#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: QLUM

#### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I - TO BE COMPLETED BY THE			HE STAT	E STATE SURVEY AGENCY Facility ID: 00303		
MEDICARE/MEDICAID PROVIDER     (L1) 245455      STATE VENDOR OR MEDICAID NO.     (L2) 673342500		3. NAME AND AD (L3) <b>GOOD SAM</b> (L4) <b>601 WEST J</b> (L5) <b>JACKSON</b> , 1	ARITAN SOCI ACKSON		(L6) 56143	4. TYPE OF ACTION: 7 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OV (L9)		7. PROVIDER/SU	05 HHA	RY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint	
6. DATE OF SURVEY <b>04/2</b> 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	<b>4/2017</b> (L34) — (L10)	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	
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds	53 (L18) 53 (L17)	Compliand1.		ram	And/Or Approved Waivers Of Th  2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code	6. Scope of Services Limit 7. Medical Director	
14. LTC CERTIFIED BED BREAKDOV 18 SNF 18/19 SNF 53 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)	(vers.	* Code: <b>A</b> 15. FACILITY MEETS  1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):  17. SURVEYOR SIGNATURE  Date:  06/19/2017				):	18. STATE SURVEY AGENCY A		
	Gary Nederhoff, Unit Supervisor 06/19/2017 (L19) Joanne Simon, Certification Specialist 09/05/2017 (L20)						
P	PART II - TO BE	COMPLETED		_ ` /	Joanne Simon, Certification  OFFICE OR SINGLE ST.	09/03/2017	(L20)
19. DETERMINATION OF ELIGIBILIT  _X 1. Facility is Eligible to P  2. Facility is not Eligible	TY 'articipate	20. COM		EGIONAL	21. 1. Statement of Finan	ATE AGENCY  cial Solvency (HCFA-2572)  I Interest Disclosure Stmt (HCFA-1513)	(L20)
19. DETERMINATION OF ELIGIBILIT  _X 1. Facility is Eligible to P  2. Facility is not Eligible  22. ORIGINAL DATE  OF PARTICIPATION  04/01/1987	rarticipate (L21) 23. LTC AGREEM BEGINNING	20. COM RIG	BY HCFA REMPLIANCE WITH GHTS ACT:  4. LTC AGREEM ENDING DAT	EGIONAI CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above  26. TERMINATION ACTION:  VOLUNTARY 01-Merger, Closure	ATE AGENCY  cial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) :  (L30)  INVOLUNTARY  05-Fail to Meet Health/Safety	(L20)
19. DETERMINATION OF ELIGIBILIT  _X 1. Facility is Eligible to P  2. Facility is not Eligible  22. ORIGINAL DATE  OF PARTICIPATION	rry carticipate (L21) 23. LTC AGREEM	20. COM RIG	BY HCFA REMPLIANCE WITH GHTS ACT:	EGIONAI CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above  26. TERMINATION ACTION: VOLUNTARY 00	ATE AGENCY  cial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) :  (L30)  INVOLUNTARY  05-Fail to Meet Health/Safety	((L20)
19. DETERMINATION OF ELIGIBILIT  _X1. Facility is Eligible to P 2. Facility is not Eligible  22. ORIGINAL DATE  OF PARTICIPATION  04/01/1987  (L24)  25. LTC EXTENSION DATE:	rarticipate (L21)  23. LTC AGREEM BEGINNING (L41)  27. ALTERNATIV A. Suspension B. Rescind Sus	20. COM RIG	BY HCFA RI  MPLIANCE WITH GHTS ACT:  4. LTC AGREEM ENDING DAT  (L25)  (L44)  (L45)	EGIONAI CIVIL	21. 1. Statement of Finan 2. Ownership/Contro 3. Both of the Above  26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	ATE AGENCY  cial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513) :  (L30)  INVOLUNTARY  05-Fail to Meet Health/Safety  of the Meet Agreement  OTHER  07-Provider Status Change	(L20)
19. DETERMINATION OF ELIGIBILIT  _X1. Facility is Eligible to P 2. Facility is not Eligible  22. ORIGINAL DATE  OF PARTICIPATION  04/01/1987  (L24)  25. LTC EXTENSION DATE:  (L27)	rarticipate (L21)  23. LTC AGREEM BEGINNING (L41)  27. ALTERNATIV A. Suspension B. Rescind Sus	20. COM RIG	BY HCFA REMPLIANCE WITH GHTS ACT:  4. LTC AGREEM ENDING DAT  (L25)  (L44)  (L45)  CARRIER NO.	EGIONAL CIVIL ENT E (L31)	21. 1. Statement of Finan 2. Ownership/Contro 3. Both of the Above  26. TERMINATION ACTION:  VOLUNTARY 00  01-Merger, Closure  02-Dissatisfaction W/ Reimburseme  03-Risk of Involuntary Termination  04-Other Reason for Withdrawal	cial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)  (L30)  INVOLUNTARY  05-Fail to Meet Health/Safety  of the month of th	(L20)

DETERMINATION APPROVAL



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245455

June 19, 2017

Mr. Daren Rife, Administrator Good Samaritan Society - Jackson 601 West Jackson Jackson, MN 56143

Dear Mr. Rife:

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 March 31, 2017 the above facility is certified for or recommended for:

57 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 57 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,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 19, 2017

Mr. Daren Rife, Administrator Good Samaritan Society - Jackson 601 West Jackson Jackson, MN 56143

RE: Project Number S5455028

Dear Mr. Rife:

On March 21, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 9, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 24, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 7, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 9, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 31, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 9, 2017, effective March 31, 2017 and therefore remedies outlined in our letter to you dated March 21, 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,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted

July 25, 2017

Mr. Daren Rife, Administrator Good Samaritan Society Jackson 601 West Jackson Jackson, MN 56143

Subject: Good Samaritan Society - Jackson - IDR

Provider # 245455 Project # S5455028

Dear Mr. Rife:

This is in response to your letter of April 10, 2017, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tags F170, F280, F315, F329, and F441 issued pursuant to the survey event QLUM11, completed on 3/9/17.

The information presented with your letter, the CMS 2567 and corresponding plan of correction, a telephone meeting with the facility on May 9, 2017, as well as survey documents and discussion with representatives of licensing and certification staff have been carefully considered, and the following determination has been made:

F170 (E) 42 CFR §483.10 The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service.

Summary of the facility's reason for IDR of this tag: The facility alleges this tag was cited appropriately, however, disputes the scope and severity level at an E (pattern, with no harm with a potential for more than minimal harm that is not immediate jeopardy). The facility maintains that not receiving mail on a Saturday does not constitute a potential for more than minimal harm.

Summary of facts: Review of interviews with residents and staff indicate residents did not receive mail on Saturdays. This was cited appropriately, however, the scope and severity level should be at a C (widespread, with no actual harm with potential for minimal harm).

Good Samaritan Society - Jackson July 25, 2017 Page 2

This is a valid deficiency at this tag, however, the scope and severity has been changed to a level C.

F280 (D) 42 CFR §483.21 (b) Comprehensive Care Plans. A comprehensive care plan must be developed within 7 days after completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes but is not limited to the attending physician, a registered nurse with responsibility for the resident; a nurse aide with the responsibility for the resident; a member of food and nutrition services staff; to the extent practicable, the participation of the resident and the resident's representative(s); other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident; and reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

Summary of the facility's reason for IDR of this tag: The facility alleges a comprehensive pain assessment was completed for R49 on 11/13/16, and 2/2/17, which both indicated R49 had no pain. The facility indicates the regulation directs the facility to develop a comprehensive care plan within 7 days of the comprehensive assessment. The comprehensive assessment indicated R49 had no pain, so no pain care plan needed to be developed.

Summary of facts: R49's pain assessments indicated he had no pain. A review of R49's use of acetaminophen (Tylenol) 500 mg 1 tablet by mouth every 6 hours for pain or fever indicated in the three months prior to the survey R49 had used the acetaminophen three times (one time each month in January, February, and March of 2017).

A care plan is developed following an assessment, and since R49's pain assessment indicated he had no pain, it would not be expected a care plan would be developed. R49 also had pain so rarely, it would not be expected a care plan would be developed on a resident who had a diagnosis of osteoarthritis and received pain medication approximately one time a month.

This is not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies.

F315 (E) 42 CFR §483.25 (e) Incontinence. A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

Summary of the facility's reason for IDR of this tag: The facility alleges that a deficiency should not be issued because they did not document three signs and symptoms of a urinary tract infection (UTI) prior to asking for an urinalysis (UA) to determine if the residents had a UTI. Also, R5's laboratory test for a UTI was done in the emergency room, not in the facility.

Summary of facts: The regulation indicates a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections. The interpretive guidelines indicate because many residents have chronic bacturemia, the research suggests treating only

Good Samaritan Society - Jackson July 25, 2017 Page 3

symptomatic UTIs, and residents without a catheter should have at least three signs and symptoms of a UTI prior to treating the UTI. The regulation does not indicate three signs and symptoms of infection must be documented.

This is not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies.

F329 (D) 42 CFR §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 in excessive dose (including duplicate drug therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of these reasons.

Summary of the facility's reason for IDR of this tag: The facility alleges an as needed dose of acetaminophen is not an unnecessary medication, and did not meet any of the 5 criteria listed in the regulations for the definition of an unnecessary medication. The facility indicated R49 received acetaminophen three times in the previous three months; once in January for generalized pain, once in February for generalized pain, and once in March for generalized pain. The facility alleges when a resident has pain and requests a pain medication such as Tylenol, it should be given, and because it is not an unnecessary medication, they did not feel they had to offer and document non-pharmacological interventions for pain prior to administration of the acetaminophen.

Summary of facts: R49 had an order for acetaminophen 500 milligrams (mg) one tablet every 6 hours as needed for pain or fever. R49 received this medication for pain three times in the previous three months. R49 also had a diagnosis of osteoarthritis. Acetaminophen as used by R49 on as needed basis for pain, does not constitute an unnecessary medication.

This is not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies.

F441(F) 42 CFR §483.80 Infection Control. The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

Summary of the facility's reason for IDR of this tag: The facility alleges the current regulation under F441 went into effect on November 28, 2016, and the facility should not be cited on practices prior to the updated regulation. The facility alleges infection control monitoring is done at monthly QA meetings, and provided the agenda and meeting minutes for January and February 2017.

Summary of facts: There was not a change in the infection control regulation on November 28, 2016, and the requirement to conduct surveillance had been in effect for a number of years. The facility's infection control program was incomplete, and the infection control logs did not include resolution of the infection, ongoing surveillance, or data analysis. Review of the provided QA agenda and meeting

Good Samaritan Society - Jackson July 25, 2017 Page 4

minutes lacked any infection control discussion for the month of January 2017.

The facility's infection control program lacked complete infection control logs, and as a result, the facility did not provide ongoing surveillance or data analysis in order to prevent, to the extent possible, the onset and spread of infection.

This is a valid deficiency at this tag and at the correct scope and severity of an F.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

#### Meresa Ament

Teresa Ament, Unit Supervisor Minnesota Department of Health Licensing and Certification Program 11 East Superior Street, Suite 290 Duluth, MN 55802

Telephone: 218-302-6151 Fax: 218-723-2359

Teresa.Ament@state.mn.us

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Gary Nederhoff, Rochester District Office Unit Supervisor

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

PRINTED: 07/25/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

		245455	B. WING _		03/09/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON	
GOOD S	AMARITAN SOCIETY	- JACKSON		JACKSON, MN 56143	
(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 APPROPF DEFICIENCY)	BE COMPLÉTION
F 000	INITIAL COMMENT	rs	F 00	00	
F 156 SS=C	The facility's plan of as your allegation of Department's accept enrolled in ePOC, yat the bottom of the form. Your electronic be used as verificated. Upon receipt of an accompany on-site revisit of your validate that substate regulations has been your verification.  "REVISED 2567 as Dispute Resolution 483.10(d)(3)(g)(1)(4) RIGHTS, RULES, Significant of contacting the phyprofessionals response \$483.10(g) Information (1) The resident has his or her rights and governing resident during his or her states (g)(4) The resident notices or ally (meansement).	of correction (POC) will serve of compliance upon the otance. Because you are rour signature is not required a first page of the CMS-2567 ic submission of the POC will cion of compliance.  acceptable electronic POC, an air facility may be conducted to antial compliance with the en attained in accordance with the en attained in accordance with services, CHARGES.  SERVICES, CHARGES.  Sust ensure that each resident of the name, specialty, and way any sician and other primary care on sible for his or her care.  Ition and Communication. Is the right to be informed of the of all rules and regulations conduct and responsibilities are in the facility.  The compliance with the entitle of the name in the right to receive the ning spoken and in writing a format and a language he	F 15		3/15/17
		DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	(X6) DATE
Electron	ically Signed				03/31/2017

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_

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 OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245455	B. WING _		03	/09/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 601 WEST JACKSON JACKSON, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 156	The facility must further description of legal (A) A description of personal funds, unsection;  (B) A description of procedures for est including the right resources under security Act.  (C) A list of names email), and telephostate regulatory arresident advocacy Survey Agency, the State Long-Term of protection and adviservices where stain long-term care fragency for information community and the and  (D) A statement the concerning any suffederal nursing faction in the facility, non-directives requirement information regard	s as specified in this section.  Irnish to each resident a written I rights which includes -  If the manner of protecting der paragraph (f)(10) of this  If the requirements and ablishing eligibility for Medicaid, to request an assessment of ection 1924(c) of the Social  In addresses (mailing and one numbers of all pertinent and informational agencies, groups such as the State estate licensure office, the Care Ombudsman program, the ocacy agency, adult protective at law provides for jurisdiction acilities, the local contact ation about returning to the estate Survey Agency spected violation of state or compliance with the advance ments and requests for ing returning to the community.  If contact information for State	F 18	56			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		245455	B. WING		03	/09/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP COI 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 156	not limited to the St Long-Term Care Or (established under Americans Act of 19 U.S.C. 3001 et seq advocacy system (a as established under Disabilities Assistar 2000 (42 U.S.C. 15 [§483.10(g)(4)(ii) w November 28, 2017 (iii) Information regaligibility and covera [§483.10(g)(4)(iii) w November 28, 2017 (iv) Contact information 20(a)(20)(Act); or other No W [§483.10(g)(4)(iv) w November 28, 2017 (v) Contact information 28, 2017 (v) Contact information 28, 2017 (vi) Contact information 28, 2017 (vi) Information and I§483.10(g)(4)(v) w November 28, 2017 (vi) Information and I§483.10(g)(4)(vi) w November 28, 2017 (vi) Information and Igievances or compassion of Igievances or compassion o	organizations including but rate Survey Agency, the State inbudsman program section 712 of the Older 965, as amended 2016 (42) and the protection and as designated by the state, and er the Developmental ince and Bill of Rights Act of 001 et seq.) ill be implemented beginning 7 (Phase 2)]  arding Medicare and Medicaid age; will be implemented beginning 7 (Phase 2)]  ation for the Aging and Center (established under (B)(iii) of the Older Americans frong Door Program; will be implemented beginning 7 (Phase 2)]  tion for the Medicaid Fraud ill be implemented beginning 7 (Phase 2)]  I contact information for filing blaints concerning any of state or federal nursing including but not limited to	F 15			

