her in was working properly. The record is was working properly. The record is was working properly. The record is noted the battery was rounded to hich had been placed on the sent of the battery was rounded the battery was rounded the walker.  The material Set (MDS) 10/5/17, prior to R20's licated she wandered 1 to 3 kback period of 7 days at that red after her return on she had made no attempts to the location of the lopement or wandering view. She explained the social sible for adding any MDS assessment related to	F 6	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(	(X3) DATE SURVEY COMPLETED	
		245593	B. WING			12/0	04/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE 1000 SOUTH SECOND STREE ST JAMES, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ACTION SHOULD E FO THE APPROPRI	BE	(X5) COMPLETION DATE
F 689	confused- thought to sounding. The reside confusion. Staff too to calm her. Dr. rev Currently has Wand The report made not being amended and When interviewed case manager (CM R20 had a Wanders been employed with the registered nurse (RN/HIM)-C inputs physician orders after reviewed with anoth CM-B stated when meaning confined to Wanderguard device not the resident. CM was mobile with the should be placed of Upon reviewing the lacked any mention did it address the worders were double return from hospital (device).  Document review for physician order for no assessment relawandering. The MD was to calm the place of the physician order for no assessment relawandering. The MD was to calm the place of the physician order for no assessment relawandering. The MD was to calm the place of the physician order for no assessment relawandering. The MD was the place of the physician order for no assessment relawandering. The MD was the place of the physician order for no assessment relawandering. The MD was the place of the physician order for no assessment relawandering. The MD was the place of the place o	Jummarized the "Resident was here was a fire due to alarm lent had more recent k [R20] out for a walk outside iewing her medications. derGuard, reviewed meds." mention of the care plan d/or revised.  On 12/1/17, at 10:18 a.m. RN JB indicated she was aware guard placed since she has a the facility (June 2017) and e/health information manager into the computer all the ter a readmission which is her case manager (CM-A). a resident is immobile,	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245593	B. WING		12/	/04/2017	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 SOUTH SECOND STREET ST JAMES, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH: CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 689	attempts to leave the behavior.  Interview on 12/1/1 12:39 p.m. with the the expectation that periodically assess Wanderguard to redevice, elopement of the administrator afor the device was a orders were followed accuracy should be EMR. The administrator aforthe device was a orders were followed accuracy should be EMR. The administrator the device was accuracy should be EMR. The administrator the device was accuracy should be EMR. The administrator the device was accuracy should be EMR. The facility had no was accurately the facility had no was accurately the device was accurately the facility had no was accurately had no was accurately the facility had no was accurately the facility had no was accurately had no was accura	ge 22 esident's rooms and/or whether he facility with exit-seeking  7, at 11:48 a.m. and again at administrator confirmed it was t R20 should have been ed for placement of a revaluate the necessity of the risk and supervision needs. Also agreed a physician order necessary and when previous ed post hospitalization, a verified prior to input into the rator confirmed that staff also the device to ensure it was  WanderGuard or Elopement	F6	89			
F 695 SS=D	Documentation poliobservations, assess comprehensive car medications and coinformation related aspects will be clean Respiratory/Trache CFR(s): 483.25(i)  § 483.25(i) Respirat tracheostomy care The facility must enneeds respiratory care and tracheal scare, consistent with	ostomy Care and Suctioning	F 6	95		1/3/18	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP CO 1000 SOUTH SECOND STREET ST JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	Continued From pa	_	F 69	95		
	and 483.65 of this see This REQUIREMENT by: Based on observative review, the facility for nebulizer medication 2 residents (R12) reduring medication at Findings include: Review of R12's signification solution 0.083%, 1 dose inhitimes a day for whe obstructive pulmonorders further indicated resultive pulmonorders further indicated resultive pulmonorders further indicated resultive pulmonorders further indicated R12 Albuterol sulfate at 8:00 p.m.  On 11/28/17, at 7:2 (RN)-A was observed administering medication receptated to the tumachine. The medication receptated reduction into the interesting reduction into the medication into the medication into the interesting reduction	ion, interview and document ailed to properly rinse a n receptacle after use for 1 of eviewed who used a nebulizer administration.  Index physician orders dated an order for Albuterol sulfate in (2.5 milligrams/3 milliliters) ale orally via nebulizer three rezing related to chronic ary disease. The physician ated R12 may self-administer set-up.  Index physician orders dated an order for Albuterol sulfate in (2.5 milligrams/3 milliliters) ale orally via nebulizer three rezing related to chronic ary disease. The physician ated R12 may self-administer set-up.  In ordication red (eMAR) dated November 2 received the scheduled 10:00 a.m., 4:00 p.m., and		The nurse involved was ree regarding cleaning the nebul medication receptacle. Other receiving nebulizer treatment monitored to ensure proper policy and procedure for this communicated to all licensed and Medication Aides. Followill be completed at the Janumeeting. Nebulizer cleaning continue to be completed by of Nursing or designee week month then biweekly for two Audit results will be monitored Director of Nursing and forw Quality Committee for review	lizer er residents nts were practice. The s practice was d nursing staff ow-up training uary Nurse g audits will the Director kly for one months. ed by the varded to the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - ST JAMES				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 SOUTH SECOND STREET ST JAMES, MN 56081	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 695	advised R12 to kee then exited the roor immediately following confirmed there had R12's nebulizer received the current dose of was probably left on nebulizer treatment nurse who administ stated she would clamask and medications that after the 8:00 power been administered. The right of the same medication of the same med	hen switched the machine on, p the mask on for 15 minutes, m. When interviewed on the observation, RN-A destill been moisture/liquid in eptacle prior to administering medication. RN-A stated it wer from the 4:00 p.m. and confirmed being the tered that treatment. RN-A ean and disinfect the nebulizer on receptacle at the end of the p.m. nebulizer treatment had RN-A confirmed she did not ation receptacle between the p.m. treatments since it was on. RN-A questioned the should be rinsed. RN-A also sometimes take the nebulizer the medication had been on 12/1/17, at approximately cor of nursing (DON) shulizer medication receptacle er insed with hot water and on aper towel to dry after each and disinfected at the end of edure titled Nebulizer, revised	F 69			1/2/18
SS=D		any risiated Social Service	1 7			1/2/10

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245593	B. WING		12/0	04/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 SOUTH SECOND STREET ST JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 745	maintain the highes and psychosocial was the Requirement of 2 residents (R92 property.  Findings include:  During observation 3:09 p.m. R92 and indicated R92 had aid since July 2017 visits daily and exphearing aid one ever morning it was misted the process of public the process of public the right hearing aid that R92 had a hear in the right. When stated he was havin normal conversation aid in the right ear. difficult to commun hearing aid was mi Minimum Data Set 6/27/17, identifies F	_	F 745	R 92 s hearing aid was reordered payment offered on 12-1-17. The care was reviewed and updated to the use of the devices. The Social Services Director reviewed missing to identify any other concerns. The Services Director will review the mitems log daily and immediately fol with residents and family regarding missing item concerns. To ensure compliance, missing items logs an related suggestion/concern form a will be completed weekly for three by the Director of Nursing or desig Audit results will be monitored by the Director of Nursing and forwarded Quality Committee for review.	plan of include g items e Social issing low up g d udits months nee.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP CO 1000 SOUTH SECOND STREET ST JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 745	moderately impaire is usually understood Review of the Nurs form dated 6/20/17 and right hearing at Review of R92's curesident as having related to hard of hearing aid. Interve effectiveness of coassistive devices, eplace and keep in radithough R92 was having hearing imputilizing a hearing aplan of care.  Review of the facilidated 9/16/17, indicright hearing aid wifacility licensed soon.  Review of the nurs 6/20/17 to 12/4/17, R92's right and left cart each evening, indicated only the left the medication cart further documental aid.  R92's treatment record for R92's right and left reatment record for R92's right and left reatment record for R92's right and left.	IS) score of "9" (meaning ed cognition) and the resident od and understands.  Ing Admission Data Collection in it is in the ability to hear.  It is in the acommunication problem earing (HOH) and needs a entions listed: monitor in munication strategies and ensure left hearing aid is in medication cart at bedtime. It is in indentified upon admission as earment in the right ear and aid, this was not included in the intention in the included in the	F 74	.5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		245593	B. WING _		12	/04/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP CO 1000 SOUTH SECOND STREET ST JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 745		age 27 ecord for September, October licated only the left hearing aid	F 74	5		
	had been stored in was no documenta hearing aid was no	the medication cart. There tion addressing why the right longer being stored on the the past 3 months.				
	clinical manager (C admission, R92's ri CM-A confirmed R9 hearing aid since the	on 11/29/17, at 3:14 p.m. CM)-A indicated shortly after ight hearing aid was missing. 92 has not utilized the right nat time, and consequently, ime hearing without an				
	3:20 p.m. indicated missing right hearin missing personal it confirmed R92's rig as missing in the lo	th the LSW on 11/29/17, at I she was not aware of R92's and aid and was unable to find a em report. The LSW ght hearing was documented est and found record on to investigate the whereabouts thearing aid.				
	licensed practical n was aware of R92's confirmed it had be months. LPN-A furt LSW had followed missing item with the confirmed R92 was	on 11/30/17, at 7:52 a.m. nurse (LPN)-A, indicated she is missing right hearing aid and een missing for several ther indicated she thought the through and had discussed the ne resident/family. LPN-A is HOH and had difficulty inversation without his right				
	nursing (DON) and staff initially was av	17, at 8:07 a.m. the director of the administrator confirmed vare of R92's missing right 17, when it was first				

F 745  Continued From page 28 documented and the LSW should have followed through with resolving the missing item as the facility policy directs.  Review of the facility policy and procedure for Missing Items to the supervisor immediately, start a search for the item, if the item is not found and is of normial value, complete a suggestion/concern form and social services (SS) will report to the resident/tamily or responsible party on the attempts to locate the item. A record is kept in the SS office no less than 15 months.  F 757 SS=D  CFR(s): 483.45(d)(1)-(6)  §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-  §483.45(d)(1) In excessive dose (including duplicate drug therapy); or  §483.45(d)(3) Without adequate monitoring; or  §483.45(d)(4) Without adequate indications for its use; or  §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or  §483.45(d)(6) Any combinations of the reasons	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
Indicate the continued from and social services (SS) will report to the resident/family or responsible party on the attempts to locate the item. A record is kept in the SS office no less than 15 months.    F.757   SS=D   CFR(s): 483.45(d)(1)   No excessive dose (including duplicate drug therapy); or \$483.45(d)(4)   Without adequate indications for its use; or \$483.45(d)(5)   In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or \$483.45(d)(6)   Any combinations of the reasons			245593	B. WING		12/	04/2017	
FREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 745  Continued From page 28 documented and the LSW should have followed through with resolving the missing item as the facility policy directs.  Review of the facility policy and procedure for Missing Items dated 4/16, included reporting missing items to the supervisor immediately, start a search for the item, if the item is not found and is of nominal value, complete a suggestion/concern form and social services (SS) will report to the resident/family or responsible party on the attempts to locate the item. A record is kept in the SS office no less than 15 months.  F 757  F 757  CFR(s): 483.45(d)(1)-(6)  §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-  §483.45(d)(1) In excessive dose (including duplicate drug therapy); or  §483.45(d)(3) Without adequate monitoring; or  §483.45(d)(4) Without adequate indications for its use; or  §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or  §483.45(d)(6) Any combinations of the reasons			- ST JAMES		1000 SOUTH SECOND STREET			
documented and the LSW should have followed through with resolving the missing item as the facility policy directs.  Review of the facility policy and procedure for Missing Items dated 4/16, included reporting missing items to the supervisor immediately, start a search for the item, if the item is not found and is of nominal value, complete a suggestion/concern form and social services (SS) will report to the resident/family or responsible party on the attempts to locate the item. A record is kept in the SS office no less than 15 months.  F 757  SS=D  CFR(s): 483.45(d)(1)-(6)  §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-  §483.45(d)(1) In excessive dose (including duplicate drug therapy); or  §483.45(d)(2) For excessive duration; or  §483.45(d)(3) Without adequate monitoring; or  §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or  §483.45(d)(6) Any combinations of the reasons	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETION	
stated in paragraphs (d)(1) through (5) of this section.	F 757	documented and the through with resolving facility policy directs. Review of the facility missing items to the asearch for the iter is of nominal value, suggestion/concern will report to the resparty on the attemptiskept in the SS off Drug Regimen is Fr CFR(s): 483.45(d)(1) S483.45(d) Unneces Each resident's drug unnecessary drugs. drug when used-s483.45(d)(1) In example and the same series of the same ser	e LSW should have followed ng the missing item as the state of the missing item and social reporting and social services (SS) ident/family or responsible to the item. A record ice no less than 15 months. The from Unnecessary Drugs of the missing regimen must be free from the missing regimen must be free from the An unnecessary drug is any continuous depution; or the missing regimen missing or the missing response of adverse the indicate the dose should be must or combinations of the reasons of the reasons in the missing item as the mis				1/5/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245593	B. WING		12/0	04/2017	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 SOUTH SECOND STREET ST JAMES, MN 56081	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETION DATE	
F 757	by: Based on observareview, the facility findications for the umedication) to ensign effectiveness for 1 for unnecessary medications include: R20 had been read 11/9/17, after a briefacility for behavior dementia. Diagnos dementia with behavestlessness and a When interviewed licensed practical inhad recently return after approximately R20's behaviors had cooperative with caprior to hospitalizat hallucinations, new some medications that prior to hospitaroom to eat and sinhad been participated dining room and visions were (1) On 11/28/17, at Wanderguard on home conversation and more with the use (2) On 11/29/17, at	tion, interview, and record failed to identify adequate use of Gabapentin (anti-seizure ure adequate monitoring for it's of 5 resident (R20) reviewed edications.  Idmitted to the facility on ef discharge to a psychiatric as associated with her es included Alzheimer's and avioral disturbances and gitation.  In 11/28/17, at 2:12 p.m. nurse (LPN)-A indicated R20 ed from a psychiatric hospital of 2 weeks. LPN-A stated that ad improved and was ares. LPN-A explained that ion, R20 had experienced of meds had been started and discontinued. LPN-A indicated alization, R20 remained in her noce medication adjustments, ting with eating meals in the esiting with other residents.  In the siting with other residents.  In the siting with other residents are right wrist, was pleasant in moved independently about the	F 757	R 20 s Gabapentin order and clarification was reviewed and sign the primary Physician on 12-13-17 plan of care was reviewed and up include the use of the medication agitation and restlessness. Targe behaviors were identified and include the plan of care. R 20 was reass for elopement risk. An order for a wanderguard device was obtained 19-17. The plan of care elopement was reviewed and updated. Resi with wanderguards were identified reassessed for elopement risk. To Case Managers were reeducated regarding reviewing and clarifying Physicians orders, as well as reviewed regarding reviewing and clarifying Physicians orders, as well as reviewed proper diagnosis. Reeducation was given to the Case Managers regal assessing residents for elopement upon admission. This assessmer include prior risk, the admission Umonitoring each shift for wandering elopement risks and elopement and Order verification audits as well as elopement risk assessment audits done by the Director of Nursing or Designee with each admission an readmission for three months. Rethe audits will be monitored by the Director of Nursing and forwarded Quality Committee for review.	7. The dated to for tuded in essed I on 12-nt risk dents and the ewing for as also rding trisk will DA, and g, tempts.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245593	B. WING _		12	/04/2017	
NAME OF PROVIDER OR S		- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP 1000 SOUTH SECOND STREET ST JAMES, MN 56081	<u>.</u>		
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F 757 Continued	From pa	age 30	F 75	57			
dining room and a Wan (3) On 11/3 a recliner let her and Wa behaviors in (4) Later at seated in a her walker attached to Review of it for R20 indicated the psychiatric return, indicated the telephologome of the psychiatric return, indicated the note dated and independent of the psychiatric return.	n with of derguar 10/17, at ocated in anderguar 11/30/1 dining of the walche electricated Catric hose entin 300 mouth it is and a centin 100 at day related 11 hospital cated the entin was anosis related by the entin was an	ther residents; no behaviors d was noted on the right wrist. 8:15 a.m. R20 was seated in her room, walker in front of ard on her right wrist. No  7, at 12:36 p.m. R20 was chair in the dining room with her; Wanderguard was liker and not on her wrist.  tronic medical record (EMR) cabapentin was initiated during pital stay prior to return to the an's orders inputted into the aff were:  0 milligrams (MG) give 1 n the evening related to	F 75				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245593	B. WING			12/	04/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		10	REET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH SECOND STREET F JAMES, MN 56081		
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F 757	on 12/1/17, when read Review of the Minimassessment dated psychiatric stay, including days during the loo time. The MDS datindicated she had read indicated she had read information to the read information to the read clinical managers (the Gabapentin or unaware the Gabapentin was agitation. CM-A agreegarding the need clarified with the phefact the returning the countersigned. In a monitor the effective unsure the rational medication. CM-A order received from been countersigned R20 never had a distinctive on 12/1/1 administrator confining reads.	notes in the EMR per the DON equested.  mum Data Set (MDS) 10/5/17, prior to R20's dicated she wandered 1 to 3 kback period of 7 days at that ed after her return on 11/16/17 made no attempts to wander.  17 at 1:30 p.m. with the (DON) the facility had no pement or wandering. The responsible for adding any MDS assessment related to	F 7	757			

AND PLAN OF CORRECTION   (X1) PROVIDER/SUPPLIER/CLIA   (X2) MULTIPLE CONSTRUCTION   A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 757	of a new medication Review of the facilit Physician/Practition purpose was to pro each resident and p obtaining appropria physician's orders. signed and dated b period required by s be documented as a physician order. We the hospital, physic to reflect the reside Clarification orders any type of physicia raises questions. N	ate, especially upon initiation in.  by's November 2016 fer Orders policy indicated its vide individualized care to provide staff a procedure by te, accurate, and timely Telephone orders will be by the physician within the time state law. Nursing orders must care plan approaches, not as When a resident returns from ian's orders must be updated int's current needs.  The area in the area i	F 7	57		
F 758 SS=D	Documentation poliobservations, assess comprehensive car medications and coinformation related aspects will be clear Free from Unnec P CFR(s): 483.45(c)(3) \$483.45(c)(3) A psy affects brain activiti processes and behinders of the service of the s	sychotropic Meds/PRN Use 3)(e)(1)-(5)	F 7	58		1/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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F 758	resident, the facility §483.45(e)(1) Reside psychotropic drugs unless the medication as in the clinical record §483.45(e)(2) Reside drugs receive grade behavioral intervent contraindicated, in addrugs; §483.45(e)(3) Reside psychotropic drugs unless that medicate diagnosed specific in the clinical record §483.45(e)(4) PRN are limited to 14 da §483.45(e)(5), if the prescribing practitic appropriate for the beyond 14 days, he rationale in the residenticate the duratio §483.45(e)(5) PRN drugs are limited to renewed unless the	chensive assessment of a must ensure that dents who have not used are not given these drugs on is necessary to treat a sidiagnosed and documented di; dents who use psychotropic and dose reductions, and tions, unless clinically an effort to discontinue these dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented	F 7	58		