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPL		E SURVEY MPLETED			
		245455	B. WING		03/	09/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 156	(g)(5) The facility manner accessible residents, resident  (i) A list of names, a and telephone numagencies and advosurvey Agency, the protective services jurisdiction in long-tof the State Long-T program, the protect home and communand the Medicaid F  (ii) A statement that complaint with the sconcerning any susfederal nursing facilimited to resident a misappropriation of facility, and non-condirectives requirem I) and requests for to the community.  (g)(13) The facility written information, applicants for adminformation about he Medicare and Medireceive refunds for such benefits.	ng returning to the community.  nust post, in a form and and understandable to	F 150			

1		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245455	B. WING _		03	/09/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP C 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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) COMPLETION DATE
F 156	(i) The facility must and in writing in a la understands of his regulations governi responsibilities duri (ii) The facility must the State-develope obligations, if any.  (iii) Receipt of such amendments to it, writing;  (g)(17) The facility (i) Inform each Medwriting, at the time facility and when the Medicaid of-  (A) The items and sonursing facility serv for which the reside (B) Those other item facility offers and for charged, and the asservices; and  (ii) Inform each Medicaid in paragraphics section.	inform the resident both orally anguage that the resident or her rights and all rules and ng resident conduct and ng the stay in the facility.  It also provide the resident with d notice of Medicaid rights and information, and any must be acknowledged in	F 15			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245455	B. WING _		03	/09/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 156	periodically during available in the faci services, including covered under Med facility's per diem ration (i) Where changes and services cover Medicaid State plan notice to residents reasonably possible (ii) Where changes items and services facility must inform 60 days prior to impossible (iii) If a resident die transferred and dog facility must refund representative, or experience of the facility must refund representative, or experience and in the facility must refund representative, or experience and dog facility must refund representative.	the of admission, and the resident's stay, of services lity and of charges for those any charges for services not licare/ Medicaid or by the ate.  in coverage are made to items ed by Medicare and/or by the n, the facility must provide of the change as soon as is e.  are made to charges for other that the facility offers, the the resident in writing at least plementation of the change.  s or is hospitalized or is es not return to the facility, the to the resident, resident estate, as applicable, any	F 15	56		
	per diem rate, for the resided or reserved facility, regardless of discharge notice resident representation the resident within a date of discharge from the terms of an behalf of an individicality must not conthese regulations.	st refund to the resident or utive any and all refunds due 30 days from the resident's				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245455	B. WING			03/0	09/2017
_	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		6	STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 156	Based on interview failed to ensure the Federal and State In Residents in Medic Nursing Facilities of 11/28/16 was provided This had the potent currently residing in Findings include:  During the initial tout 11:13 a.m., the Bill wall in the facility hasouth and north wire of Nursing to not be should contain revision of Nursing to not should contain revision and conform of Nursing to not should contain revision and conform of Nursing to not should contain revision and conform of Nursing to not should be not sho	and record review, the facility most current Combined Bill of Rights (BOR) for are/Medicaid Certified Skilled r Nursing Facilities dated ded to the facility residents. ial to affect all 43 residents the facility.  For of the facility on 3/6/17 at of Rights poster hanging on a allway located between the ags was found by the Director of the most current BOR which sions dated 11/28/16.  For a.m. the director of nursing veyor the Bill of Rights in the acket given to residents upon firmed at the time the and Minnesota State Bill of sion packet was dated BOR ated 12/2015.  For a.m. the administrator when are of the most current Bill of a month of 11/2016, stated he as a more current Bill of strator stated residents had at current BOR but when the ents was reviewed it was most current which had been	F1	56	A new Bill of Rights poster with codate and information was posted in hallway located between South and wings.  All residents received an updated of Resident Rights policy  Any time there is a change in Resident's legal representative or interested family member.  All new admission will receive new resident rights.  This will be audited by Social service weekly X 4 then monthly X 3 and be to QAPI for further recommendation.	d North copy of dent bill of	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		E SURVEY MPLETED
		245455	B. WING _		03/	09/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		
(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)	LD BE	(X5) COMPLETION DATE
F 167 SS=C	we should have cor the residents and we The facility Resider 11/16, Purpose To enotification of change Policy The location resident, the reside interested family me in resident rights und 483.10(g)(10)(i)(11) RESULTS - READI (g)(10) The resident (i) Examine the resident facility condusurveyors and any prespect to the facility (g)(11) The facility residents, the result the facility.  (ii) Post in a place reand family member residents, the result the facility.  (iii) Have reports with certifications, and corespecting the facility years, and any plant respect to the facility to review upon requirements.	Inmunicated the changes to be have not done that.  It Rights Policy dated revised ensure the resident prompt ges in the resident rights. Will promptly notify the not's legal representative or ember when there is a change of der federal or state law.  RIGHT TO SURVEY LY ACCESSIBLE  It has the right to-cults of the most recent survey of the development of correction in effect with y; and must-ceadily accessible to residents, and legal representatives of its of the most recent survey of the specific procedure in effect with y, available for any individual mest; and the availability of such reports in that are prominent and	F 10			3/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING		03/	09/2017	
	ROVIDER OR SUPPLIER	- JACKSON	6	STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST JACKSON JACKSON, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  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 167	Continued From pa	=	F 167				
	information about c This REQUIREMEN by: Based on observat review, the facility for current survey resu all 43 residents, vis review this informat	I not make available identifying omplainants or residents. NT is not met as evidenced ion, interview and document ailed to post the location of the lts. This had potential to affect itors and staff who wished to ion.		Survey book is labeled and posted main entrance to the facility where residents and visitors			
	11:35 a.m. the curre observed to be in a file hanger near the Although the binder was not labeled nor location.  During an interview	ur of the facility on 3/6/17, at ent survey results were n 3 ring binder placed in a walk front entrance of the facility included the survey results it was there a posting to the on 3/7/17, at 7:20 p.m. R38,	C				
	know they were ava knew the location o results from the las During an interview administrator verific identified and would visitor to realize the	on 3/8/17, at 10:38 a.m. the ed the survey results were not d be difficult for a resident or binder in the wall hanger					
F 170 SS=C	PRIVACY - SEND/F (g)(8) The resident receive mail, and to other materials deli	nt surveyor results(iii)(h)(2) RIGHT TO RECEIVE UNOPENED MAIL has the right to send and receive letters, packages and vered to the facility for the means other than a postal	F 170			3/25/17	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	DING (X3) DAT CON		
		245455	B. WING		03/09/20	017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COM	(X5) IPLETION DATE
F 170	with this section; ar  (g)(9) communications ar  (i) If the access is a  (ii) At the resident's expense is incurred access to the resident in Such use must law.  (h)(2) The facility must be personal privacy in his or her oral (the electronic communication in the presentation in the pre	communications consistent and cons such as email and video and for internet research.  Evaluable to the facility  Expense, if any additional and by the facility to provide such ent.  Comply with State and Federal comply with State and Federal and the right to privacy expense, including the right to privacy expense, including the right to receive unopened mail and ges and other materials	F 170			
	those delivered through the postal service. This REQUIREMENT by: Based on interview facility failed to ensimal to residents or practice had the point the facility.  Findings include:  During interview on	ility for the resident, including bugh a means other than a NT is not met as evidenced and document review, the ure delivery of personal postal a Saturdays. This deficient tential to affect all 43 residents a 3/8/17 at 9:00 a.m. R38 et mail delivered on Saturday.		Post Office was notified to deliver Saturdays.  All residents who receive mail on Saturday will be delivered to them  Mail was delivered on Saturday 2/2 and will continue to be delivered or Saturdays here on out  Any Concerns with mail delivery wi	5/17	

				E SURVEY PLETED			
		245455	B. WING			03/	09/2017
	ROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		60	TREET ADDRESS, CITY, STATE, ZIP CODE D1 WEST JACKSON ACKSON, MN 56143		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 170	Continued From pa	ge 10	F 1	70			
	During interview on nurse (RN)-E, activity Saturday mail is new when the old admin sorting concerns.  Interview on 3/9/17 was asked about the Administrator stated residents every day been like that since issues when the passes when the passes when the passes when the passes on page 27; N	3/9/17 at 8:42 a.m. registered ity staff-A and B, stated ver delivered as it stopped istrator was here due to  at 9:01 a.m. the administrator is mail delivery on Saturdays. It the mail is delivered to except Saturday and it has he was hired due to sorting st administrator was here.  book with the administrator, it handbook revised 10/16 your personal mail will be it to your room Monday			discussed at resident council, will randomly audit residents regarding delivery on Saturdays 2X a month 1 months and then information obtain discussed at QAPI meeting for furth recommendations	or 3 ned	
F 282	through Saturday, w Administrator stated agreed 100% that the Saturdays.  Request of policy re was provided from the	with the exception of holidays. It that it is a mistake and the mail should be delivered on egarding mail delivery, none the facility. RVICES BY QUALIFIED	F2	82			3/31/17
<b>&gt;&gt;=</b> D	(b)(3) Comprehensi The services provid						
	care. This REQUIREMEN by:	qualified persons in the character resident's written plan of the variation of the character with the character of the charac			R7 care plan was updated for a		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING			03/09/2017	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON			01 WEST JACKSON		
40050	AMARITAN GOGIETT	on one of the original origin		J	ACKSON, MN 56143		
(X4) ID PREFIX TAG			PREFIX (EACH CORRECTIVE ACTION SHOL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	_	F 2	282			
	review, the facility for 1 of 1 residents non-pressure relate follow the care plar was dependent on Findings include:  R7 was observed or bruises identified of were dark purplish  During an observative registered nurse at this tim Right/wrist:  1) Bruise 2.6 centing 2) Bruise 3.8 cm by 3) Bruise 1 cm x 1  Review of R7's plan plan review complet (had been updated interviewed, 3/8/17 an actual impairment the use of aspirintoby licensed nurse, to protect the skin at linterview on 3/8/17 assistant (NA)-B verifications.	railed to follow the plan of care (R7) reviewed for ed skin conditions and failed to a for 1 of 3 residents (R49) who staff for nail care.  on 3/6/17, at 3:32 p.m. to have n right hand. These bruises in color and varied in size.  tion of R7's bruises with egistered nurse (RN)-B on R7 was identified to have est hat varied in size on right ements of the bruises obtained e and were as noted:  meters (cm) by 2 cm  y 2 cm  cm  on of care with the Last Care eted date of 10/4/14 for skin, with information after staff  had identified the resident as ent to the skin integrity due to Interventions include; report uising, weekly skin observation Resident needs arm sleeves at all times.  Tat 9:47 a.m. with nursing erified R7 has bruises on the			non-pressure related skin condition Nurses were educated on process follow for documenting and monitoresident skin condition including we of arm sleeves as noted on the car Nurse Aides were educated on folk R7's care plan to wear arm sleeves Will audit R7 daily X 1 week to ass sleeves are on, then 3 X week for a weeks audits will be reviewed by Q team for further recommendations residents who have been identified wearing arm protection will be audit random weekly for 2 weeks then as determined by QAPI Committee  R49 fingernails have been trimmed both hands All other resident fingernails have be trimmed  Nurses and Nurse Aides received education on when nail care should done, how to mark care record if a resident refuses  Audits will be conducted weekly X4 as determined by QAPI Committee attain compliance.	to ring earing e plan. owing s. ure arm Other as ted at s	
	place. At 9:56 a.m.	sleeve protectors were in NA-C stated R7 has bump there for a while, verified no					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245455		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING	<del> </del>	03/09/2017	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP 601 WEST JACKSON JACKSON, MN 56143		
(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 CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 282	Continued From pa	age 12	F 2	82		
	has had bruises for wrist, review of elec- confirmed that ther monitoring of any b found.	at 10:14 a.m. RN-B stated R7 r a couple of weeks on right ctronic medical record (EMR), e is no documentation or cruises on the right wrist for R7 at 10:26 a.m. with director of				
	nursing (DON) who assessment, monit bruises. DON said documenting is cor	o explained the process of oring and documenting the that monitoring and mpleted on all residents ectation would be to follow the	C			
	provided by the fac R49's care plan pri	nt date 3/8/17, indicated ne staff assist and personal				
		ant Kardex report dated 3/8/17, ired one staff assist for nd bathing.				
	have long uneven f at the time stated the	on 3/6//17, at 2:12 p.m. to ingernails on both hands. R49 heir fingernails need to be een looking for nail clippers.				
	observed R49's fing confirmed R49's find uneven. R49 stated them cut." RN-C in some clippers and stated fingernails was	a.m. registered nurse (RN)-C gernails on both hands and agernails were long and to RN-C at the time, "I need aformed R49 she would obtain trim his nails today. RN-C yere to be trimmed on the RN-C reviewed R49				