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F 758	the appropriateness This REQUIREMEN	ge 34 s of that medication. NT is not met as evidenced	F 7	758			
	review, the facility f justify the continued medications and/or for as needed (PRN of 5 residents (R11 unnecessary medical record including include:  R11's diagnoses in medical record includisorder, dementia Parkinson's and ge R11 was admitted of During observation appeared calm and door waiting for stainterviewed at this tired and wanted to During morning car R11 appeared plea restless/fidgety, asleven when redirect time, R11 indicated with cares had bee she felt bad.  Interview on 11/30/assistant (NA)-A, in paranoid and restle pleasant and cooperations.	formation obtained in the uded: Major depressive with lewy body disease, neralized anxiety disorder. on 10/18/16.  on 11/28/17, at 7:00 p.m. R11 pleasant, seated by her room ff to assist her into bed. When ime, R11 indicated feeling get into bed.  es on 11/29/17, at 9:00 a.m. sant but slightly king staff repetitive questions ed. When interviewed at this she thought staff assisting in talking about her and that			R 11 s plan of care was updated of -17 to include the use of Ativan. Tabehaviors were identified and put in plan of care, as well as monitoring specific side effects/adverse reactive Education was given to the resident family regarding the necessity of a reduction, and a gradual dose reduction, and a gradual dose reduction, and a gradual dose reduction was initiated on 12-6-17. All reside antianxiety, antidepressant and psychotropic medications were revito identify the need for any further of reductions. The Case Managers we educated to initiate the use of a medication monitoring calendar to dose reductions are completed at the proper times. The Director of Nursidesignee will audit this practice monothly and with newly ordered medications that require gradual doreductions. Results of the audits whom monitored monthly and forwarded the Quality Committee for review.  R36 s Diagnosis and indication for use of Paxil was reviewed. The placare was reviewed and updated to specific target behaviors and interviewed. Residents on antidepression were identified and plans of care reand updated as appropriate. The Committee of the services of the services of the summand updated as appropriate. The Committee of the services	rget of the for cons. to so dose ction on the wed dose ere ensure the ing or of the control of t	

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 758	Set (MDS) assessridentified as having Status (BIMS) scor severely impaired). exhibited moods of or sleeping too mudassessment period R11 exhibited behaded assessment period R11 exhibited behaded R11 exhibited B11 exhibit	ment dated 8/30/17, R11 was a Brief Interview of Mental e of "4" (meaning cognition is The MDS indicated R11 having trouble falling asleep ch 12-14 days during the . The MDS further indicated viors of delusions.  Trent physicians orders of milligrams (mg) four times mg tablet (1) as needed ight (for generalized anxiety of the medication rd (MAR) indicated R11 had ativan since 10/27/17 (34 days was admitted with these control of the care did not ativan nor did it include any	F 75	with any new medication. Thursing or Designee will cobi-monthly care plan audits months to ensure compliant the audits will be monitored Director of Nursing and forw Quality Committee for revie	mplete for three ce. Results of by the varded to the		

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F 758	the continued use initial 14 days. The continue the curre request; and (4) dated 10/20/17 continued use of the duration for use for physician respond Ativan order due to Review of the physician respond Ativan order due to Review of the physician respond Ativan order due to Review of the physician respond Ativan order due to Review of the physician respond Ativan order due to Review of the physician responding to the physician for the Program of the program of the past 6 months episodes of being wanting certain standard documenta and the frequency confirmed there we the use of the Ativity gradual dose reduited past year.  Interview on 12/01 practical nurse (LF)	uration of use was needed for of the PRN Ativan following the ephysician responded to nt Ativan order due to family and described in the PRN Ativan as well as the llowing the initial 14 days. The ed to continue the current or husband request.  Sicians dictated notes dated of 1/9/17, 3/13/17, 4/10/17, and 10/9/17, addressed R11's rekinson's, lewy body disease, and the physician did not rent Ativan use or the continued use.  Gress notes for R11, did not mented mood or behaviors in other than exhibiting 2 identified as "needy" and not	F 7	758		

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F 758	reported in the pass not recall the last the exhibit these behands. R36, admitted on including depressive dementia with behand physician ordered physician progress indicated: [R36] is antidepressant but and may make syntapering off the Paphysician ordered decreased for a word medication. The magnetic magnetic depressive depressive depressive depressive decreased for a word medication. The magnetic depressive depressive depressive depressive depressive decreased for a word decreased for a	rved or that the NA's have st several weeks. LPN-A could ime R11 was observed to viors.  10/26/17, had diagnoses we episodes and unspecified avioral disturbance and had Paxil 10 milligrams daily. The stone dated 11/16/17, on Paxil which is a good in the elderly that if forgetful mptoms worse, recommend xil. Subsequently, the the Paxil 10 mg daily dose be seek with discontinuation of the redication administration record at Paroxetine HCI (Paxil) 10 ninistered daily related to other	F 7	758			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	NG		COMPLETED	
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F 758	During review of manager administrator were rationale for the adford depressive epis inappropriate with the medication bas	attempt non-pharmacological to vent feelings.  bood/behavior documentation 10/26/17, nursing of the that R36 made all comments to female staff on 11/22 (twice), 11/24 and of 11/22 (twice), 11/24 and of 11/30/17, at 8:00 a.m. of 12/1/17, at 10:06 a.m. of 12/1/17, at 10:06 a.m. of R36 usually made of the evening but it can the day. NA-B also stated that of the that one does not want to off are scared of R36 and worry of the that R36 talks the female staff and when he re of him, R36 becomes upset ovide care.	F 7	58		

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F 758		When further requested lentify the rationale for the	F 7	58		
F 770 SS=D	sexually inappropria and indicated she h to monitor related to	specific interventions on the	F 7	70		1/3/18
	laboratory services residents. The facility and timeliness of the (i) If the facility proviservices, the service requirements for lab of this chapter. This REQUIREMENT by:  Based on interview facility failed to ensumonitoring was obtathyroid stimulating by value (a test to find working the way it so (R21) reviewed for Findings include:  R21's annual Minimassessment dated Interview for Menta	acility must provide or obtain to meet the needs of its ty is responsible for the quality		R 21 s TSH was drawn on 12-12-a result of 4.4. The Primary Physic ordered a repeat draw in six month Audit was completed to identify any residents that may require orders f draws. The Case Managers will co to monitor this with routine Physicia rounds. The DNS or designee will this practice following Physicians rounds will be monitored by the Dire Nursing and forwarded to the Qual Committee for review.	cian is. An y other or lab ontinue an s audit ound of the ector of	

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F 770	indicated R21 was room/corridor and a utilized a walker; di obstructive pulmon  Review of R21's latincluded an elevater reference range: 0 to the physician dat laboratory results h questioned if there physician response chg [sik] will just wa R21's medical reco a follow-up TSH be  Review of R21's we (12/2/16 - 11/24/17' gain of 22 pounds (symptoms of hypotor increased difficu)  The physician progindicated a weight (months. The plan is Lasix; the elevated addressed.  The physician progindicated R21 was gain because she is indicated R21's weil last seen and up 8 physician progress elevated TSH from no follow up of elevated Further review of the series of	independent with walking in ambulation on/off the unit and agnoses included chronic ary disease (COPD).  coratory results dated 1/24/17, and TSH value of 5.29 (normal .27-4.20). The facility fax sent and been received and were any new orders. The dated 1/24/17 indicated: "No atch TSH". Further review of and the received and were any new orders. The dated 1/24/17 indicated: "No atch TSH". Further review of and did not include evidence of ing completed.  eights over the past year indicated a gradual weight lbs) (140- 162 lbs). Common hyroidism include weight gain	F 7	70			

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F 770	address R21's elev When interviewed of director of nursing (expected R21's elefollowed up on by numedical record and	ge 41 ated TSH from 1/24/17. on 12/1/17, at 12:45 p.m. the DON) stated she would have vated TSH from 1/24/17 to be ow. DON reviewed R21's confirmed the TSH had not would contact the physician	F 7	70			
F 865 SS=D	QAPI Prgm/Plan, D CFR(s): 483.75(a)(s) §483.75(a) Quality improvement (QAP) §483.75(a)(2) Press Survey Agency no I promulgation of this §483.75(h) Disclose A State or the Secret disclosure of the re- except in so far as a the compliance of secret requirements of this §483.75(i) Sanction Good faith attempts and correct quality a basis for sanction This REQUIREMENT by: Based on interview facility failed to ensigned assurance (QA compliance related services to ensure	assurance and performance I) program.  ent its QAPI plan to the State ater than 1 year after the sequipart regulation;  ure of information.  etary may not require cords of such committee such disclosure is related to such committee with the se section.  s.  by the committee to identify deficiencies will not be used as	F 8	The Quality Coordinator was insinclude annual survey results in monthly Quality minutes. Survey remedies will be reviewed and a the quality Committee on a quarbasis. The Director of Nursing of	the / tags and udited by terly		

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F 865	in lack of coordinated 4 residents (R18, F services.  Findings include:  Interview and docut QAA coordinator or indicated the QAA obasis. Review of the annual survey on 1 8/17/17, 5/18/17, 2/1000 committee attended coordinator, activity director, social servicetor, director of pharmacist and me concerns identified discussed with the lack of coordination services as well as plan of care. When committee monitore communication bet services since this previous recertificate coordinator indicated ongoing audits and which had been improved the provious receiting and/or a compliance. The Q had been unaware concerns and indicated ongoing and indicated ongoing and compliance. The Q had been unaware concerns and indicated ongoing and indicated ongoing and/or a compliance. The Q had been unaware concerns and indicated ongoing and indic	ion of hospice services for 2 of (41) reviewed for hospice care ment review with the facility in 12/1/17, at 11:42 a.m. committee met on a quarterly emeeting dates since the last 0/20/16, included: 11/16/17, 16/17 and 11/17/16. The es included the QAA director, housekeeping vice director, maintenance nursing (DON), administrator, idical director. Current during the survey were QAA coordinator, including incommunication of hospice implementation of the hospice questioned how the QAA ed the coordination and ween facility staff and hospice was identified during the tion survey, the QAA ed she was unaware of any dor corrective action plans plemented over the past year. or was unable to provide any of that coordination of hospice discussed at any of the QAA corrective action plan had to achieve continued AA coordinator verified she of any hospice service atted this needs to be QAA committee for review and	F8	365	Designee will audit the Quality min quarterly for compliance, and bring to the Quality Committee for review	back	

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F 865	confirmed the defic services had not be meetings with the c explained she had i correction for the d lack of hospice coo of the previous surv	PON on 12/1/17, at 12:10 p.m. ient practice related to hospice en discussed at the QAA ommittee members and implemented a plan of deficient practice related to rdination identified at the time vey but failed to involve the implement a plan to sustain	F 8	365			

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(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245593 B. WING 11/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 SOUTH SECOND STREET **GOOD SAMARITAN SOCIETY - ST JAMES** ST JAMES, MN 56081 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 **FIRE SAFETY** THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on November 30, 2017. At the time of this survey, Good Samaritan Society St. James was found not to be in 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 Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/08/2018

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTI A, BUILDING 01 - MAIN BUIL				E SURVEY PLETED
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	The requirement at NOT MET as evide Subdivision of Build CFR(s): NFPA 101	of 44 at time of the survey.  42 CFR, Subpart 483.70(a) is enced by: ding Spaces - Smoke Barrie	K3	372			12/14/17
	Construction						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
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K 372	fire resistance ratin be permitted to terr Smoke dampers are penetrations in fully an approved sprink smoke compartme barrier.  19.3.7.3, 8.6.7.1(1) Describe any mechin REMARKS. This REQUIREMED by:  Based on observate facility failed to mais construction that multiple failed to mais construction failed from the failed fail	all be constructed to a 1/2-hour ag per 8.5. Smoke barriers shall minate at an atrium wall. The not required in duct of ducted HVAC systems where a system is installed for antistication and staff interview, the intain smoke barrier walls a section and staff interview, the intain smoke barrier walls a section and staff interview, the intain smoke barrier walls a section and affect 41 of 41 and smoke to propagate from a smoke to propagate from a smoke to propagate from a smoke to another.  It is constructed to a 1/2-hour ag per 8.5. Smoke barriers are to terminate at an atrium wall, are not required in duct of ducted HVAC systems where a staff and a smoke to the smoke the smoke to the smoke the smoke to the smoke the s	K 37	Surveyor 245593 on November 3 2017 found an improper smoke be penetration. The penetration in the barrier wall on the 100 wing was and sealed by the Director of Mainusing concrete and plaster. The of Maintenance will follow up with contractors who perform work in facility to verify there are no pene prior to them leaving the job site. inspections of the smoke barriers conducted and monitored by the of Maintenance or his designee a findings will be reviewed by the Q Committee. This corrective actio completed on December 14, 2017	arrier e smoke repaired ntenance Director any the trations Monthly will be Director nd API n was	

PRINTED: 01/12/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 245593 B. WING 11/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 SOUTH SECOND STREET **GOOD SAMARITAN SOCIETY - ST JAMES** ST JAMES, MN 56081 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 372 Continued From page 3 K 372 On facility tour between 10:00 AM and 2:00 PM on 11/30/2017, a vent pipe was observed penetrating the wall in the Section 1 North smoke barrier. NOTE: All smoke barriers in the Facility need to be checked to ensure there are no penetrations in the smoke barriers. These deficient practices were verified by the Facility Maintenance Director. K 912 Electrical Systems - Receptacles K 912 12/29/17 SS=E CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate. highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor 245593 on November 30th, Electrical Systems - Receptacles 2017 found that documentation could not Power receptacles have at least one, separate. be provided to show that the yearly highly dependable grounding pole capable of electrical receptacles inspection of maintaining low-contact resistance with its mating resident rooms was conducted. Sellner plug. In pediatric locations, receptacles in patient Electric was here immediately that day to rooms, bathrooms, play rooms, and activity conduct electrical checks and repairs. An rooms, other than nurseries, are listed electrical receptacle inspection was tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit completed and the documentation was interrupters (GFCI) are listed. retained and added to our records. The 6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99) This deficient Director of Maintenance or his designee practice could affect 41 of 41 residents. will continue to perform annual electrical receptacle inspections of resident rooms

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01  (X3) DATE SUICOMPLET			
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K 912	on 11/30/2017, doc located to show tha had occurred through	veen 10:00 AM and 2:00 PM umentation could not be at an electrical outlet inspection ghout the facility.	K 91	and place documentation of the ir and findings in the documentation kept in the maintenance office. T action will be performed and mon the Director of Maintenance and r by the QAPI Committee. This cor action was completed on December 2017.	book his tored by eviewed rective	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 29, 2017

Ms. Ursula Hagstrand, Administrator Good Samaritan Society - St James 1000 South Second Street St James, MN 56081

RE: Project Number S5593028

Dear Ms. Hagstrand:

On December 4, 2017, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

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

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 201
Marshall, Minnesota 56258-2504
Email: kathryn.serie@state.mn.us

Phone: (507) 476-4233 Fax: (507) 344-2723

#### OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 13, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

### 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.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

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

### Original deficiencies not corrected

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

### Original deficiencies not corrected and new deficiencies found during the revisit

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

### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 4, 2018 (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 4, 2018 (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 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,

Kumalu Fish 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

cc: Licensing and Certification File

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	NH LICENSING CORRECTION ORDER						
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 01/08/18

TITLE

STATE FORM 6899 If continuation sheet 1 of 32 QLQ611

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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Minnesota Department of Health STATE FORM

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MN Rule 4658.0070 Quality Assessment and Assurance Committee		2 255			1/2/18
A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and					
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Minnesota Department of Health STATE FORM