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		245455	B. WING		03/09/2017	
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F 282	documentation for I stated R49 had refureceived a bath on stated with R49's be baths per week R48 been trimmed, thernails not to be trimmed, thernails not to be trimmed, thernails not to be trimmed in the refusal of nail care.  On 3/7/17, a t 5:35 stated residents ge trimmed once a we trim nails for reside NA-A stated the factorically nails har resident refuses not adocument refusal of On 3/8/17, at 9:48 arequired extensive with hygiene.  On 3/8/17, at 2:03 processes and if the do it again.  The facility Compresses to provide assessing, implementating the resident's higher the resident higher the resident higher the resident higher the resident higher	naving received a bath and used a bath on 3/5/17, but had 3/3/17 and 3/1/17. RN-C athing frequency of three 9's fingernails should have e was no excuse for R49's ned. RN-C stated I have been staff trimming the resident the facility does not document the facility does not document p.m. nursing assistant (NA)-A nerally have their nails ek with baths. Activities would not who had their nails painted, sility does not document d been trimmed and when a il care the facility does not f the care.  a.m., RN-A stated R49 (weight bearing assist) assist p.m. the director of nursing expect nails to be trimmed on a resident refuses, attempt to the shensive Care Plan and Care revised 11/16, indicated an ongoing method of the enting, evaluating and not's care plan to help maintain est level of functioning.	F 283			0/04/47
F 309 SS=D	. , , , ,	) PROVIDE CARE/SERVICES ELL BEING	F 309	9		3/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING		03	03/09/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 601 WEST JACKSON JACKSON, MN 56143			
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUT FAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		(X5) COMPLETION DATE	
F 309	applies to all care residents. Each refacility must provide services to attain or practicable physical well-being, consist comprehensive as 483.25 Quality of Quality of care is a applies to all treatrefacility residents. Eassessment of a rethat residents receaccordance with practice, the composite plan, and the but not limited to the working of the comprehensive and the residents. (I) Dialysis. The facility must exprovided to resident consistent with proting the comprehensive and the residents. (I) Dialysis. The facility must expressed to practice, the concare plan, and the preferences. This REQUIREMED by: Based on observations.	ife fundamental principle that and services provided to facility esident must receive and the de the necessary care and or maintain the highest al, mental, and psychosocial tent with the resident's resessment and plan of care.  Care a fundamental principle that ment and care provided to Based on the comprehensive esident, the facility must ensure review treatment and care in rofessional standards of orehensive person-centered residents' choices, including the following:  Tent.  Insure that pain management is not who require such services, of essional standards of practice, the person-centered care plan, goals and preferences.  Cacility must ensure that fuire dialysis receive such and with professional standards in the with professional standards in the more person-centered residents' goals and the services and the services and standards in the professional standar	F3	R7 care plan was updated			
		failed to identify and monitor residents (R7) and failed to		non-pressure related skin (bruising)	condition		

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		245455	B. WING			03/0	09/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		60	TREET ADDRESS, CITY, STATE, ZIP CODE D1 WEST JACKSON ACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	treatment of a skin reviewed for non-preserved for non-preserved. R7's significant chat 2/10/17 identified R cognitively impaired. On 3/6/17, at 3:32 purises identified or were dark purplish. During an observat registered nurse (RR7 was identified to that varied in size of Measurements of that varied in size of Measurements of that this time and were Right/wrist:  1) Bruise 2.6 centing 2) Bruise 3.8 cm by 3) Bruise 1 cm x 1 of Review of R7's currous Care plan review constant, (had been upon staff interviewed, 3/2 resident as impairrous the use of aspirintobservations of bruist by licensed nurse, to protect the skin as	and documentation for tear for 1 of 3 residents (R41) ressure related skin concerns.  Inge Minimum Data Set dated 7 as a 12 which is moderately d.  In R7 observed to have a right hand. These bruises in color and varied in size. Sin color and varied in size. Sin of R7's bruises with N)-B on 3/8/17 at 9:51 a.m., o have dark purplish bruises in right wrist area. The bruises obtained by RN-B re as noted:  Interest (cm) by 2 cm of the completed date of 10/4/14 for dated with information after 8/17) had identified the ment to the skin integrity due to Interventions include; report ising, weekly skin observation Resident needs arm sleeves	F3	09	Nurses were educated on process follow for assessing (gathering data)documenting and monitoring skin condition on R7 and any other resident who may have a non-pres related skin condition. Education we given to follow individual resident coplans.  Audit will be done weekly X 4 on R assure bruises are healing and any resident who may have non-pressurelated skin issues then audits will reviewed at QAPI meeting for furth recommendations. Audits will be completed at random any other reswho has skin related condition.	resident sure as are 7 to 7 other ire be er	
	through 3/4/17 did i	not identify any new skin areas r weekly skin check on her					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245455		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING _		03	03/09/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 309	Interview on 3/8/17 assistant (NA)-B w verified she has br sleeve protectors w. At 9:51 a.m., NA-C charge nurse or casystem, which is a needed. NA-C find computer care plaresidents, on bath complete skin cheshower room. At 9:56 a.m. NA-C bruises, been theresleeves on, was now would have to chethat she checked to supposed to have she is to have som Interview on 3/8/17 regarding any know stated R7 has had on right wrist, plac bruises monitored asked about how s RN-B said informanext shift or expecting and recount 10:19 a.m. of element of the confirmed that the	7 at 9:47 a.m. with nursing while in therapy working with R7 ruises on the right hand and nowere in place.  2 stated skin issues reported to an place in their computer nalert to update the nurses if ds the information on their ns on how to care for the days nurse is notified to ck either in R7's room or  2 stated R7 has bump and e for a while, verified noot sure what her care plan read, ck. At 10:10 a.m., NA-C stated he care plan and read R7 is sleeves on and now knows that	F 30	9		

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F 309	found.  Interview on 3/8/17 nursing (DON) exp assessment, monit bruises Monitoring weekly. DON's exp care plan.  R41 was observed right foot second to place. The dressing identify when the didentify when	10:26 a.m. with director of lained the process of oring and documenting the g is completed on all residents ectation would be to follow the on 3/7/17, at 5:25 p.m. R41's be had a white dressing in g had no date written on it to ressing had been changed.  I.m., R41 was observed to be and had sandals on both feet and to had a white dressing ing had no date written on the expense of the mechanical lift day part of the mechanical lift tear to second toe, cleansed	F 30	9			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING _		03	/09/2017	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP 601 WEST JACKSON JACKSON, MN 56143	<u> </u>		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 309	inform resident/fambreakdown. Provid mattress and cush immediately of any redness, blisters, bounded during bath olacked to identify Rinterventions related R41's Medication and Record (MAR/TAR and 3/3017, were redocumentation of too located on R41's rion of the skin tear and was not documented at the treatment of the dressing for R4 having a bath and the surveyor or right second toe. Record to the skin tear and the surveyor or right second toe. Record to the skin tear and the surveyor or right second toe. Record to the skin tear and the surveyor or right second toe. Record to the skin tear and the surveyor or right second toe. Record to the skin tear and the surveyor or right second toe. Record to the skin tear and the surveyor or right second to the skin tear and the surveyor or right	nence. Interventions included nily of any new area of skin e pressure redistribution ion to wheelchair. Notify nurse new areas of skin breakdown: oruises, discoloration, etc. or daily care. The care planted to the skin tear and ed to the skin tear.  Ind Treatment Administration of alted for the month of 2/2017 eviewed and lacked to include reatment for the skin tear	F 30	9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		
245455	B. WING		03/09/2017	
KSON		601 WEST JACKSON		
BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
	F 309	O TOTAL CONTRACT OF THE PROPERTY OF THE PROPER		
PROVIDED FOR TS  Inable to carry out ceives the necessary d nutrition, grooming, and e. not met as evidenced atterview and document to ensure 1 of 3 residents and alls were long and N-C at the time, "I need ed R49 she would obtain is nails today. RN-C to be trimmed on the C reviewed R49 greceived a bath and a bath on 3/5/17, but had	C	R49 fingernails have been trimmed both hands  All other resident who needed nail of were cleaned and trimmed  Nurses and Nurse Aides received education on when nail care should done and how to mark care record resident refuses  Audits will be conducted weekly X4	d on care d be if a , then	3/31/17
	245455  EKSON  IT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)  Skin tears was requested PROVIDED FOR TS  unable to carry out receives the necessary d nutrition, grooming, and e. not met as evidenced  interview and document	245455  B. WING	245455  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143  TO FDEFICIENCIES THE PRECODED BY FULL NTIFYING INFORMATION)  F 309  Skin tears was requested PROVIDED FOR TS  Inable to carry out ceives the necessary do nutrition, grooming, and e. not met as evidenced interview and document to ensure 1 of 3 residents of on staff for meeting IDLs) had trimmed  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143  PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)  F 309  F 309  F 312  F 312  F 312  F 312  F 312  A. BUILDING  B. WING  PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)  F 309  F 312  F 312  F 312  F 312  A. BUILDING  PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)  F 309  F 309  F 312  F 312  F 312  F 312  All other resident who needed nail over cleaned and trimmed  Nurses and Nurse Aides received education on when nail care should done and how to mark care record resident refuses  Audits will be conducted weekly X4 as determined by QAPI Committee attain compliance.  A BUILDING  PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)  F 309  F 309  F 309  F 312  F	245455  B. WING  245455  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143  PREFIX REPRECEDED BY FULL WITHYING INFORMATION)  F 309  Skin tears was requested PROVIDED FOR TS  Inable to carry out ceives the necessary d nutrition, grooming, and e.e. not met as evidenced interview and document to ensure 1 of 3 residents int on staff for meeting IDLs) had trimmed  All other resident who needed nail care were cleaned and trimmed  Nurses and Nurse Aides received education on when nail care should be done and how to mark care record if a resident refuses  Audits will be conducted weekly X4, then as determined by QAPI Committee to attain compliance.  A BUILDING  STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143  PREFIX TAG  F 309  F 309  F 309  F 309  F 49 fingernails have been trimmed on both hands  All other resident who needed nail care were cleaned and trimmed  Nurses and Nurse Aides received education on when nail care should be done and how to mark care record if a resident refuses  Audits will be conducted weekly X4, then as determined by QAPI Committee to attain compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245455		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING _		03	/09/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIF 601 WEST JACKSON JACKSON, MN 56143		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 312	been trimmed, ther nails not to be triminals not to be triminaving trouble with nails. RN-C stated refusal of nail care.  R49's quarterly Mir 2/2/17, identified refor personal hygien assist with bathing.  R49's care plan pribathing: requires of hygiene: requires of hygiene: requires of hygiene assist identified R49 requires of hygiene and hygiene and the facility bath should be a state of the facility bat	9's fingernails should have the was no excuse for R49's med. RN-C stated I have been staff trimming the resident the facility does not document and been trimmed and when a fail care the facility does not	F 31	2		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	NG	(X3) DATE SURVEY COMPLETED		
		245455	B. WING		03/09/2017	
	PROVIDER OR SUPPLIER	- JACKSON	•	STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143	,	
(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 APPROPRIED TO THE	D BE	(X5) COMPLETION DATE
F 312 F 334 SS=D	bath days and if the do it again.  The facility policy N indicated Purpose 1 trimmed to promote condition and to pre 483.80(d)(1)(2) INF PNEUMOCOCCAL  (d) Influenza and procedures to 6 (i) Before offering the ach resident or the receives education potential side effect (ii) Each resident is immunization Octobannually, unless the contraindicated or trimmunized during the contraindicated or trimmunized duri	ail Care dated revised 5/16, To keep nails clean and well-being, to observe nail event nail discomfort. ILUENZA AND IMMUNIZATIONS neumococcal immunizations acility must develop policies ensure that- ne influenza immunization, e resident's representative regarding the benefits and sof the immunization; offered an influenza per 1 through March 31 immunization is medically he resident has already been his time period; the resident's representative to refuse immunization; and medical record includes indicates, at a minimum, the	F3			3/31/17
	and potential side e immunization; and	ation regarding the benefits ffects of influenza				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING		03/09/20		09/2017
NAME OF PROVIDE		- JACKSON		601 WEST	DRESS, CITY, STATE, ZIP COD JACKSON I, MN 56143		
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(E/	PROVIDER'S PLAN OF CORRE ACH CORRECTIVE ACTION SH SS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
(B) Trimmulation immulation refuse (2) Prodevel (i) Be immulated representation (ii) Easimmulated (iii) Trimmulated (iii) Trimmulated (iii) Trimmulated (iii) Trimmulated (iii) Trimmulated (A) Trimmulated (B) Trimmulated (c) Trimmulated (c	inization or did inization due to inization due to inization due to inization due to inization, each sentative rece fits and potential inization; ach resident is inization, unle cally contrained dy been immu- the resident or the opportunity the resident's mentation that ving: that the reside provided educ- totential side earlization; and that the reside mococcal immoneumococcal aindication or REQUIREME	nt either received the influenza d not receive the influenza do not receive the influenza do medical contraindications or disease. The facility must ad procedures to ensure that the pneumococcal not resident or the resident's eives education regarding the tial side effects of the discated or the resident has unized; the resident's representative or to refuse immunization; and medical record includes to indicates, at a minimum, the entire received the nunization or did not receive immunization or did not receive immunization due to medical	F3		R48, R49. documentatio	on provided	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING			03/	09/2017	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - JACKSON			STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143					
(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 APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 334	provided for 3 out of R49) prior to receive and for 1 of 5 reside the pneumococcal in	of 5 residents (R46, R48 and ing influenza immunization ents (R46) before receiving immunization.  ecord dated 3/9/17, identified (16. R46's update didentified immunization: of the function	F3		All residents who are provided ed on the Influenza and pneumococchave a date listed for the informat provided in the medical record.  This will be audited in Influenza so and on admission for pneumococcvaccine.  Audits will be submitted to the QA for further recommendations.	cal will ion eason cal		
	not been document DON stated I would	mococcal immunization had led for R46, R48 and R49. The I say it was an oversight.						