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GOOD S	AMARITAN SOCIETY	- ST.IAMES	SOUTH SEC				
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(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREF	ΊX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	ì	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
					DEFICIENCY)		
2 255	Continued From pa	20.2	2 255				
2 233	Continued From pa	2 233					
	Interview and docu	ment review with the facilit	:y				
		n 12/1/17, at 11:42 a.m.					
		committee met on a quarte	erly				
		e meeting dates since the					
		0/20/16, included: 11/16/1					
		/16/17 and 11/17/16. The	,				
		es included the QAA					
		director, housekeeping					
	director, social service director, maintenance						
	director, director of nursing (DON), administrator						
		edical director. Current					
		during the survey were					
		QAA coordinator, including					
		n/communication of hospic					
	services as well as	implementation of the hos	pice				
	plan of care. When	questioned how the QAA					
	committee monitore	ed the coordination and					
	communication bet	ween facility staff and hos	pice				
		was identified during the					
		tion survey, the QAA					
	•	ed she was unaware of an	,				
		d/or corrective action plans					
		plemented over the past y					
		for was unable to provide a					
		y that coordination of hosp					
		discussed at any of the QA	AA				
		corrective action plan had					
		to achieve continued					
		AA coordinator verified she	Э				
	had been unaware	of any hospice service					
	concerns and indica	ated this needs to be					
	addressed by the C	QAA committee for review	and				
	subsequent correct						
	Documentation rev	iew identified that lack of					
		pice services was evident	for				
	R18 and F41.	7.10 00. 1.000 1140 0 1140 III					
	1110 4110 1 41.						
	Intonvious with the d	lirector of pureing (DON)	n				
		lirector of nursing (DON) o					
	12/1/17, at 12:10 p.	.m. confirmed the deficient	L				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00697	B. WING		12/0	4/2017
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- ST JAMES	TH SECONE 5, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 255	Continued From pa	ge 4	2 255			
	discussed at the Que committee member implemented a plar practice related to I identified at the time failed to involve the a plan to sustain consumption of correction for as on-going complications. Suggested to discussion survey results at the plan of correction for as on-going complications of correction for as on-going complications.	THOD OF CORRECTION: res should be implemented ins and review of the state e QAPI meetings to include a or the deficient practice as well ance. The administrator or lit facility compliance ort to the QAPI committee for ations for facility practice and				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 560	MN Rule 4658.0409 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			1/5/18
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The c must include the increquired by Minnes subdivision 14, para					
	by:	ent is not met as evidenced				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00697	B. WING		12/04/2017	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- ST JAMES	TH SECONE 5, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 5	2 560			
	review the facility fa interventions on the 2 of 5 residents (R unnecessary medic	on, interview and document alled to develop and implement experson centered care plan for 11, R36) reviewed for action and for 1 of 1 resident hearing impairment.		Corrected R11 on 12-6-17 Corrected R92 on 12-1-17		
	Findings include:					
	R11's Diagnosis information obtained in the medical record included: major depressive disorder, dementia with Lewy body disease, Parkinsons and generalized anxiety disorder. The resident was admitted on 10/18/16.					
	Observation and interview on 11/28/17, at 7:00 p.m. R11 was observed to be calm and pleasant. Sitting by her room door waiting for staff to assist her into bed. She indicated she was very tired and just wanted to get into bed. Observation and interview on 11/29/17, at 9:00 a.m. R11 was observed to be pleasant but slightly restless/fidgety with am cares. R11 would ask the staff repetitive questions even when redirected. R11 indicated she thought the staff assisting her with cares had been talking about her and that she felt bad.					
	assistant (NA)-A, in	17, at 9:00 a.m. with nursing dicated R11 will become ss at times, but is usually erative.				
	Set (MDS) dated 8/ having a Brief Inter- score of "4" (meani impaired). The MDS moods of having tro	ficant change Minimum Data 30/17, R11 was identified as view of Mental Status (BIMS) ng cognition is severely S indicated R11 exhibited buble falling asleep or sleeping				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY DMPLETED	
		00697	B. WING		12/0	4/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY - ST JAMES  1000 SOUT ST JAMES,							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
	behaviors of delusion Review of R11's cuincluded: Ativan 0.5 daily (QID) and 0.5 (PRN) during the nit disorder). Review of administration reconstraceived PRN Aprior). The resident with these orders of Review of R11's cuinclude the use of Amonitoring of target	rrent physicians orders is milligrams (mg) four times mg tablet (1) as needed ght (for generalized anxiety of the medication rd (MAR) indicated R11 had ativan since 10/27/17 (34 days was admitted to the facility in 10/18/16.					
	director of nursing (care for R11 did no did it include specif effect monitoring for During observation 3:09 p.m. R92 and indicated R92 had aide since July 201 visits daily and explained aide since july and explained in the missing hearing locate the hearing of in the process of pubut was unsure who for the replacement staff had not offered the right hearing aid	17, at 3:00 p.m. with the (DON), confirmed the plan of tinclude the use of Ativan nor ic target behaviors or side in the use of the Ativan.  and interview on 11/29/17, at family member (FM)-B been missing his right hearing in the family member (FM)-B seen missing his right hearing in the following in the following in the following in the stated she was urchasing another hearing aid, ether she would have to pay it. FM-B revealed the facility in the left ear but none included in the left ear but none					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00697	B. WING		12/	04/2017
	PROVIDER OR SUPPLIER	- ST.JAMES 1000	ET ADDRESS, CITY,  SOUTH SECONI AMES, MN 5608	D STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 560	in the right. When stated he was havin normal conversatio aide in the right ear difficult to communi hearing aide was more resident has a moderately impaire is usually understood. Review of R92's curesident as having related to hard of hearing aide. Interveffectiveness of conassistive devices, eplace and keep in related to hard of hearing aide. Interveffectiveness of conassistive devices, eplace and keep in related to hard of hearing aide. Interveffectiveness of conassistive devices, eplace and keep in related to hard of hearing aide. Interveffectiveness of conassistive devices, eplace and keep in related to hard of hearing aide. Interveffectiveness of conassistive devices, eplace and keep in related to hard of hearing imputilizing a hearing imputilizing a hearing aplan of care.  Interview on 11/30/roconfirmed R92 was and utilized hearing with hearing and coverified R92's HOH	interviewed at this time, Ring a difficult time hearing n due to the missing hearing. FM-B responded it was ricate with R92 since the ricate.	ng more ght stion left ear.  Iring. ng ent sthe d as			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY COMPLETED		
			A. BUILDING.					
		00697	B. WING		12/0	4/2017		
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
GOOD S	GOOD SAMARITAN SOCIETY - ST JAMES  1000 SOUTH SECOND STREET ST JAMES, MN 56081							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
2 560	Continued From pa	age 8	2 560					
	including depressive dementia with behat admitted the physic milligrams daily. The dated 11/16/17, indies a good antidepressing forgetfulness and more recommend tapering the physician order be decreased for a the medication. The record (MAR) ident (Paxil) 10 mg table related to other "sponse included: 10 mg daily? Also worse since meds response included:	0/26/17, with diagnoses be episodes and unspecified avioral disturbance. When can ordered Paxil 10 the physician progress note dicated: [R36] is on Paxil which essant but in the elderly that of may make symptoms worse, and off the Paxil. Subsequently, and the Paxil 10 mg daily dose week with discontinuation of the medication administration diffied that Paroxetine HCl at was administered daily decified depressive episodes.  7, from facility staff was the physician, which allowing: having some ments and unable to sleep continued? Can we restart at memory is no better and were changed. The physician restart Paxil 10 mg per oral at month; Dx dementia; dated						
	cognitive function videntified on the MI depression score in 11/1/17, was 1/27. dated 11/14/17, rediagnosis included interventions, allow plan lacked any interventions.	dicated R36 had impaired with a BIMS score of 8/15, as DS dated 11/1/17. The dentified on the PHQ-9 dated The identified intervention lated to the depression attempt non-pharmacological to vent feelings. The care erventions related to the lated to inappropriate sexual during cares.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00697	B. WING		12/	04/2017
	PROVIDER OR SUPPLIER	- ST.JAMES 1000 SO	ODRESS, CITY, S UTH SECONE ES, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 560	since admission on documentation ider inappropriate sexual 11/19, 11/20 (twice) 11/29/17.  When interviewed or clinical manager (Corestarted due to an made by R36 to fer When interviewed on NA-B indicated that inappropriate comments about providing care comments.  During interview with at 10:13 a.m. it was inappropriate with attempts to take call if the "girls" don't providing care comments are depressive episorial inappropriate comments.  When interviewed or licensed social work administrator were rationale for the addinger for depressive episorial inappropriate commacknowledged she inappropriate behavior indicated she had to instruct them how to 2 staff) but confirmed interventions on the interventions on the interventions on the confirmation of the conf	bood/behavior documentation 10/26/17, nursing atified that R36 made al comments to female staff or 11/22 (twice), 11/24 and and an 11/30/17, at 8:00 a.m.  M)-B explained that Paxil was increase in sexual comments nale staff.  In 12/1/17, at 10:06 a.m.  R36 usually made and and an ents in the evening but it can he day. NA-B also stated that ents that one does not want to fi are scared of R36 and worry and to the day. NA-B also stated that ents that one does not want to fi are scared of R36 and worry and the due to the sexual  In a male NA-D on 12/01/17, at stated that R36 talks he female staff and when he are of him, R36 becomes upset ovide care.  In 12/01/17, at 10:46 a.m. the ker (LSW) and the unable to verify whether the ministration of the Paxil was odes and/or sexually				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00697	B. WING		12/0	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- ST.IAMES	TH SECONE 5, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Resident displays/h sexual advances to cognitive impairme comments-initiated Contact health care behavior and seek SEXUALLY INAPP non-pharmacologic questioned further interventions to imprommunicated.  SUGGESTED MET The director of nursidevelop and impler related to the devel DON or designee, on ursing staff related The quality assessi committee could peensure compliance	which included the following: has displayed inappropriate ward staff R/T [related to] ht E/B [evidenced by] sexual 12/1/17 -Interventions were: e provider to report new input (dated initiated 12/1/17) ROPRIATE- attempt hal interventions. When related to how staff know what blement, a response was not  THOD OF CORRECTION: sing (DON) or designee, could ment policies and procedures opment of the care plan. The could provide training for all d to care plan development. ment and assurance erform random audits to	2 560			
2 830	(21) days.  MN Rule 4658.052  Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			1/8/18
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the tin in bed or the resident				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00697	B. WING		12/04/20	)17
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST.JAMES 1000	T ADDRESS, CITY, SOUTH SECON	D STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE CO	(X5) MPLETE DATE
2 830	Continued From pa		2 830			
	by: Based on observati review the facility fa was coordinated wi individual needs for reviewed who recei failed to properly as need for a Wander, hospitalization to er 1 of 1 resident (R20	ent is not met as evidenced ion, interview and documentailed to ensure nursing care the the hospice agency to mean of 2 residents (R41) eved hospice services and assess/reassess the continuency guard device after assure adequate supervision of the continuency	t eet ed for ied	Corrected R 41 on 1-2-18 Corrected R 20 on 12-19-17		
	R41 was admitted of cancer of the brain. hospice was dated	record (EMR) review identif on 8/10/17, with a diagnosis Subsequent admission to 8/22/17, and remained unti	of			
	nurse identified that nurse (HN)-B received asking whether host resident yet. She state to make a visit later doing ok. R41's sist breathe." HN-B were Upon entering his report minute (normal short, and labored. physician] to obtain Morphine [controls]	7, in the EMR by the hospice at at 11:42 a.m., the hospice wed a call from R41's sister spice had come to see the ated another nurse was go today and asked if he was ter replied to her "No, he can to the facility to see R41. oom, his respirations were = 16 to 20), they were rapid HN-B placed a call to [the an order to schedule pain and shortness of breat ocess]. An order was received.	ng n't 44 d,			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00697	B. WING		12/	04/2017
NAME OF	PROVIDER OR SUPPLIER		EET ADDRESS, CITY,			
GOOD S	AMARITAN SOCIETY	- ST.IAMES	0 SOUTH SECONI JAMES, MN 5608			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	for scheduled Morp HN-B administered R41's respirations of and the nursing star morphine if R41's respirations of and the nursing star morphine if R41's respiration was recommunicate his not becommunicated by communicate his not becommunicated by communication was staff and the hospic documentation reventered between 8/health status and/or linterview on 12/1/1 nurse (HN)-B indicated R41's shortness of member told HN-B of nursing (DON) almorning had been devaluated the Morp administered, but stated she understo in charge of contact HN-B explained a volumentation related the EMR on days streview. HN-B confired the solution is solved.	hine and as needed morp the first dose at that time decreased to 35 per minural ff was instructed to give espirations exceeded 24 /or if they were labored. To ized understanding. R41 was but was not able to eeds; not restless or anxious as lacking to indicate that far ontacted and/or communicate to report abnormal vitage death. During the period of spice benefit, limited as documented between far the enurse related to R41's of the ealed only 5 nursing notes 22/17 and 9/24/17, related	the the was bus. acility cated all discontinuous acility care; and to the celebrate all discontinuous acility care; and to the celebrate all discontinuous acility care ition.			