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING		03	/09/2017
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - JACKSON				STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		
(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 SHOUND CROSS-REFERENCED TO THE APPRINTED DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 334 F 441 SS=F	Upon admit each re representative will r information sheets pneumococcal vaccand potential side e resident and/or resi 483.80(a)(1)(2)(4)(e PREVENT SPREAL (a) Infection preven The facility must es and control programa minimum, the following services upon the communicable disevolunteers, visitors, providing services upon the resident of the communicable disevolunteers of the communicable disevolunte	esident and/or resident esident and/or resident eceive the vaccination for influenza and sines. Discuss the benefits effects of vaccinations with dent representative.  (a) (f) INFECTION CONTROL, D, LINENS  tion and control program.  (a) (IPCP) that must include, at owing elements:  (b) (e) (e) (e) (e) (e) (e) (e) (e) (e) (e	F 4	34		3/31/17
	conducted accordin accepted national s implementation is F  (2) Written standard for the program, who limited to:  (i) A system of surve possible communicate before they can spreadility;  (ii) When and to who	g to §483.70(e) and following tandards (facility assessment				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245455	B. WING		03/	/09/2017	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - JACKSON				STREET ADDRESS, CITY, STATE, ZIP 601 WEST JACKSON JACKSON, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C  (EACH CORRECTIVE ACTIC  CROSS-REFERENCED TO TH  DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 441	to be followed to p  (iv) When and how resident; including  (A) The type and of depending upon the involved, and  (B) A requirement least restrictive positive circumstances.  (v) The circumstances must prohibit emporal disease or infected contact with residence contact will transmit (vi) The hand hygical by staff involved in (4) A system for residence contact with residence contact will transmit (vi) The hand hygical by staff involved in (4) A system for residence contact with residence contact will transmit (vi) The hand hygical by staff involved in (4) A system for residence contact with residence contact with residence contact will transmit contact with residence contact with r	transmission-based precautions revent spread of infections; v isolation should be used for a	F 4	41			
	actions taken by the (e) Linens. Person process, and transspread of infection (f) Annual review. annual review of it program, as necess This REQUIREME by:	nnel must handle, store, sport linens so as to prevent the in.  The facility will conduct an s IPCP and update their		Infection Control logs for	all residents as		
	facility failed to en	sure analysis and surveillance		applicable, will include a D	ata sheet		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245455	B. WING		03	/09/2017	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - JACKSON			STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143			33.33.25.11	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTED CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	obtained from 7/11/identified for tracking wing, infection, treat (culture and sensition of the logs identified infections: 7/16 - 1 urinary trace pneumonia, 1 celluteye, 1 cystitis 8/16 - 1 UTI, 1 CAFF candidiaysis/skin 9/16 - 4 UTI, 1 aspiconjunctivitis, 1 skin infection), 1 cystitis 10/16 - 1 UTI, 1 cocongestion/product congestion, one ter 11/16 - 3 UTI, 1 cocongestion, cough, 12/16 - 3 UTI, 1 Cocongestion, cough, 12/16 - 3 UTI, 1 URI diarrhea, 1 colitis, 13 gastroenteritis (various signs and sextra cleaning by his spoke with medical facility with consisted in rooms, lasted 1 to 2/17 - 1 UTI, 2 upp	Infection Control Logs were (16 through 2/2017. The logs on the date, resident name, atment, nosocomial, C and S vity) and miscellaneous.  The following for urinary tract of infection (UTI), 2 litis, 1 C-diff (stool infection), 1 or, 1 cellulitis/skin, 1 C-diff, 1 oration pneumonia, 1 or, 1 URI (upper respiratory /hematuria orgestion/sore throat, 1 oration/sore thr	F4	implemented, me and effectivenes implemented.  The data sheets meetings to assume	onitoring of the actions is of the actions which are will be reviewed at QAPI are compliance and if the difficulty of the actions which are compliance and if the action of the actions which are will be reviewed at QAPI are compliance and if the actions which are will be reviewed at QAPI are compliance and if the actions which are will be reviewed at QAPI are compliance and if the actions which are will be reviewed at QAPI are compliance and if the actions which are will be reviewed at QAPI are compliance and if the actions which are will be reviewed at QAPI are compliance and if the actions which are actions are actions at a second control of the actions which are actions at a second control of the actions are actions at a second control of the action at a second control o		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING _		03	/09/2017	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - JACKSON				STREET ADDRESS, CITY, STATE, ZIP ( 601 WEST JACKSON JACKSON, MN 56143			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 441	prevention and con of observations relaimplementing meast transmission of information of 1/17 relations timely training interprevent further infermonth of 1/17 relations timely training interprevent further infermonth of 1/17 relations interprevent further infermonth of 1/17 relations interprevent further infermonth of 1/17 relations interprevent further infermonth of the actions implemented information may be assurance notes) of meetings held. Adoprovided, but lacked analysis as above.  The facility policy In Control Program of Policy The infection program will attempregulations for infermonth of infermonth of 1/17 infections. Its definition collection, collation of information to the take action. Once a can be determined procedure 3. Determined procedure 3. Determined procedure 3.	ctiveness of infection and state of the DON sated the education and effectiveness of the education and sures to prevent the ectious agents (except for the editous needed to occur to ections from developing.  2 a.m., the director of nursing evided by her which included documentation of education that actions were implemented, editous and effectiveness of the ed. The DON sated the editous and effectiveness of the editous and information was editous information was editous include surveillance and enfection Prevention and control of the editous entrol exception and control entropy to meet federal and state ection control where applicable.  Infection Monitoring and Eurveillance dated revised externous exceptions and prevent nosocomial exception and prevent nosocomial extension in the extension of the editous exception is needed.  Infection further include:  In analysis of data and passing one who need to know and a baseline is established then it where control is needed.  In the purpose of the data and obtain baseline, b.	F 44				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING		03	/09/2017	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - JACKSON				STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 441 F 492	Perform routine sur outbreaks. e. Preve	level of specific organisms. c. veillance activities. d. Identify ent spread.	F 4	141 192		3/31/17	
F 492 SS=D	(b) Compliance with Laws and Profession The facility must oper compliance with all local laws, regulation accepted profession that apply to professuch a facility.  (c) Relationship to the Information of the applicable proving a provingulations, including pertaining to nondiscrimination of the CFR part 84); nondingulations of the CFR part 84 (42 CFR parts 160 and provisions may resingulations may resingulations may resingulations of the CFR parts 160 and provisions may resingulations may resingulations may resingulations of the CFR parts 160 and provisions may resingulations may resingulations may resingulations.	reacte and provide services in applicable Federal, State, and Local onal Standards.  Therefore and provide services in applicable Federal, State, and ons, and codes, and with anal standards and principles sionals providing services in Other HHS Regulations.  Therefore are obliged to meet sions of other HHS are obliged to meet sions of other HHS and but not limited to those scrimination on the basis of anal origin (45 CFR part 80); on the basis of disability (45 iscrimination on the basis of 1); nondiscrimination on the part 45); protection of human (45 CFR part 46); and fraud a part 455) and protection of ble health information (45 164). Violations of such other all tin a finding of the this paragraph.  Therefore are and Local services in and Local services in a finding of the this paragraph.			iewed at	3/31/17	
	local laws, regulation accepted profession that apply to professuch a facility.  (c) Relationship to the applicable provisions may result in this subpart the applicable provision and is race, color, or nation nondiscrimination of CFR part 84); nonding (45 CFR part 9 basis of race, color, disability (45 CFR part 9 bas	Other HHS Regulations.  Other HHS Regulations.  Itiance with the regulations set, facilities are obliged to meet sions of other HHS ag but not limited to those scrimination on the basis of nal origin (45 CFR part 80); on the basis of disability (45 iscrimination on the basis of 1); nondiscrimination on the hasis of 1); nondiscrimination of human has 1); protection of human has 1); protection of hasis of such other alt in a finding of hasis paragraph.		R55 their demand bill was rev	iewed at		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245455	B. WING			03/0	09/2017	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		6	TREET ADDRESS, CITY, STATE, ZIP CODE 01 WEST JACKSON ACKSON, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 492	appeals process for requested a demandary findings included:  R55's record reflect (Skilled Nursing Fact Continued Stay on R55 had met goals level of care. The niqualified as covered 12/31/16 and was subeneficiary/represe 3/8/17, at 1:26 p.m. stated R55's beneficiary/represe via phone on 12/29, marked option was for service I continuate intermediary for be informed when to not required to pay covered by Medicary has been made." Apayments were recomputed to pay covered by Medicary for the computer service service for 3/8/17, at 1:37 pthey did not stop bil resident wanted serintermediary. OF-Cointo the computer services for the service service service for the service service for the service service service for the service service service for the service service service for the service service for the service service service service service for the service serv	billing for daily stay during the of 1 resident (R55) who do bill.  Is the facility issued the SNF cility) Determination of 12/28/16. The SNF indicated and no longer required skilled otice indicated R55 no longer drunder Medicare beginning igned by R55's intative on 11/12/17. On the registered nurse (RN)-A ciary/representative: must ong date when singing the intified R55's intative was given verbal notice of 16. The SNF identified the marked for "I do want my bill be to receive to be submitted to a Medicare decision. You will he bill is submitted. You are for services which could be referred to the counting records reflect beived for R55 on 2/16/17 for 28/17 for \$1420.00, confirmed OF)-C.  So.m., OF-C stated it looks like ling during the period the roices reviewed by stated the SNF was scanned system and the corporate office for billing) should be aware	F	192	corporate level and R55 should not been billed  R55 and any other resident who rea demand bill of rights will be audite facility level to assure payment is nor requested. Audits will be conducted monthly X2 then reviewed at QAPI further recommendations	quests ed on ot		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245455	B. WING		03/	/09/2017
	PROVIDER OR SUPPLIER					
(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	LD BE	(X5) COMPLETION DATE
F 492	The facility policy M Notifications dated The provider will for issuance of the not continued stay in of beneficiaries of del Specific Delivery Is disagrees and aske to the MAC, you maccept deposit or of beneficiary for the	Medicare Part A Non-Coverage revised 1/17, indicated Policy allow the regulations to tice of non-coverage on the rder to appropriately inform mand bill rights. Procedure usues If the beneficiary so you to submit a demand bill ay not require, request or other payment from the services until the MAC makes tion that the services are not	F 4	92		

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: QLUM Facility ID: 00303

		10 22 00			ESCHIEFICE		raemity 12. occor
1. MEDICARE/MEDICAID PROVID NO.(L1) <b>245455</b>	ER	3. NAME AND AL (L3) <b>GOOD SAM</b>			ACKSON	4. TYPE OF ACT	TION: <u>2</u> (L8)  2. Recertification
2. STATE VENDOR OR MEDICAID (L2) <b>673342500</b>	NO.	(L4) <b>601 WEST J</b> (L5) <b>JACKSON</b> ,			(L6) <b>56143</b>	3. Termination 5. Validation	<ul><li>4. CHOW</li><li>6. Complaint</li></ul>
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEO	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey A	9. Other fter Complaint
6. DATE OF SURVEY 03/08. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	<b>)9/2017</b> (L34) (L10)	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 EN	DING DATE: (L35)
11. LTC PERIOD OF CERTIFICATIO From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds	57 (L18) 57 (L17)	Compliance1. A:  X B. Not in Con	equirements e Based On:	ogram	And/Or Approved Waivers Of  2. Technical Personne  3. 24 Hour RN  4. 7-Day RN (Rural SI  5. Life Safety Code  * Code: <b>B</b> *	6. Scope of 7. Medical	Services Limit Director oom Size
14. LTC CERTIFIED BED BREAKDO	WN		• • • • • • • • • • • • • • • • • • • •		15. FACILITY MEETS		
18 SNF 18/19 SNF <b>57</b>	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Jennifer Kolsrud, HFE	NE II	0	4/05/2017	(L19)	Kamala Fiske-Downing,	Enforcement Spe	ecialist 05/10/2017 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	STATE AGENCY	
DETERMINATION OF ELIGIBII     1. Facility is Eligible to I     2. Facility is not Eligible	Participate		IPLIANCE WIT ITS ACT:	H CIVIL	21. 1. Statement of Fina 2. Ownership/Contr 3. Both of the Abov	ol Interest Disclosure St	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEI	MENT	26. TERMINATION ACTION	[:	(L30)
OF PARTICIPATION <b>04/01/1987</b>	BEGINNING		ENDING DA		VOLUNTARY 01-Merger, Closure	<u>0</u> <u>INVOL</u>	UNTARY to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail	to Meet Agreement
25. LTC EXTENSION DATE: (L27)		VE SANCTIONS n of Admissions: uspension Date:	(L44) (L45)		03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	OTHER	rider Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		00140					
	(L28)	00140		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	L DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

March 21, 2017

Mr. Daren Rife, Administrator Good Samaritan Society - Jackson 601 West Jackson Jackson, MN 56143

RE: Project Number S5455028

Dear Mr. Rife:

On March 9, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

<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:

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904 Email: gary.nederhoff@state.mn.us

Telephone: (507) 206-2731 Fax: (507) 206-2711

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

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 18, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 18, 2017 the following remedy will be imposed:

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

#### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

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

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

#### Original deficiencies not corrected

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

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

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

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

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

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

If substantial compliance with the regulations is not verified by June 9, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 9, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <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>

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

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

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

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

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fish Downing

Program Assurance Unit Health Regulation Division

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

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

PRINTED: 04/05/2017 FORM APPROVED OMB NO. 0938-0391

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245455	B. WING		03	C 3/ <b>09/2017</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143	•	009/2017
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F 000	INITIAL COMMENT	rs	F 00	00		
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are rour signature is not required a first page of the CMS-2567 ic submission of the POC will cion of compliance.				
F 156 SS=C	on-site revisit of you validate that substa regulations has bee your verification. 483.10(d)(3)(g)(1)(4	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with 4)(5)(13)(16)-(18) NOTICE OF SERVICES, CHARGES	F 1	56		3/15/17
	remains informed o of contacting the ph	ust ensure that each resident of the name, specialty, and way hysician and other primary care onsible for his or her care.				
	(1) The resident has his or her rights and	tion and Communication. s the right to be informed of d of all rules and regulations conduct and responsibilities ay in the facility.				
	notices orally (mear	has the right to receive ning spoken) and in writing a a format and a language he , including:				
	The facility must fur	as specified in this section. rnish to each resident a written rights which includes -				
	(A) A description of	the manner of protecting				
ABORATOR	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

Electronically Signed 03/31/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION  NG	COM	(X3) DATE SURVEY COMPLETED		
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F 156	(B) A description of procedures for estatincluding the right to resources under set Security Act.  (C) A list of names, email), and telepho State regulatory and resident advocacy (Survey Agency, the State Long-Term C protection and advoservices where statin long-term care fat agency for informat community and the and  (D) A statement the concerning any susfederal nursing facinot limited to reside exploitation, misappin the facility, non-cdirectives requirem information regardinal (ii) Information and and local advocacy not limited to the St Long-Term Care Of (established under	the requirements and ablishing eligibility for Medicaid, or request an assessment of action 1924(c) of the Social addresses (mailing and ne numbers of all pertinent dinformational agencies, groups such as the State State licensure office, the are Ombudsman program, the ocacy agency, adult protective the law provides for jurisdiction acilities, the local contact acion about returning to the Medicaid Fraud Control Unit; at the resident may file a State Survey Agency spected violation of state or lity regulations, including but	F 15	56			

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  ING		COMPLETED	
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F 156	U.S.C. 3001 et seq advocacy system (a as established under Disabilities Assistar 2000 (42 U.S.C. 15 [§483.10(g)(4)(ii) with November 28, 2017 (iii) Information regaligibility and covera [§483.10(g)(4)(iii) with November 28, 2017 (iv) Contact information 202(a)(20)(Act); or other No With [§483.10(g)(4)(iv) with November 28, 2017 (v) Contact information Control Unit; and [§483.10(g)(4)(v) with November 28, 2017 (vi) Information and grievances or compassion of acility regulations, resident abuse, negmisappropriation of facility, non-compliad directives requirement (g)(5) The facility mission and (g)(5) The facility mission and (g)(5) The facility mission acility mission regarding (g)(5) The facility mission action ac	and the protection and as designated by the state, and are the Developmental nee and Bill of Rights Act of 001 et seq.)  Ill be implemented beginning (Phase 2)]  Arding Medicare and Medicaid age;  It is implemented beginning (Phase 2)]  Attion for the Aging and Center (established under B)(iii) of the Older Americans rong Door Program;  It is implemented beginning (Phase 2)]  It contact information for filing plaints concerning any of state or federal nursing including but not limited to glect, exploitation, resident property in the ance with the advance ents and requests for ang returning to the community.  The provided Head of the state of the state of the ance with the advance ents and requests for ang returning to the community.	F1	56			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION	COM	E SURVEY PLETED
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F 156	and telephone numagencies and advo Survey Agency, the protective services jurisdiction in long-of the State Long-T program, the protection and communant the Medicaid F (ii) A statement that complaint with the concerning any susfederal nursing facilimited to resident a misappropriation of facility, and non-codirectives requirem I) and requests for to the community.  (g)(13) The facility written information, applicants for adminiformation about hedicare and Medireceive refunds for such benefits.  (g)(16) The facility and services to the admission and duriting in a light and in writing in a light and services.	addresses (mailing and email), abers of all pertinent State cacy groups, such as the State estate licensure office, adult where state law provides for term care facilities, the Office ferm Care Ombudsman ction and advocacy network, nity based service programs, fraud Control Unit; and the resident may file a State Survey Agency spected violation of state or allity regulation, including but not abuse, neglect, exploitation, fresident property in the mpliance with the advanced ents (42 CFR part 489 subpart information regarding returning must display in the facility and provide to residents and ssion, oral and written now to apply for and use icaid benefits, and how to previous payments covered by must provide a notice of rights resident prior to or upon ng the resident's stay.  Inform the resident both orally anguage that the resident or her rights and all rules and	F 1	56			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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F 156	regulations governing responsibilities during the State-developed obligations, if any.  (iii) Receipt of such amendments to it, rowriting;  (g)(17) The facility rowriting, at the time of facility and when the Medicaid of-  (A) The items and some surrousing facility serving for which the reside (B) Those other iter facility offers and for charged, and the arservices; and  (iii) Inform each Medicaid of the services; and  (iii) Inform each Medicaid in paragrating the section.  (g)(18) The facility robefore, or at the timperiodically during the available in the facility services, including a services, including a services, including a services, including a services.	ng resident conduct and ng the stay in the facility.  also provide the resident with d notice of Medicaid rights and information, and any must be acknowledged in	F 1	56		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	PLE CONSTRUCTION  G	COM	(X3) DATE SURVEY COMPLETED		
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F 156	and services covery Medicaid State plar notice to residents reasonably possible (ii) Where changes items and services facility must inform 60 days prior to impose (iii) If a resident die transferred and doe facility must refund representative, or edeposit or charges per diem rate, for the resided or reserved facility, regardless of discharge notice received the resident within a date of discharge from the terms of an behalf of an individual facility must not conthese regulations. This REQUIREMED	in coverage are made to items ed by Medicare and/or by the n, the facility must provide of the change as soon as is e.  are made to charges for other that the facility offers, the the resident in writing at least elementation of the change.  s or is hospitalized or is es not return to the facility, the to the resident, resident estate, as applicable, any already paid, less the facility's ne days the resident actually or retained a bed in the of any minimum stay or quirements.  St refund to the resident or ative any and all refunds due 30 days from the resident's rom the facility.  admission contract by or on unal seeking admission to the inflict with the requirements of the notice of the notic	F 15					
	failed to ensure the Federal and State I Residents in Medic	and record review, the facility most current Combined Bill of Rights (BOR) for are/Medicaid Certified Skilled r Nursing Facilities dated		A new Bill of Rights poster wit date and information was post hallway located between South wings.	ed in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 156	11/28/16 was provided This had the potent currently residing in Findings include:  During the initial total 11:13 a.m., the Bill wall in the facility has south and north wire of Nursing to not be should contain revision. On 3/8/17, at 10:09 (DON) showed surfacility admission and concombined Federal Rights in the admission and been of the was aware there was aware	ded to the facility residents. tial to affect all 43 residents in the facility.  The facility on 3/6/17 at of Rights poster hanging on a allway located between the fings was found by the Director of the most current BOR which sions dated 11/28/16.  The a.m. the director of nursing veyor the Bill of Rights in the acket given to residents upon firmed at the time the and Minnesota State Bill of sion packet was dated BOR lated 12/2015.  The administrator when are of the most current Bill of the month of 11/2016, stated he as a more current Bill of strator stated residents had st current BOR but when the ents was reviewed it was the most current which had been the strator that the strator which had been the strator whi	F 1	56	All residents received an updated of Resident Rights policy  Any time there is a change in Resi Rights facility will notify resident, resident's legal representative or interested family member.  All new admission will receive new resident rights.  This will be audited by Social servi weekly X 4 then monthly X 3 and by the total part of the properties of the properties of the policy of the p	dent bill of ces	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		(X3) DATE SURVEY COMPLETED		
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F 156	Policy The location resident, the reside interested family me in resident rights ur	ges in the resident rights. will promptly notify the nt's legal representative or ember when there is a change nder federal or state law.	F 1				
F 167 SS=C	(g)(10) The residen  (i) Examine the resof the facility condu	t has the right to- sults of the most recent survey cted by Federal or State plan of correction in effect with	F 1	67			3/24/17
	and family member residents, the result the facility.  (ii) Have reports wit certifications, and crespecting the facility years, and any plan respect to the facilit to review upon requiii) Post notice of the	eadily accessible to residents, is and legal representatives of its of the most recent survey of the respect to any surveys, complaint investigations made to during the 3 preceding of correction in effect with any available for any individual lest; and the availability of such reports in that are prominent and					
	information about c This REQUIREMEN by:	I not make available identifying omplainants or residents.  NT is not met as evidenced ion, interview and document			Survey book is labeled and posted	at the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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				JACK	(SON, MN 56143		
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F 167	current survey resu	ailed to post the location of the lts. This had potential to affect itors and staff who wished to	F 1	m	ain entrance to the facility where sidents and visitors		
	Findings include:	ur of the facility on 2/6/17, at					
	11:35 a.m. the currobserved to be in a file hanger near the Although the binder	ur of the facility on 3/6/17, at ent survey results were n 3 ring binder placed in a wall front entrance of the facility. Included the survey results it was there a posting to the					
	resident council rep know they were ava	on 3/7/17, at 7:20 p.m. R38, presentative, stated, "Did not ailable" when asked if R38 f the CMS2567 with survey t survey.					
F 170 SS=E	administrator verificidentified and would visitor to realize the contained the curre 483.10(g)(8)(i)(9)(i)	on 3/8/17, at 10:38 a.m. the ed the survey results were not do be difficult for a resident or eliminating binder in the wall hanger ent surveyor results.  -(iii)(h)(2) RIGHT TO RECEIVE UNOPENED MAIL	F 1	70			3/25/17
	receive mail, and to other materials deli	has the right to send and preceive letters, packages and vered to the facility for the means other than a postal ne right to:					
	(i) Privacy of such of with this section; an	communications consistent ad					

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		PLETED
		245455	B. WING _		03/0	; 9/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143	, 337	
(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 170	communications ar  (i) If the access is a  (ii) At the resident's expense is incurred access to the resident acces	expense, if any additional by the facility to provide such	F 17	Post Office was notified to deliv Saturdays.  All residents who receive mail o Saturday will be delivered to the Mail was delivered on Saturday and will continue to be delivered Saturdays here on out  Any Concerns with mail delivery discussed at resident council, w randomly audit residents regard delivery on Saturdays 2X a mon months and then information ob discussed at QAPI meeting for formation of the saturdays of the saturdays and the saturdays 2X a mon months and then information ob discussed at QAPI meeting for formation of the saturdays and the saturdays 2X a mon months and then information obtains the saturdays and the saturdays 2X a mon months and then information obtains the saturday and the saturdays 2X a mon months and then information obtains the saturday and the sa	n m 2/25/17 I on will be ill ing mail th for 3 tained	

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED
		245455	B. WING				C <b>09/2017</b>
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		60	REET ADDRESS, CITY, STATE, ZIP CODE 11 WEST JACKSON ACKSON, MN 56143		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 280 SS=D	was asked about the Administrator stated residents every day been like that since issues when the particular the particular that since issues when the particular that since issues when the particular that saturday is a state of the particular that the particular tha	at 9:01 a.m. the administrator e mail delivery on Saturdays. It the mail is delivered to except Saturday and it has he was hired due to sorting st administrator was here.  book with the administrator, thandbook revised 10/16 four personal mail will be to your room Monday with the exception of holidays. It that it is a mistake and the mail should be delivered on egarding mail delivery, none	F 1		recommendations		3/31/17

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
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		245455	B. WING			03/0	09/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	601 WEST JACKSON  JACKSON, MN 56143				
040.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	15			.1	0/5)
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F 280	Continued From pa	ge 11	F 2	:80			
	(iv) The right to receive the services and/or items included in the plan of care.						
		the care plan, including the gnificant changes to the plan					
	right to participate i	nall inform the resident of the n his or her treatment and sident in this right. The nust					
	(i) Facilitate the incl resident representa	lusion of the resident and/or ative.					
	(ii) Include an assesstrengths and need	ssment of the resident's ls.					
		resident's personal and s in developing goals of care.					
	483.21 (b) Comprehensive	Care Plans					
	(2) A comprehensiv	ve care plan must be-					
	(i) Developed within the comprehensive	n 7 days after completion of assessment.					
	(ii) Prepared by an includes but is not I	interdisciplinary team, that imited to					
	(A) The attending p	hysician.					
	(B) A registered nur resident.	rse with responsibility for the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED	
		245455	B. WING			09/ <b>2017</b>	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, Z 601 WEST JACKSON JACKSON, MN 56143	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 280	resident.  (D) A member of formula in the resident and the resident and the An explanation multiple medical record if the and their resident in not practicable for it resident's care plant.  (F) Other appropriated disciplines as deteror as requested by.  (iii) Reviewed and it team after each as comprehensive and assessments. This REQUIREMED by:  Based on observative review, the facility for the administion for the administion of the reviewed for medical formula in medications for reviewed for medical findings include:  R49 on 3/8/17, at 8 registered nurse (Findings include:	od and nutrition services staff.  racticable, the participation of e resident's representative(s). It is included in a resident's representative in the participation of the resident representative is determined the development of the included by the resident's needs the resident.  The staff or professionals in mined by the resident's needs the resident.  The vised by the interdisciplinary resessment, including both the diguarterly review  Now it is not met as evidenced the tion, interview and record ailed to revise the care plan for stration of as needed (PRN) or 1 of 5 residents (R49)	F 2	Resident R49 care plan reflect non-pharmalogica prior to any pain adminis  All other residents care previewed to assure any finedications have non-plinterventions listed on the Nurses have been re-edupdating care plans as restatus changes.  Residents who have PRI medication will be audite to assure non-pharmalogical plans as residents who have PRI medication will be audited to assure non-pharmalogical plans as residents who have PRI medication will be audited to assure non-pharmalogical plans as residents who have PRI medication will be audited to assure non-pharmalogical plans as residents who have PRI medication will be audited to assure non-pharmalogical plans as residents who have PRI medication will be audited to assure non-pharmalogical plans as residents.	al intervention tration  blans have been PRN pain narmalogical eir care plans  ucated on esident needs or  N orders for pain d Q 2 weeks X 2		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COMI	SURVEY PLETED
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GOOD S	AMARITAN SOCIETY	- JACKSON	601 WEST JACKSON JACKSON, MN 56143				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	noted that RN-C ha non-pharmacologic Tylenol medication. R49's current care not interventions we minimum should ha non-pharmacologic pain. R49's Medication Rorder for Acetamino (milligrams) every sfever, start date 9/2 Review of the R49's records (MAR) date March 2017 reveale September 2016 refor right shoulder painterventions offere October 2016 receifor cramps legs, ge No non-pharmacol prior to administrati December 2016 receifor generalized pain interventions offere January 2017 receigeneralized pain. Ninterventions offere February 2017 receigeneralized pain. Ninterventions offere March 2017 receive leg cramps. No nor interventions offere	plan failed to address pain so are developed which at a ave included al interventions to manage deview Report identified an apphen (Tylenol) 500 mg six hours as needed for pain or 20/16.  Is medication administration and September 2016 through and prior to administration. The deview Tylenol PRN two times are and the pain. The pain of 20/16 through and prior to administration. The pain of 20/16 through and prior to administration. The pain of 20/16 through and prior to administration. The pain of 20/16 through and prior to administration. The pain of 20/16 through and prior to administration. The pain of 20/16 through and 20/16 through	F 2	280	have been attempted prior to giving medication. These results will be reat the QAPI meeting for further recommendations to assure compl sustained.	eviewed	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING		03	C / <b>09/2017</b>
	PROVIDER OR SUPPLIER	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CO 601 WEST JACKSON JACKSON, MN 56143		709/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 280	current care plan la interventions. RN-A generalized pain he care plan for pain of I do not care plan p acute pain. RN-A sta anything in R49's not 2:56 p.m., RN-A sta admitted R49's care fracture. RN-A state R49's care plan in N fracture had resolved. RN-A for November resolved, the reside post fall (date initiat 11/22/16).  On 3/8/17, at 1:57 p (DON) stated she waddressed with internon-pharmacological plan, if R49 was har she would expect not be offered before medications unless non-pharmacological for the resident.  The facility policy N Interventions, dated use non-pharmacological dentified by the resolution of the resident in the pharmacological register in	cked to address pain with stated sometimes if managed are and there we do not always ontrol, unless more of a focus. ain if I do not think chronic or ated she had not picked up on otes regarding leg pain. At ated when R49 was first e plan addressed pain due to ed pain was removed from November 2016, because a ed. The care plan provided by 2016 identified Focus: ent has fracture of right arm ed 9/20/16 and date resolved out., the director of nursing yould expect pain to be	F 2	80		