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STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00607	B. WING		10/0	4/0017
		00697			12/0	4/2017
NAME OF PROV	IDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOOD SAMA	RITAN SOCIETY	- ST JAMES	TH SECONE 5, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
price who per come and me need of the reliable to be how addressed in the lack corround to the lack repersed in th	ether nursing assiformed. HN-B furnmunication was all hospice. HN-B dication were not eded as staff assife during the proview of the R41's nutified that no Propegiven or ally or urs as needed forministered prior to facility on 9/23/1 king that a nursimple of the hospice nursimalition had been tine medications he hospice nursimality staff were to ort to health care view of R41's 8/2 ficated nursing story status. Siministration, schedication for respect of Morphine. Me part of the plan of billingual (under the pain or SOB.  View of the R41's nutified that no Propegiven or ally or urs as needed fours as needed for the plan or so as needed for the pl	was difficult to determine sessments had been urther indicated is not good between the staff stated that PRN doses of it always administered when sume the symptoms were part is and to provide symptom cess.  Is nursing progress notes in a nursing progress	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00697	B. WING		12/	04/2017
	PROVIDER OR SUPPLIER	- ST.JAMES 1000 SC	DUTH SECOND	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	the facility on 9/23/1 lacking that a nursing condition had been routine medications to the hospice nurs.  Interview and recorp.m. with the adminand the events lead she agreed docume cares provided. The staff responsibility the agreed there was a between nursing standministrator commeducation with nursensure documentation and timely communicated she parking lot that day concerns and was a contact the hospice should have contact the hospice sh	17. Documentation was ng assessment of R41's performed even though a had been administered prior e arrival.  d review on 12/1/17, at 12:53 histrator (A) related to R 41 ding up to his death indicated entation was lacking related to e administrator verified it was to contact hospice not FM and lack of communication aff and hospice staff. The mented that additional sing staff was required to cition reflected cares provided nication with the hospice staff.  In 12/1/17, at 1:30 p.m. the met the R41's FM in the and was aware of their aware they were going to enurse. The DON agreed staff the pool of the p	f			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00697	B. WING		12/	04/2017
	PROVIDER OR SUPPLIER	- ST.JAMES 1000 SC	ADDRESS, CITY, S DUTH SECONE ES, MN 56081	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 830	comprehensive care medications and co information related aspects will be clear R20 had been read 11/9/17, after a brie facility for behaviors dementia. Diagnose dementia with behaverestlessness and ag When interviewed clicensed practical in had recently returned after approximately R20's behaviors had cooperative with caprior to hospitalizatinallucinations, new some medications of that prior to hospital room to eat and sin had been participated dining room and visual conversation and moreom with the use of (2) On 11/29/17, at wheelchair enjoying dining room with oth and a Wanderguard (3) On 11/30/17, at a recliner located in her and Wanderguard (3) On 11/30/17, at a recliner located in her and Wanderguard (3) On 11/30/17, at a recliner located in her and Wanderguard behaviors noted.	e plan, physician's orders, impletion of orders, and to emotional and mental rly documented.  mitted to the facility on f discharge to a psychiatric associated with her es included Alzheimer's, ivioral disturbances and gitation.  on 11/28/17, at 2:12 p.m. urse (LPN)-A indicated R20 ed from a psychiatric hospita 2 weeks. LPN-A stated that d improved and was res. LPN-A explained that on, R20 had experienced meds had been started and discontinued. LPN-A indicated lization, R20 remained in her ce medication adjustments, ing with eating meals in the siting with other residents.  noted as follows: 4:01 p.m. R20 was wearing a per right wrist, was pleasant in acoved independently about the	d e			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00697	B. WING		12/0	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SI JAMES	JTH SECONE S, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	seated in a dining of her walker beside hattached to the walker besident with a physician order with treatment administ review of R20's TA documentation to inchecked to ensure TMA-B indicated the checked it's functional. However eason the device was a walker. It was functional. However eason the device of wrist and placed or Review of the Minimassessment dated psychiatric stay, indexis during the lootime. The MDS dat 11/16/17, indicated wander.  When interviewed director of nursing assessment related was available for reworker was responsinformation to the Nelopement or wander.	chair in the dining room with her; Wanderguard was ker and not on her wrist.  on 11/30/17, at 12:40 p.m. aide (TMA)-B explained that Wanderguard, required a h documentation on the ration record (TAR). Upon R, TMA-B was unable to locate ndicate the battery had been it was working properly. The night staff may have oning and then proceeded to which had been placed on the sent noted the battery was ter, TMA-B was unclear the had been removed from R20's in the walker.  The mum Data Set (MDS) 10/5/17, prior to R20's dicated she wandered 1 to 3 akback period of 7 days at that the dafter her return on she had made no attempts to con 11/30/17, at 1:30 p.m. the (DON) confirmed no do to elopement or wandering eview. She explained the social isible for adding any MDS assessment related to				
	an elopement from 10/17/17. There we	the facility occurred on ere no witnesses to the ummarized the "Resident was				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00697	B. WING		12/0	04/2017
-	PROVIDER OR SUPPLIER	- ST JAMES 1000 SO	ODRESS, CITY, S UTH SECOND ES, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	confused- thought to sounding. The residence confusion. Staff too to calm her. Dr. rev Currently has Wand The report made not being amended and When interviewed a case manager (CM of R20 had a Wandbeen employed with the registered nurse (RN/HIM)-C inputs physician orders after reviewed with anoth CM-B stated that womeaning confined to Wanderguard device not the resident. CM was mobile with the should be placed on Upon reviewing the lacked any mention did it address the use CM-B stated she wore related to wandering was the social work wandering. She further should be placed on Upon reviewing the lacked any mention did it address the use CM-B stated she wore related to wandering was the social work wandering. She further should be placed on Upon reviewing the lacked any mention did it address the use CM-B stated she worders were double return from hospital (device).  Document review for physician order for no assessment relawandering. The MD unclear whether R2 facility, into other residence in the confusion of the resident of the confusion of the co	here was a fire due to alarm dent had more recent k [R20] out for a walk outside iewing her medications. derGuard, reviewed meds." o mention of the care plan d/or revised.  on 12/1/17, at 10:18 a.m. RN )-B indicated she was aware lerguard placed since she has a the facility (June 2017) and e/health information manager into the computer all the ter a readmission which is her case manager (CM-A). hen a resident is immobile,				