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
		245455	B. WING _		C 03/09/2017
	PROVIDER OR SUPPLIER	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTION
F 280	Conferences dated procedure 8. c. In a	hensive Care Plan and Care revised 11/16, indicated ddition to updates during a are plans must be revised as	F 2	30	
F 282 SS=D	483.21(b)(3)(ii) SEF PERSONS/PER CA (b)(3) Comprehens The services provid as outlined by the c must- (ii) Be provided by o	RVICES BY QUALIFIED ARE PLAN ive Care Plans led or arranged by the facility, omprehensive care plan,	F 2	32	3/31/17
	care. This REQUIREMENT by: Based on observative review, the facility for 1 of 1 residents non-pressure related follow the care plan was dependent on services. Findings include: R7 was observed obruises identified or were dark purplish During an observative registered nurse regi	ion, interview and document ailed to follow the plan of care (R7) reviewed for d skin conditions and failed to for 1 of 3 residents (R49) who		R7 care plan was updated for a non-pressure related skin condition Nurses were educated on process follow for documenting and monitor resident skin condition including wo farm sleeves as noted on the can Nurse Aides were educated on follow R7's care plan to wear arm sleeve Will audit R7 daily X 1 week to assisteeves are on, then 3 X week for weeks audits will be reviewed by the team for further recommendations residents who have been identified wearing arm protection will be audit random weekly for 2 weeks then a determined by QAPI Committee R49 fingernails have been trimmer both hands All other resident fingernails have	s to pring earing re plan. lowing s. sure arm 2 QAPI c. Other d as lited at liss d on

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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GOOD S	AMARITAN SOCIETY	- JACKSON	601 WEST JACKSON JACKSON, MN 56143				
(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 282	1) Bruise 2.6 centin 2) Bruise 3.8 cm by 3) Bruise 1 cm x 1 or Review of R7's plan plan review comple (had been updated interviewed, 3/8/17') an actual impairmenthe use of aspirin. Observations of bruist by licensed nurse. To protect the skin as Interview on 3/8/17 assistant (NA)-B veright hand and no splace. At 9:56 a.m. and bruises, been the sleeves on.  Interview on 3/8/17 has had bruises for wrist, review of election confirmed that there monitoring of any befound.  Interview on 3/8/17 nursing (DON) who assessment, monitobruises. DON said documenting is conweekly. DON's expectance plan.  Request of skin monitobruises of skin monitoring of skin moni	neters (cm) by 2 cm 2 cm cm of care with the Last Care ted date of 10/4/14 for skin, with information after staff had identified the resident as nt to the skin integrity due to Interventions include; report ising, weekly skin observation Resident needs arm sleeves at all times.  at 9:47 a.m. with nursing wrified R7 has bruises on the leeve protectors were in NA-C stated R7 has bump here for a while, verified no  at 10:14 a.m. RN-B stated R7 a couple of weeks on right etronic medical record (EMR), the is no documentation or ruises on the right wrist for R7  at 10:26 a.m. with director of explained the process of oring and documenting the that monitoring and inpleted on all residents ectation would be to follow the	F 2	282	trimmed Nurses and Nurse Aides received education on when nail care should done, how to mark care record if a resident refuses Audits will be conducted weekly X2 as determined by QAPI Committee attain compliance.	, then	
	provided by the fac						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CO 601 WEST JACKSON JACKSON, MN 56143	•	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	hygiene: requires of The nursing assistated identified R49 requires on R49 was observed have long uneven from the time stated the trimmed and had be trimmed and had be on 3/8/17, at 9:41 observed R49's find confirmed R49's find confirmed R49's find uneven. R49 stated them cut." RN-C in some clippers and stated fingernails were sident bath days. documentation for stated R49 had refered a bath on stated with R49's beaths per week R4 been trimmed, ther nails not to be trimmed having trouble with nails. RN-C stated refusal of nail care. On 3/7/17, at 5:35 stated residents getrimmed once a wetrim nails for reside NA-A stated the facts specifically nails have a stated the facts of the stated the stated the facts of the stated the stat	ne staff assist and personal one staff assist.  ant Kardex report dated 3/8/17, ired one staff assist for and bathing.  on 3/6//17, at 2:12 p.m. to fingernails on both hands. R49 their fingernails need to be een looking for nail clippers.  a.m. registered nurse (RN)-C gernails on both hands and agernails were long and to RN-C at the time, "I need afformed R49 she would obtain trim his nails today. RN-C were to be trimmed on the RN-C reviewed R49 thaving received a bath and used a bath on 3/5/17, but had 3/3/17 and 3/1/17. RN-C athing frequency of three 9's fingernails should have be was no excuse for R49's med. RN-C stated I have been staff trimming the resident the facility does not document and been trimmed and when a fill care the facility does not document and been trimmed and when a fill care the facility does not document and been trimmed and when a fill care the facility does not	F 28	32		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		245455	B. WING			03/	09/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		60	TREET ADDRESS, CITY, STATE, ZIP CODE 01 WEST JACKSON ACKSON, MN 56143		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 18	F 2	282			
		a.m., RN-A stated R49 (weight bearing assist) assist					
	stated she would ex	o.m. the director of nursing expect nails to be trimmed on expect resident refuses, attempt to					
F 309 SS=D	Conferences dated purpose to provide assessing, impleme updating the reside the resident's higher	chensive Care Plan and Care revised 11/16, indicated an ongoing method of enting, evaluating and nt's care plan to help maintain est level of functioning.  PROVIDE CARE/SERVICES ELL BEING	F3	309			3/31/17
	applies to all care a residents. Each re- facility must provide services to attain or practicable physica well-being, consiste	re undamental principle that and services provided to facility sident must receive and the ethe necessary care and maintain the highest I, mental, and psychosocial ent with the resident's sessment and plan of care.					
	applies to all treatm facility residents. Be assessment of a re that residents recei accordance with pr practice, the compr	fundamental principle that nent and care provided to assed on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered residents' choices, including					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		245455	B. WING		03/09/2017
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143	
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 309	provided to resident consistent with profithe comprehensive and the residents' general comprehensive and the residents' general comprehensive and the residents who requiservices, consistent of practice, the compact complete comprehensive consistent of practice, the compact complete comprehensive compact complete comprehensive compact complete comprehensive complete complete comprehensive complete	e following:  ent. sure that pain management is ts who require such services, essional standards of practice, person-centered care plan, goals and preferences.  cility must ensure that ire dialysis receive such the with professional standards aprehensive person-centered residents' goals and  NT is not met as evidenced and document ailed to identify and monitor residents (R7) and failed to and documentation for tear for 1 of 3 residents (R41) ressure related skin concerns.  Inge Minimum Data Set dated as a 12 which is moderately defined in size. In color and varied in size. In color and varied in size. In color and varied in size. In the set of the size of th	F 309	R7 care plan was updated for a non-pressure related skin condition (bruising) Nurses were educated on process to follow for assessing (gathering data)documenting and monitoring reskin condition on R7 and any other resident who may have a non-pressurelated skin condition. Education was given to follow individual resident car plans.  Audit will be done weekly X 4 on R7 assure bruises are healing and any or resident who may have non-pressure related skin issues then audits will be reviewed at QAPI meeting for further recommendations. Audits will be completed at random any other resid who has skin related condition.	sident ure s re to other

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245455	B. WING		03	C / <b>09/2017</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 601 WEST JACKSON JACKSON, MN 56143	•	
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F 309	2) Bruise 3.8 cm b 3) Bruise 1 cm x 1  Review of R7's cur Care plan review of skin, (had been up staff interviewed, 3 resident as impair the use of aspirin. observations of bruises of protect the skin  Review of R7's protect the skin  Review of R7's protect the skin  Review of R7's protect through 3/4/17 did of concern from he right wrist.  Interview on 3/8/17 assistant (NA)-B werified she has bruseleeve protectors where the standard of the s	meters (cm) by 2 cm y 2 cm cm  rent plan of care with the Last ompleted date of 10/4/14 for dated with information after /8/17) had identified the ment to the skin integrity due to Interventions include; report uising, weekly skin observation Resident needs arm sleeves at all times.  gress notes dated, 2/4/17 not identify any new skin areas er weekly skin check on her  at 9:47 a.m. with nursing hile in therapy working with R7 uises on the right hand and no	F 3	09		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
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	PROVIDER OR SUPPLIER	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CO 601 WEST JACKSON JACKSON, MN 56143		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	regarding any know stated R7 has had on right wrist, place bruises monitored asked about how s RN-B said informat next shift or expect Interview and recor at 10:19 a.m. of ele read 3/4/17 had ba forgot to mention b better way to monit calendar RN-B stat wrote in there to mc Confirmed that their monitoring of any b found.  Interview on 3/8/17 nursing (DON) exp assessment, monit bruises Monitoring weekly. DON's exp care plan. R41 was observed right foot second to place. The dressing identify when the did on 3/8/17 at 9:47 at in the therapy room R41's right foot second R41's right foot second place. The dressing in place.		F 30	09		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245455	B. WING				C <b>09/2017</b>
	PROVIDER OR SUPPLIER	- JACKSON		601	EET ADDRESS, CITY, STATE, ZIP CODE WEST JACKSON CKSON, MN 56143	<u>, 00,</u>	03/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	following: 2/16/17, while trans second toe bumped causing small skin and applied primap 2/19/17, small skin toe, applied Vaselin and scab noted. 2/26/17, skin tear to no active bleeding, 3/5/17, skin tear no scabbed over, no reached over, no reached vaseline armonitor.  R41's care plan print the resident has podevelopment relate immobility, incontin inform resident/fambreakdown. Provide mattress and cushi immediately of any redness, blisters, bouted during bath clacked to identify Rinterventions relate. R41's Medication and Record (MAR/TAR) and 3/3017, were redocumentation of transport of the second of the seco	gress notes identified the afterring resident, right foot dapart of the mechanical lift tear to second toe, cleansed ore bandage. Shear noted to right second te and primapore. Site is clean oright foot second toe is intact, new primapore applied. The ted to right second toe, edness or drainage noted. The date 3/8/17, indicated focus: tential for pressure ulcer date altered mental status, ence. Interventions included and primapore applied. The pressure redistribution on to wheelchair. Notify nurse new areas of skin breakdown: ruises, discoloration, etc. or daily care. The care plan 41 had a skin tear and dated for the month of 2/2017 deviewed and lacked to include reatment for the skin tear		309			
	physician orders ar	nd MAR/TAR and stated R41's vsician order for the treatment					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		245455	B. WING _			09/ <b>2017</b>
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - JACKSON				STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 312 SS=D	was not documents stated if the treatment of the MAR/TAR. Feather on the Market of R4 having a bath and the Surveyor corright second toe. Reading the dressing R41 curred applied by her this in the dressing should consider the dressing should consider on the skin teather of R4 having at least needed.  A policy for treatment of R4 having at least needed.  A policy for treatment of R4 having at least needed.  A policy for treatment of R4 having at least needed.  A policy for treatment of R4 having at least needed.  A policy for treatment of R4 having at least needed.  A policy for treatment of R4 having at least needed.  A policy for treatment of R4 having at least needed.  A policy for treatment of R4 having at least needed.  A policy for treatment of R4 having at least needed.  A policy for treatment of R4 having at least needed.  A policy for treatment of R4 having at least needed.  A policy for treatment of R4 having at least needed.  A policy for treatment of R4 having at least needed.  B policy for treatment of R4 having at least needed.  A policy for treatment of R4 having at least needed.  B policy for treatment of R4 having at least needed.  A policy for treatment of R4 having at least needed.  B policy for treatment of R4 having at least needed.	the treatment for the skin teared on R41's MAR/TAR. RN-Bent was not loaded into the an the treatment would not be RN-B stated she had changed 1's skin tear due to R41 he dressing had become wet.  p.m., RN-B asked R41 if she ould look at the skin tear on his 41 replied no. RN-B stated the ntly had on his toe had been past weekend. RN-B stated I be changed every three days.  p.m., the director of nursing would expect staff to document of skin tear on the TAR, to rewas observed and assessed every three days and as  ant of skin tears was requested the RARE PROVIDED FOR IDENTS  no is unable to carry out ing receives the necessary in good nutrition, grooming, and	F 31			3/31/17

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			E SURVEY PLETED
		245455	B. WING				C <b>09/2017</b>
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - JACKSON				60	TREET ADDRESS, CITY, STATE, ZIP CODE D1 WEST JACKSON ACKSON, MN 56143	1 00/1	00/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	have long uneven fi at the time stated the trimmed and was look.  On 3/8/17, at 9:41 and observed R49's find confirmed R49's find uneven. R49 stated them cut." RN-C in some clippers and stated fingernails we resident bath days. documentation for his stated R49 had refured a bath on stated with R49's be baths per week R49 been trimmed, there nails not to be trimmed, there nails. RN-C stated for furefusal of nail care.  R49's quarterly Min 2/2/17, identified refor personal hygien assist with bathing.  R49's care plan prin bathing: requires or hygiene: requires or hygiene: requires or The nursing assists.	on 3/6//17, at 2:12 p.m. to ingernails on both hands. R49 he fingernails need to be toking for a nail clippers.  a.m. registered nurse (RN)-C gernails on both hands and gernails were long and I to RN-C at the time, "I need formed R49 she would obtain trim his nails today. RN-C ere to be trimmed on the RN-C reviewed R49 having received a bath and used a bath on 3/5/17, but had 3/3/17 and 3/1/17. RN-C athing frequency of three er was no excuse for R49's need. RN-C stated I have been staff trimming the resident the facility does not document the facility does not document and one person physical hat date 3/8/17, indicated he staff assist and personal ne staff assist.	F3	112	Nurses and Nurse Aides received education on when nail care should done and how to mark care record resident refuses  Audits will be conducted weekly X4 as determined by QAPI Committee attain compliance.	if a , then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245455	B. WING			C <b>09/2017</b>
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - JACKSON				STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143	1 00/	03/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE	D BE	(X5) COMPLETION DATE
F 312	Continued From page 25		F 3	12		
		eet identified R49 received a y shift, Wednesday and Friday				
	stated residents ger trimmed once a wer trim nails for residen NA-A stated the fac specifically nails ha	p.m. nursing assistant (NA)-A nerally have their nails ek with baths. Activities would nt who had their nails painted. ility does not document d been trimmed and when a il care the facility does not f the care.				
		a.m., RN-A stated R49 (weight bearing assist) assist				
	stated she would ex	o.m. the director of nursing expect nails to be trimmed on e resident refuses, attempt to				
F 315 SS=E	indicated Purpose 1 trimmed to promote condition and to pre 483.25(e)(1)-(3) NC	ail Care dated revised 5/16, To keep nails clean and well-being, to observe nail event nail discomfort. O CATHETER, PREVENT UTI, ER	F 3 <sup>-</sup>	15		3/31/17
	continent of bladder receives services a continence unless h	t ensure that resident who is r and bowel on admission nd assistance to maintain nis or her clinical condition is nat continence is not possible				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	COM	(X3) DATE SURVEY COMPLETED	
		245455	B. WING _			C <b>09/2017</b>	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - JACKSON				STREET ADDRESS, CITY, STATE, ZIP CC 601 WEST JACKSON JACKSON, MN 56143		JUN 100 11	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 315	on the resident's confacility must ensured indwelling catheter resident's clinical contact catheterization was subject to the ensured indwelling catheter is assessed for remanding catheter is	ith urinary incontinence, based imprehensive assessment, the enthat- Inters the facility without an is not catheterized unless the condition demonstrates that incressary; Inters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary  is incontinent of bladder the treatment and services to extinfections and to restore extent possible.  In the facility with an or subsequently receives to extend the catheter as soon the resident's clinical condition catheterization is necessary  is incontinent of bladder the treatment and services to extend possible.  In the facility with an or subsequently receives and to restore as much normal the extend possible.  In the facility with an or subsequently receives and the resident who is the facility cumentation of three signs and the possible.  In the facility with an or subsequently receives appropriate the facility cumentation of three signs and the possible of the facility cumentation of three signs and the possible of the facility cumentation of three signs and the possible of the facility cumentation of three signs and the possible of the facility cumentation of three signs and the possible of the facility cumentation of three signs and the possible of the facility cumentation of three signs and the facility cumentation of three signs are t	F 31	Residents R5, R8, R13, and and urine specimans were of physicians nurses completed symptomology they saw with after residents were seen by Residents R5, R8, R13, R62 other residents identified recantibiotics for a urinary tractibe audited X 1 month to assi	rdered by If the the resident physician.  and any eiving infection will		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245455	B. WING				C
NAMEOFI			B. 11.11G		CTREET ADDRESS CITY STATE ZID CODE	03/	09/2017
NAIVIE OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	/ - JACKSON			601 WEST JACKSON		
				J	JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 315	Continued From page	age 27	F3	315			
		on control logs and resident			and symptoms of UTI are obtained or as indicated by their physician.		
	urinary tract infecti (antibiotic). Nosoco obtained in ER (en (culture and sensit documented. The Control Reporting three signs and sy identified 1/10/17 (milligrams) daily f (antibiotic) 100 mg R5's medication and dated 1/17, identificand Macrodantin arecord lacked culture	in control log dated 1/8/17, with on (UTI), treatment Levaquin omial yes, UA (urine analysis) nergency room) C and Stivity): no information log, R5's record and Infection Form lacked documentation of mptoms. R5's physician orders discontinue Levaquin 250 mg or UTI, start Macrodantin twice daily for seven days. It wice daily for seven days. It will be defined and R5's condered. The log and R5's cure results. Culture results were clinic after surveyor had			Audits will be completed on all res 1 month identified with a UTI, then will be reviewed by QAPI for further recommendations.	audits	
	UTI, treatment Leves: no culture. Misconshe needed. R8's order on 12/20/16 hallucinations and 12/21/16 identified days. R8's MAR datevaquin was give record lacked threaculture results.  R13 was on infection UTI, treatment Celeyes. C and S: no infection MAR dated 11/16 identified to the control of the cont	on control log dated 12/21/16, vaquin. Nosocomial yes. C and c. (miscellaneous): doctor felt physician orders identified UA one time only for repeat falls. An order on Levaquin 250 mg daily for 10 ated 12/16 identified the en as ordered. The log and R8's e signs and symptoms and fon control log dated 11/25/16, fdinir (antibiotic). Nosocomial information documented. R13 identified R13 had received vice daily for UTI. The log and					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		045455	B. WING				C
NAME OF I	PROVIDER OR SUPPLIER	245455	b. Wind		TREET ADDRESS, CITY, STATE, ZIP CODE	03/	09/2017
					11 WEST JACKSON		
GOOD S	AMARITAN SOCIETY	- JACKSON			ACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 315	gustify the use of an R62 was on infection UTI, treatment Leva S: no information do orders identified 9/2 seven days. Urine of dated 9/16 identified Levaquin as ordere lacked three signs a results. Culture residentification.	d three signs and symptoms to	F3	315			
F 329 SS=D	(DON) verified the include documental symptoms and cult. The DON stated we with getting culture  A policy for UTI's warprovided.	a.m., the director of nursing infection control logs lacked to tion of three signs and ure results as above for UTI's. It have been having trouble results from the clinic.  As requested, but not DRUG REGIMEN IS FREE SARY DRUGS	F 3	329			3/31/17
	Each resident's dru	sary Drugs-General. g regimen must be free from . An unnecessary drug is any					
	(1) In excessive dos therapy); or	se (including duplicate drug					
	(2) For excessive d	uration; or					
	(3) Without adequa	te monitoring; or					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED
		245455	B. WING _		C <b>03/09/2017</b>
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143	1 00/03/2011
(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)	LD BE COMPLÉTION
F 329	(5) In the presence which indicate the ordiscontinued; or  (6) Any combination paragraphs (d)(1) the second of the	te indications for its use; or of adverse consequences dose should be reduced or as of the reasons stated in arough (5) of this section.  opic Drugs.	F 32	29	
	gradual dose reducinterventions, unless an effort to disconti This REQUIREMEI by: Based on observative review, the facility finon-pharmacologic prior to the administic pain medications for reviewed for medicinerviewed for mediciners.  R49's Admission research and service and servic	tions, and behavioral solinically contraindicated, in nue these drugs; NT is not met as evidenced cion, interview and record called to offer and document al interventions attempted tration of as needed (PRN) or 1 of 5 residents (R49)		Resident R49 care plan was uporeflect non-pharmalogical interve prior to any pain administration  All other residents care plans have reviewed to assure any PRN pair medications have non-pharmaloginterventions listed on their care plans have been re-educated oupdating care plans as resident re-	ntion ve been n gical blans

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245455	B. WING			09/ <b>2017</b>	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP COD 601 WEST JACKSON JACKSON, MN 56143			
(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 CORRE (EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 329	R49 had moderate no pain.  On 3/8/17, at 8:44 registered nurse (F to arise for breakfa his leg. RN-C aske Tylenol. RN-C then Tylenol. RN-C state his left lower leg ar Tylenol and R49 sa gets pain pills. No nintervention was of leg pain.  R49's Medication F order for Acetamina (milligrams) every sfever, start date 9/2 Review of the R49' records (MAR) date March 2017 reveals September 2016 refor right shoulder pinterventions offered October 2016 rece for cramps legs, gen No nonpharmaco prior to administrat December 2016 refor generalized pain interventions offered January 2017 rece generalized pain. Ninterventions offered February 2017 rece fered for generalized pain. Ninterventions offered February 2017 rece	(MDS) dated 2/2/17, indicated ly impaired cognition and had a.m., R49 was laid in bed and RN)-C tried to encourage R49 st. R49 complained of pain in d R49 if he would like some left R49's room to obtain the ed to surveyor R40 had pain in ad she will be giving him aid he would get up after he non-pharmacological fered to R49 for complaints of Review Report identified an ophen (Tylenol) 500 mg six hours as needed for pain or 20/16.	F 329	Residents who have PRN ord medication will be audited Q 2 to assure non-pharmalogical i have been attempted prior to medication.  Audit results will be reviewed a meeting for further recommen assure compliance is sustained.	weeks X 2 nterventions giving pain at the QAPI dations to		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING _	<del></del>		C / <b>09/2017</b>
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CO 601 WEST JACKSON JACKSON, MN 56143		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	March 2017 received leg cramps. No not interventions offered R49's Pain Data Condicated Pain mar non-medication into Received PRN pair and declined, no.  On 3/8/17, at 9:48 confirmed R49's c	ed prior to administration. ed Tylenol PRN one time for application effective date 2/2/17, agement: received ervention for pain, no. a medications or was offered exercised enterventions are plan lacked to attended to attended to attended to attended to exercise plan pain, unless more care plan pain if I do not think ain. RN-A stated she had not ing in R49's notes regarding m., RN-A stated when R49 R49's care plan addressed e. RN-A stated pain was 's care plan in November fracture had resolved. The by RN-A for November 2016 esolved, the resident has a post fall (date initiated	F 32			

PRINTED: 04/05/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245455	B. WING			C ( <b>09/2017</b>	
NAME OF F	PROVIDER OR SUPPLIER	110.100	1	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	09/2017	
COOD C	AMARITAN COCIETY	IACKCON		601 WEST JACKSON			
GOOD S	AMARITAN SOCIETY	- JACKSON		JACKSON, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 329	Continued From pa	ge 32	F 3	29			
F 334 SS=D	Interventions, dated use non-pharmacol identified by the res Non-pharmacologic attempted first; how successful, they may pharmacological reresident what has we past.  483.80(d)(1)(2) INF PNEUMOCOCCAL  (d) Influenza and procedures to expect the contraindicated or the contrain	IMMUNIZATIONS neumococcal immunizations acility must develop policies ensure that- ne influenza immunization, e resident's representative regarding the benefits and s of the immunization; offered an influenza per 1 through March 31 e immunization is medically he resident has already been his time period; the resident's representative to refuse immunization; and medical record includes indicates, at a minimum, the	F3	34		3/31/17	
	(A) That the resider	nt or resident's representative					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION  NG	_ (X3	(X3) DATE SURVEY COMPLETED	
		245455	B. WING			C <b>03/09/2017</b>
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, ST 601 WEST JACKSON JACKSON, MN 56143	ATE, ZIP CODE	03/03/2311
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTING CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIAT ICIENCY)	COMPLETION DATE
F 334	was provided educa and potential side e immunization; and  (B) That the resider immunization or did immunization due to refusal.  (2) Pneumococcal of develop policies and (i) Before offering the immunization, each representative recebenefits and potential immunization;  (ii) Each resident is immunization, unless medically contrained already been immunization or has the opportunity  (iv) The resident or has the opportunity  (iv) The resident or has the opportunity  (iv) That the resider was provided educated and potential side e immunization; and  (B) That the resider pneumococcal immunication immunication; and	ation regarding the benefits ffects of influenza at either received the influenza at not receive the influenza at medical contraindications or addisease. The facility must add procedures to ensure that- are pneumococcal aresident or the resident's aives education regarding the all side effects of the affered a pneumococcal as the immunization is aicated or the resident has	F3	34		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		245455	B. WING				C <b>09/2017</b>
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		60	TREET ADDRESS, CITY, STATE, ZIP CODE D1 WEST JACKSON ACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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 334	contraindication or This REQUIREMEN by: Based on interview failed to ensure doo provided for 3 out of R49) prior to receiv and for 1 of 5 reside the pneumococcal findings include: R46's Admission Readmission date 9/6, immunization record Influenza. Given: reDate: 10/25/16. Edit Resident/Family: no Pneumococcal Cord (PPSV23). Given: roDate: 10/24/16. Edit Resident/Family: no R48's Admission date 9/10 immunization record Influenza. Given: codate: 10/25/16. Edit Resident/Family: no R49's Admission date 9/20 immunization record Influenza. Given: reDate: 10/25/16. Edit Resident/Family: no R49's Admission date 9/20 immunization record Influenza. Given: reDate: 10/25/16. Edit Resident/Family: no On 3/9/17, at 10:12	refusal. NT is not met as evidenced  and record review, the facility cumentation of education was of 5 residents (R46, R48 and ing influenza immunization ents (R46) before receiving immunization.  ecord dated 3/9/17, identified and identified immunization:  fused. Consent Confirmed acation provided to information documented.  In provided to information documented.  Ecord dated 3/9/17, identified acation provided to information documented.  Ecord dated 3/9/17, identified acation provided to information documented.  Ecord dated 3/9/17, identified acation provided to information documented.  Ecord dated 3/8/17, identified acation provided to information documented.  Ecord dated 3/8/17, identified acation provided to information documented.  Ecord dated 3/8/17, identified acation provided to information documented.  Ecord dated 3/8/17, identified acation provided to information documented.  Ecord dated 3/8/17, identified acation provided to information documented.  Ecord dated 3/8/17, identified acation provided to information documented.  Ecord dated 3/8/17, identified acation provided to information documented.  Ecord dated 3/8/17, identified acation provided to information documented.	F3	34	R46, R48, R49. documentation proper and resident continued to refuse variation and residents who are provided edu on the Influenza and pneumococca have a date listed for the information provided in the medical record.  This will be audited in Influenza seand on admission for pneumococca vaccine.  Audits will be submitted to the QAF for further recommendations.	accine. cation al will on ason al	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCT			E SURVEY PLETED
		245455	B. WING				C <b>09/2017</b>
	PROVIDER OR SUPPLIER	- JACKSON		STREET ADDRES 601 WEST JACKSON, M		1 00/	00/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441 SS=F	not been document DON stated I would The facility policy In dated revised 11/16 Upon admit each representative will rinformation sheets pneumococcal vacand potential side eresident and/or resident and control program a minimum, the following for president and control program and communicable disevolunteers, visitors, providing services the arrangement based conducted accordinaccepted national simplementation is Figure 12. Written standard for the program, whilmited to:  (i) A system of surve possible communication is provided accommunication in the program, whilmited to:	mococcal immunization had red for R46, R48 and R49. The I say it was an oversight.  Inmunizations for Residents of indicated procedure 1. a. resident and/or resident receive the vaccination for influenza and cines. Discuss the benefits refects of vaccinations with dent representative.  Poly (f) INFECTION CONTROL, D, LINENS  Ition and control program.  Itablish an infection prevention of (IPCP) that must include, at owing elements:  Eventing, identifying, reporting, controlling infections and rases for all residents, staff, and other individuals under a contractual of the second residents of the seco	F 4				3/31/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING			C 03/09/2017	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	03/0	J <del>3</del> /2017
GOOD S	AMARITAN SOCIETY	- IVCKSON		6	01 WEST JACKSON		
GOOD 3	AWANTAN SOCIETY	- JACKSON		J	ACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From pa facility;	ge 36	F 4	41			
		nom possible incidents of ease or infections should be					
		ansmission-based precautions event spread of infections;					
	(iv) When and how resident; including I	isolation should be used for a out not limited to:					
	depending upon the involved, and (B) A requirement t	uration of the isolation, e infectious agent or organism hat the isolation should be the sible for the resident under the					
	must prohibit emplo disease or infected	ces under which the facility byees with a communicable skin lesions from direct hts or their food, if direct t the disease; and					
		ne procedures to be followed direct resident contact.					
		cording incidents identified PCP and the corrective a facility.					
		nel must handle, store, port linens so as to prevent the					
		The facility will conduct an IPCP and update their					