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Age of the facility's September 2012  Documentation policy indicated physical health observations, assessments, comprehensive care plan, physician's orders, medications and completion of orders, and information related to emotional and mental aspects will be clearly documented.  SUGGESTED METHOD OF CORRECTION:  The director of nursing or designee could educate staff on policies and prosedures related to resident care and with monitoring and assessing residents that are at risk for wandering of	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
COOD SAMARITAN SOCIETY - ST JAMES   1000 SOUTH SECOND STREET ST JAMES, MN 56081			00697	B. WING		12/0	4/2017
XAI ID   SUMMARY STATEMENT OF DEFICIENCIES   DEFICIENCIES   PREFIX   TAG   CROSS REFERENCED TO THE APPROPRIATE   DEFICIENCY MUST BE PRECEDED BY FULL   REGULATORY OR LSC IDENTIFYING INFORMATION)   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE   DEFICIENCY   CROSS REFERENCED TO THE APPROPRIATE   DAME   DEFICIENCY	NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  2 830  Continued From page 18 behavior.  Interview on 12/1/17, at 11:48 a.m. and again at 12:39 p.m. with the administrator confirmed it was the expectation that R20 should have been periodically assessed for placement of a Wanderguard to re-evaluate the necessity of the device, elopement risk and supervision needs. The administrator confirmed that staff also needed to monitor the device to ensure it was working correctly.  The facility had no WanderGuard or Elopement policy.  Review of the facility's September 2012 Documentation policy indicated physical health observations, assessments, reassessments, comprehensive care plan, physician's orders, medications and completion of orders, and information related to emotional and mental aspects will be clearly documented.  SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff on policies and procedures related to the coordination/communication of Hospice services related to resident care and with monitoring and assessing residents that are at risk for wandering	GOOD S	GOOD SAMARIJAN SOCIETY - STJAMES					
behavior.  Interview on 12/1/17, at 11:48 a.m. and again at 12:39 p.m. with the administrator confirmed it was the expectation that R20 should have been periodically assessed for placement of a Wanderguard to re-evaluate the necessity of the device, elopement risk and supervision needs. The administrator also agreed a physician order for the device was necessary and when previous orders were followed post hospitalization, accuracy should be verified prior to input into the EMR. The administrator confirmed that staff also needed to monitor the device to ensure it was working correctly.  The facility's September 2012  Documentation policy indicated physical health observations, assessments, reassessments, comprehensive care plan, physician's orders, medications and completion of orders, and information related to emotional and mental aspects will be clearly documented.  SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff on policies and procedures related to the coordination/communication of Hospice services related to residents that are at risk for wandering	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
and elopement. The DON or designee could conduct audits tools for compliance.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830	behavior.  Interview on 12/1/1 12:39 p.m. with the the expectation that periodically assessed Wanderguard to redevice, elopement of the administrator at for the device was rorders were followed accuracy should be EMR. The administration policy.  The facility had no working correctly.  The facility had no working correctly.  Review of the facility Documentation policy.  Review of the facility Documentation policy.  Review of the facility Documentation policy.  Suggested will be clear assessing resident of the facility of the facility policies and coordination/comming related to resident of assessing residents and elopement. The conduct audits tools.  TIME PERIOD FOR	7, at 11:48 a.m. and again at administrator confirmed it was at R20 should have been ed for placement of a evaluate the necessity of the risk and supervision needs. Iso agreed a physician order necessary and when previous do post hospitalization, verified prior to input into the rator confirmed that staff also the device to ensure it was  WanderGuard or Elopement  Y's September 2012  cy indicated physical health asments, reassessments, e plan, physician's orders, and to emotional and mental rly documented.  CHOD OF CORRECTION: sing or designee could educated procedures related to the unication of Hospice services care and with monitoring and a that are at risk for wandering a DON or designee could so for compliance.				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		00697	B. WING		12/0	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE	1 1 2 7 9	.,
		1000 SQU	TH SECONE			
GOOD 5	AMARITAN SOCIETY	- ST JAMES ST JAMES	S, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21495	Continued From pa	ge 19	21495			
21495	MN Rule 4658.1009 Providing Social Se	5 Subp. 5 Social Services; rvices	21495			1/4/18
	services must be pridentified social ser according to the coassessment and co	rovided on the basis of vice needs of each resident, mprehensive resident omprehensive plan of care 4658.0400 and 4658.0405.				
	by: Based on observatireview the facility farand/or arrangemenhearing device after	ent is not met as evidenced on, interview and document illed to provide assistance ts to obtain a replacement rit was reported missing for 1 reviewed who had missing		Corrected R 92 12-1-17		
	Findings include:					
	3:09 p.m. R92 and indicated R92 had haid since July 2017 visits daily and expl hearing aid one ever morning it was miss the missing hearing locate the hearing of in the process of pubut was unsure whe for the replacement staff had not offered the right hearing aid that R92 had a hea in the right. When stated he was having	and interview on 11/29/17, at family member (FM)-B been missing his right hearing. FM-B further indicated she ained that R92 had his ening and the following sing. FM-B stated she reported a aid but staff were unable to device. FM-B stated she was urchasing another hearing aid, ether she would have to pay a three she would have to pay to assist with replacement of the state of the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00697	B. WING		12/0	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- ST JAMES	JTH SECOND S, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21495	aid in the right ear. difficult to communi hearing aid was mis Minimum Data Set 6/27/17, identifies Fhearing. The reside Mental Status (BIM: moderately impairer is usually understood Review of the Nursi form dated 6/20/17, and right hearing aid. Review of R92's curesident as having a related to hard of he hearing aid. Interve effectiveness of cor assistive devices, eplace and keep in nathough R92 was in having hearing impautilizing a hearing aplan of care.  Review of the facilit dated 9/16/17, indicated only the letter each evening. Indicated only the letter medication cart	FM-B responded it was more cate with R92 since the right sing. Review of the admission (MDS) assessment dated R92 as utilizing hearing aids for nt has a Brief Interview of S) score of "9" (meaning d cognition) and the resident of and understands.  Ing Admission Data Collection identifies R92 as having left ds to aide in the ability to hear.  Intervent plan of care identifies the a communication problem earing (HOH) and needs a notions listed: monitor munication strategies and insure left hearing aid is in nedication cart at bedtime. In dentified upon admission as airment in the right ear and id, this was not included in the sy lost and found document eated R92 was missing his inch had been reported to the				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00697	B. WING		12/0	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	GOOD SAMARITAN SOCIETY - ST JAMES  1000 SO ST JAME			O STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21495	R92's treatment rec 6/27/17 to 12/4/17 treatment record for R92's right and left in the medication of signed treatment recard November, and November, and November, and had been stored in was no documental hearing aid was no medication cart for When interviewed clinical manager (Cadmission, R92's right comparts of the missing aid since the has had a difficult treatment of the missing personal it confirmed R92's right confirmed R92's right of the missing right with the missing right was aware of R92's confirmed it had be months. LPN-A furt LSW had followed missing item with the confirmed R92 was aware of R92's confirmed R92 was aware of R92's confirmed R92 was aware of R92's confirmed R92 was aware R92 was aw	cord since admission on was reviewed. The signed or July and August indicated hearing aids had been stored art each night. Review of the ecord for September, October licated only the left hearing aid the medication cart. There attion addressing why the right longer being stored on the the past 3 months.  CM)-A indicated shortly after ight hearing aid was missing. Per has not utilized the right heat time, and consequently, ime hearing without an the LSW on 11/29/17, at I she was not aware of R92's ang aid and was unable to find a mem report. The LSW ght hearing was documented out investigate the whereabouts				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00697	B. WING		12/0	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- ST JAMES	TH SECONE S, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21495	Continued From pa	ige 22	21495			
	nursing (DON) and staff initially was aw hearing aid on 7/7/ documented and th	17, at 8:07 a.m. the director of the administrator confirmed ware of R92's missing right 17, when it was first the LSW should have followed ing the missing item as the st.				
	Review of the facility policy and procedure for Missing Items dated 4/16, included reporting missing items to the supervisor immediately, start a search for the item, if the item is not found and is of nominal value, complete a suggestion/concern form and social services (SS) will report to the resident/family or responsible party on the attempts to locate the item. A record is kept in the SS office no less than 15 months.					
	administrator could staff on the policy a missing items. The to ensure complian	THOD OF CORRECTION: The re-educate the social service and procedures related to administrator could then audit ce and bring forth to the QAA ew. Missing items could be e care conference.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21540	MN Rule 4658.1319 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			1/5/18
	monitor each reside unnecessary drug thome's policies and pharmacist must re resident's attending	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the eport any irregularity to the physician. If the attending concur with the nursing				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00697	B. WING		12/	04/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST.JAMES 1000	ET ADDRESS, CITY, SOUTH SECON AMES, MN 5608	D STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21540	Continued From particles home's recommend adequate justification believes the resider adversely affected, matter to the medical director is a the medical director is a the medical director physician does not the order and if the change the order, the review to the Qualit (QAA) committee resident the attending physist the consulting pharmal directly to the QAA.  This MN Requirement by:  Based on observation review, the facility for indications for the undication to ensure effectiveness for 1 for unnecessary metallicity in the consultation of the undication and psychoactive medical include parameters.	ge 23 dation, or does not provide on, and the pharmacist not's quality of life is being the pharmacist must refer all director for review if the not the attending physician refermines that the attendance adequate justification attending physician does the matter must be referred by Assurance and Assessmeduired by part 4658.0070. It is not met as evidence on, interview, and record alled to identify adequate use of Gabapentin (anti-seiner adequate monitoring for the use of the as need nedications and/or failed to for the use of the as need nedication for 2 of 5 reside	21540  the  If ding for not for ent If for e			
	11/9/17, after a brie facility for behaviors dementia. Diagnose	mitted to the facility on f discharge to a psychiatric s associated with her es included Alzheimer's an				
	dementia with beha restlessness and ag	vioral disturbances and gitation.				

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
20007		B. WING	<del></del>	40/0	4/0047	
		00697			12/0	4/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- ST JAMES	JTH SECONE S, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	Continued From pa	age 24	21540			
	When interviewed of licensed practical in had recently return after approximately R20's behaviors had cooperative with caprior to hospitalizat hallucinations, new some medications that prior to hospitaroom to eat and sinhad been participated dining room and visual Review of the elect for R20 indicated of the psychiatric hospitality. The physici EMR by nursing states (1) Gabapentin 300 capsule by mouth in restlessness and at (2) Gabapentin 100 two times a day relative the nurse dated 11 psychiatric hospital return, indicated the of Gabapentin was Documentation was had a diagnosis relative telephone order countersigned by the	on 11/28/17, at 2:12 p.m. nurse (LPN)-A indicated R20 ed from a psychiatric hospital 2 weeks. LPN-A stated that id improved and was ures. LPN-A explained that ion, R20 had experienced meds had been started and discontinued. LPN-A indicated alization, R20 remained in her nice medication adjustments, sing with eating meals in the esting with other residents.  Tronic medical record (EMR) cabapentin was initiated during poital stay prior to return to the aff were:  O milligrams (MG) give 1 in the evening related to gitation.  O MG, give 2 capsule by mouth ated to pain, unspecified.  One physician order signed by 78/17, received from the and provided upon R20's ereason for the administration is to treat nerve pain. In addition, it had not yet been the ordering physician.				
	indicated there was note dated 11/15/17	ood and behavior notes only one documented nurses'7, when R20 exited the bed went to the bathroom.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00697	B. WING		12/	04/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES 1000 SO	DDRESS, CITY, S UTH SECONI ES, MN 5608			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21540	Documentation indit to bed and stayed in night. No other documentation indited bed and stayed in night. No other documentation on 12/1/17, when reserview of the Minimassessment dated psychiatric stay, indicated she had not time. The MDS date indicated she had not when interviewed or clinical managers (of the Gabapentin ord unaware the Gabapentin ord unaware the Gabapentin was agitation. CM-A agregarding the need clarified with the phrace the returning the countersigned by the addition, facility state effectiveness of the rationale for the adr CM-A was unaware from the psychiatric countersigned by a never had a diagnoon. Interview on 12/1/13 administrator confirt to clarify physician of a new medication of a new medication.	cated she was assisted back in bed for the remainder of the umentation was noted relative otes in the EMR per the DON equested.  num Data Set (MDS) 10/5/17, prior to R20's licated she wandered 1 to 3 kback period of 7 days at that ed after her return on 11/16/17 nade no attempts to wander.  on 12/1/17, at 10:54 p.m. with CM)-B and CM-A regarding er, it was learned they were bentin had been identified as for nerve pain. A note from bital dated 10/26/17, identified as administered for anxiety and eed the conflicting information for the Gabapentin should be ysician especially due to the lephone order had not been be ordering physician. In if could not monitor the medication when unsure the ministration of this medication. In the original order received a facility had not been physician. CM-A agreed R20 sis related to nerve pain.  7, at 12:39 p.m. with the med the expectation for staff orders and corresponding late, especially upon initiation				

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00697		B. WING		12/0	)4/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1	
GOOD S	AMARITAN SOCIETY	- ST JAMES	JTH SECONE S, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	Physician/Practition purpose was to proeach resident and pobtaining appropria physician's orders. signed and dated be period required by be documented as a physician order. In the hospital, physician orders any type of physician raises questions. No order, even if a diaga physician may dia Review of the facility Documentation polobservations, assecomprehensive car medications and coinformation related aspects will be clear R11's diagnosis informedical record includisorder, dementian Parkinsons and gerwas admitted on 10 During observation appeared calm and door waiting for stainterviewed at this tired and wanted to During morning car R11 appeared plear	ner Orders policy indicated its ovide individualized care to provide staff a procedure by ate, accurate, and timely Telephone orders will be by the physician within the time state law. Nursing orders must care plan approaches, not as When a resident returns from sian's orders must be updated ent's current needs. The are needed when reviewing an order that is incomplete or lever assign a diagnosis to an agnosis appears obvious. Only agnose.  The september 2012 icy indicated physical health ssments, reassessments, re plan, physician's orders, and to emotional and mental arly documented.  The procedure of orders, and to emotional and mental arly documented.  The procedure of the arrival of the same of the sa	21540			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00697		B. WING		12/(	04/2017
NAME OF PROVID	ER OR SUPPLIER	- ST JAMES	1000 SOL	DRESS, CITY, S DTH SECONI S, MN 56081			
	(EACH DEFICIENCY	TEMENT OF DEFICIE / MUST BE PRECEDE SC IDENTIFYING INF	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
eventime, with she fill linter assis para pleas Revi Set (ident Statu seve exhibit or sle asse R11 Revi inclu daily (PRI dison adminot r prior orde Revi inclu moni effect use.	R11 indicated cares had been felt bad.  view on 11/30/stant (NA)-A, in noid and restle sant and coope ew of the signification (MDS) assessment in the sant and coope ew of the signification (MDS) assessment period exhibited moods of eeping too much exhibited behaves of R11's curded: Ativan 0.5 (QID) and 0.5 N) during the nitroder). Review of inistration reconsidered PRN A). The resident rs on 10/18/16 ew of R11's curded the use of A itoring of target exts/adverse reactions and the considered products of	ed. When intervishe thought stantalking about he stantalking trouble from the MDS indicated having trouble from the MDS further wiors of delusions of delusions of the medication and (MAR) indicated was admitted were stantalking since 10/2 was admitted with the medication of the medica	ff assisting er and that  with nursing become is usually  nimum Data 17, R11 was of Mental grognition is ated R11 alling asleep uring the er indicated is.  orders of four times needed is needed is a did not include any de the Ativan  at drug er following	21540			

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AND DIAN OF CODDECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00697	B. WING		12/0	)4/201 <b>7</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- ST JAMES	UTH SECOND S, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	orders and avoid p adverse reactions i responded with no months; (2) dated 2/15/17, Ativan use due to Fresponded with no (3) dated 8/13/17, Ativan order and adplan of care. The rejustification and duthe continued use of initial 14 days. The continue the currer request; and (4) dated 10/20/17, continued use of the duration for use fol physician responded Ativan order due to Review of the phys 11/22/16, 12/12/16 6/20/17, 8/14/17 ar history of falls, Part depression/anxiety address R11's currigustification for the Review of the progincluded any docur the past 6 months episodes of being i wanting certain stal Interview on 11/30/director of nursing become restless at to redirect, but controlled to the controlled to the past 6 months are pisodes of being included any docur the past 6 months are pisodes of being included any docur the past 6 months are pisodes of being included any docur the past 6 months are pisodes of being included any docur the past 6 months are pisodes of being included any docur the past 6 months are pisodes of being included any docur the past 6 months are pisodes of being included any docur the past 6 months are pisodes of being included any docur the past 6 months are pisodes of being included any docur the past 6 months are pisodes of being included any docur the past 6 months are pisodes of being included any docur the past 6 months are pisodes of being included any docur the past 6 months are pisodes of being included any docur the past 6 months are pisodes of being included any docur the past 6 months are pisodes of being included any docur the past 6 months are pisodes of being included any docur the past 6 months are pisodes of being included any docur the past 6 months are pisodes and are pisodes are pisodes and are pisodes are pisodes and are pisodes are pisode	rolonged daily use due to n the elderly. The physician changes and to reassess in 6 discontinue the scheduled R11 falling. The physician changes due to family request discontinue the scheduled ddress the Ativan use in R11's eport also included a ration of use was needed for of the PRN Ativan following the physician responded to at Ativan order due to family document a justification for the PRN Ativan as well as the lowing the initial 14 days. The ed to continue the current of husband request.  Icians dictated notes dated (1/9/17, 3/13/17, 4/10/17, and 10/9/17, addressed R11's kinson's, Lewy body disease, The physician did not ent Ativan use or the continued use.  Tess notes for R11, did not mented mood or behaviors in other than exhibiting 2 dentified as "needy" and not				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND DUAN OF CODDECTION DENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			B. WING		10/0	
		00697	b. WING		12/0	4/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- ST JAMES	ITH SECONE S, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	nor the frequency the confirmed there we the use of the Ativa gradual dose reduct the past year.  Interview on 12/01/practical nurse (LP exhibit any behavior that she has observed in the past not recall the last the exhibit these behavior that she has observed in the past not recall the last the exhibit these behavior that she has observed in the past not recall the last the exhibit these behavior that the physician ordered in the physician ordered in the physician progress indicated: [R36] is antidepressant but may make symptor tapering off the Past physician ordered the decreased for a wellow medication. The medication. The medication in the physician ordered the folional that the foli	hey occurred. The DON also are no behaviors identified for an to establish efficacy, and a stion had not been attempted in 17, at 9:11 a.m with licensed N)-A, indicated R11 did not are of anxiety or restlessness are or that the NA's have at several weeks. LPN-A could are R11 was observed to aviors.  0/26/17, had diagnoses are episodes and unspecified avioral disturbance and had avioral disturbance and had avioral disturbance and had avioral the individual of the note dated 11/16/17, an Paxil which is a good in the elderly that if forgetful, are worse, recommend at Subsequently, the he Paxil 10 mg daily dose be the with discontinuation of the eldication administration record at Paroxetine HCI (Paxil) 10 inistered daily related to other we episodes".	21540			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00697		B. WING		12/	04/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES	1000 SOL	DRESS, CITY, S JTH SECONE S, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC / MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21540	Continued From particles of the plan of care incognitive function widentified on the ME depression score in 11/1/17, was 1/27, is symptoms minimal. dated 11/14/17, rel diagnosis included: interventions, allow care lacked any refinappropriate commentation in the particles of the particles of the physician note identification in the properties of the physician note identification of the medication base administration of the medication of the medication of the particles of the physician note identification of the medication base administration of the medication of th	dicated R36 had impith a BIMS score of DS dated 11/1/17. The dentified on the PHG indicating depression. The identified into ated to the depression attempt non-pharm to vent feelings. The erence to sexually ments and effective prod/behavior docur 10/26/17, nursing attified that R36 mag all comments to ferm 11/30/17, at 8:00 pm. The explained that increase in sexual male staff. However, tified the medication ion.  On 12/01/17, at 10:4 ker (LSW) and the unable to verify when inistration of the Fodes and/or to reduce the effective on the rationale emedication, they	f 8/15, as the Q-9 dated recovention sion macological ne plan of mess of mentation de lale staff on 24 and de lale staff on 24				
	unable to respond. documentation to ic continued administr	dentify the rationale	for the				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00697	B. WING		12/0	04/2017
	PROVIDER OR SUPPLIER	- ST.JAMES 1000 SOL	DDRESS, CITY, S JTH SECONI S, MN 5608			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21540	provided.  SUGGESTED MET The director of nurs the importance of e is identified so that drug effectiveness of to ensure the accur dose is entered into An audit could be d medications for ade the results reported	THOD OF CORRECTION: sing could education staff on ensuring the correct diagnosis appropriate monitoring for can be performed. A system rate diagnosis and medication to the EMR could be developed eveloped to monitor equate indications for use and to the QAA committee.  R CORRECTION: Twenty-one	21540			

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