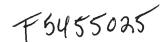
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	СОМ	E SURVEY PLETED
		245455	B. WING			C <b>09/2017</b>
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CO 601 WEST JACKSON JACKSON, MN 56143		00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	Continued From pa	•	F 44	1		
	by: Based on interview facility failed to ens of infections. This has residents, staff and Findings include: The facility monthly obtained from 7/11/identified for tracking, infection, trea (culture and sensiti) The logs identified infections: 7/16 - 1 urinary tracpneumonia, 1 cellu eye, 1 cystitis 8/16 - 1 UTI, 1 CAF candidiaysis/skin 9/16 - 4 UTI, 1 aspiconjunctivitis, 1 skin infection), 1 cystitis 10/16 - 1 UTI, 1 cocongestion/product congestion, one ter 11/16 - 3 UTI, 1 cor congestion, cough, 12/16 - 3 UTI, 1 URI diarrhea, 1 colitis, 1 agastroenteritis (tvarious signs and sextra cleaning by haspoke with medical	v and document review, the ure analysis and surveillance and the potential to affect all 43 visitors.  Infection Control Logs were (16 through 2/2017. The logsing the date, resident name, atment, nosocomial, C and S vity) and miscellaneous.  Infection (UTI), 2 litis, 1 C-diff (stool infection), 1 P, 1 cellulitis/skin, 1 C-diff, 1 irration pneumonia, 1 In, 1 URI (upper respiratory /hematuria ongestion/sore throat, 1 live cough, 1 bronchitis/nasal mperature/leukocytosis njunctivitis, 1 C-diff, 1		Infection Control logs for all applicable, will include a Data where surveillance, education implemented, monitoring of the and effectiveness of the action implemented.  The data sheets will be review meetings to assure compliant change is needed if outcome not obtained.	a sheet n, actions ne actions ons which are wed at QAPI ce and if	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING			C / <b>09/2017</b>
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP 601 WEST JACKSON JACKSON, MN 56143	•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(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 CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 441	However, the logs surveillance and da unusual or unexped determine the effect prevention and con of observations relaimplementing meast transmission of information of 1/17 relat timely training interprevent further infermonth of 1/17 relat timely training interprevent further infermonth of 1/17 relat timely training interprevent further infermonther infermonther infermonther infermonther infermonther information may be assurance notes) of meetings held. Adoprovided, but lacked analysis as above.  The facility policy in Control Program did Policy The infection program will attempregulations for infermonter infer	_	F4	41		

` '	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		E SURVEY PLETED
				С	
	245455	B. WING		03/	09/2017
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - JAC	CKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ET BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
of information to those we take action. Once a base can be determined when procedure 3. Determine collection, such as a. Observation of Determine endemic level Perform routine surveillate outbreaks. e. Prevent sp. 483.70(b)(c) COMPLY WESS=D (b) Compliance with Feed Laws and Professional St. The facility must operate compliance with all applicated laws, regulations, a accepted professional st. that apply to professional st. that apply to professional such a facility.  (c) Relationship to Other In addition to compliance forth in this subpart, facilithe applicable provisions regulations, including but pertaining to nondiscrimination on the CFR part 84); nondiscrimination on the CFR part 84); nondiscriminated in the CFR part 84); nondiscriminated in the CFR part 91); no basis of race, color, national disability (45 CFR part 91)	alysis of data and passing who need to know and seline is established then it re control is needed. It the purpose of the data btain baseline. It is eliof specific organisms. It is ance activities. It is dentify pread.  WITH AL LAWS/PROF STD deral, State, and Local Standards.  It is and provide services in licable Federal, State, and and codes, and with standards and principles als providing services in the regulations.  It is with the regulations set illities are obliged to meet is of other HHS at not limited to those innation on the basis of prigin (45 CFR part 80); is basis of disability (45 mination on the basis of condiscrimination on the ional origin, sex, age, or 62); protection of human is CFR part 46); and fraud it 455) and protection of	F 4			3/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING _			C <b>09/2017</b>
	NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - JACKSON			STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		<u> </u>
(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 APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 492	CFR parts 160 and provisions may resinon-compliance with This REQUIREMED by: Based on interview facility failed to stop appeals process for requested a demark Findings included: R55's record reflect (Skilled Nursing Fath Continued Stay on R55 had met goals level of care. The inqualified as covered 12/31/16 and was submediciary/represed 3/8/17, at 1:26 p.m. stated R55's benefit have written the written the written the written the written. The form ider beneficiary/represed via phone on 12/29 marked option was for service I continuate intermediary for be informed when the intermediary for be informed when the intermediary for the int	164). Violations of such other alt in a finding of the this paragraph.  NT is not met as evidenced and document review, the billing for daily stay during the r 1 of 1 resident (R55) who id bill.  Its the facility issued the SNF cility) Determination of 12/28/16. The SNF indicated and no longer required skilled otice indicated R55 no longer dunder Medicare beginning signed by R55's intative on 11/12/17. On the registered nurse (RN)-A ciary/representative: must ong date when singing the intified R55's intative was given verbal notice interest of the submitted to real method with the bill is submitted. You are for services which could be refer until a Medicare decision counting records reflect eived for R55 on 2/16/17 for (28/17 for \$1420.00, confirmed)	F 49	R55 their demand bill was rev corporate level and R55 should been billed  R55 and any other resident what a demand bill of rights will be a facility level to assure payment requested. Audits will be conditioned and the further recommendations.	d not have no requests audited on t is not ucted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245455	B. WING		05	C 3/ <b>09/2017</b>
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - JACKSON				STREET ADDRESS, CITY, STATE, ZIP 601 WEST JACKSON JACKSON, MN 56143	•	009/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 492	resident wanted serintermediary. OF-C into the computer s (who is responsible R55 had requested  The facility policy M Notifications dated The provider will fol issuance of the notic continued stay in or beneficiaries of den Specific Delivery Iss disagrees and asks to the MAC, you mad accept deposit or of beneficiary for the serious continued stay in or beneficiary for the serious continued stay in or beneficiaries of den Specific Delivery Iss disagrees and asks to the MAC, you mad accept deposit or of beneficiary for the serious continued stay in or serious co	revices reviewed by stated the SNF was scanned ystem and the corporate office for billing) should be aware a demand bill.  Idedicare Part A Non-Coverage revised 1/17, indicated Policy low the regulations to ce of non-coverage on the der to appropriately inform nand bill rights. Procedure sues If the beneficiary you to submit a demand bill ay not require, request or ther payment from the services until the MAC makes ion that the services are not	F4	92		



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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION ING <b>01 - MAIN BUILDING 01</b>	(X3) DATE SURVEY COMPLETED	
		245455	B. WING	<u> </u>	03/07/2017	
	PROVIDER OR SUPPLIER	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ARREST TO THE ARREST	BE COMPLETION	
K 000	ALLEGATION OF COPPARTMENT'S ASIGNATURE AT THE PAGE OF THE CMUSED AS VERIFICATION RECEIPT CONSITE REVISIT CONDUCTED TO SUBSTANTIAL COREGULATIONS HACCORDANCE WAS A Life Safety Code Minnesota Department of Market Ma	COC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE.  OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN FITH YOUR VERIFICATION.  Survey was conducted by the ment of Public Safety, State on. At the time of this survey, ociety Jackson was found not be with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the tional Fire Protection by 101 Life Safety Code (LSC), g Health Care Occupancies.  I THE PLAN OF OR THE FIRE SAFETY (FTAGS) TO: Inspections Division eet, Suite 145	K	DEPICIENCY)		
	By email to:	DEDICHED DEDDESENTATIVES SIG	NATURE	TITLE	(X6) DATE	

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

**Electronically Signed** 

03/31/2017

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

Facility ID: 00303

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245455	B, WING		03/0	7/2017
	PROVIDER OR SUPPLIER	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPE  DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Angela.Kappenmar < mailto:Angela.Kap THE PLAN OF COLDEFICIENCY MUSFOLLOWING INFO  1. A description of various to correct the deficition of various to correct the deficition of various to correct the deficition.  2. The actual, or properties of the actual, or properties of the compressible for c	tate.mn.us itney@state.mn.us> and im@state.mn.us ppenman@state.mn.us>  RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:  what has been, or will be, done ency.  oposed, completion date.  r title of the person rection and monitoring to ence of the deficiency.  ociety Jackson was ows: g was constructed in 1956, is easement, is fully fire sprinkler determined to be of Type is eas constructed in 1965, is easement, is fully fire sprinkler determined to be of Type is eas constructed in 1976, is easement, is fully fire ed and was determined to be estruction; eas constructed in 1996, is easement, is fully fire sprinkler determined to be of Type determined to be of Type in the constructed in 1996, is easement, is fully fire sprinkler determined to be of Type	KC			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245455	B. WING	B. WING		03/07/2017	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP C 601 WEST JACKSON JACKSON, MN 56143	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE	
K 000	department notifical capacity of 57 beds time of the survey.  The requirement as	monitored for automatic fire ation. The facility has a s and had a census of 44 at t 42 CFR, Subpart 483.70(a) is	KC	000			
	NOT MET as evide NFPA 101 Fire Ala Maintenance	enced by: rm System - Testing and	K 3	345		3/31/17	
	A fire alarm system accordance with an with the requireme Electric Code, and and Signaling Code.	- Testing and Maintenance is tested and maintained in approved program complying ints of NFPA 70, National NFPA 72, National Fire Alarm e. Records of system enance and testing are readily and NFPA 25					
	Based on docume the Facility failed to Alarm System in a National Electric C Fire Alarm and Sig	is not met as evidenced by: entation review and interview, to test and maintain the Fire eccordance with NFPA 70, ode, and NFPA 72, National naling Code. The deficient ect 44 out of 44 residents.		K 345 The DACT system will be to fire drills and documented. documentation will be audit quarter ending on 5/30/17 lenvironmental services direcompliance.	The ted for the next by the		
	A fire alarm system accordance with al with the requireme Electric Code, and and Signaling Code.	- Testing and Maintenance in is tested and maintained in in approved program complying ints of NFPA 70, National NFPA 72, National Fire Alarm ie. Records of system enance and testing are readily					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A, BUILDING 01 - MAIN BUILDING 01			X3) DATE SURVEY COMPLETED	
		245455	B. WING		03/07/2017		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PROVIDER OR SUPPLIER	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143			
(X4) ID PREFIX T <b>A</b> G	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 345	Continued From pa available. 9.7.5, 9.7.7, 9.7.8, FINDINGS INCLU	and NFPA 25.	K 345				
	03/07/2016, documentation that the DACT Sys	ween 2:00 PM and 5:00 PM on nentation reviewed revealed stem was not tested during the ducted on the night shift.					
K 346 SS=E	Maintenance Direct	tice was verified by the Facility ctor. rm System - Out of Service	K 346	3		3/31/17	
	services for more period, the authori notified, and the beapproved fire water parties left unprote fire alarm system 9.6.1.6 This STANDARD Based on docume the Facility failed to accurate Fire Alarm	e alarm system is out of than 4 hours in a 24-hour ty having jurisdiction shall be uilding shall be evacuated or and shall be provided for all ected by the shutdown until the has been returned to service.  is not met as evidenced by: entation review and interview, or provide a current and m Out of Service Policy. The could affect 44 out of 44		K 346 The out of service fire policy for the alarm system has been updated to include the State Fire Marshal□s of information as of 3/13/17.			
	services for more period, the authori notified, and the b	f Service re alarm system is out of than 4 hours in a 24-hour ty having jurisdiction shall be uilding shall be evacuated or an th shall be provided for all				-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A, BUILDING 01 - MAIN BUILDING 01			(3) DATE SURVEY COMPLETED	
		245455	B. WING		03/0	7/2017
	PROVIDER OR SUPPLIER	- JACKSON	60	FREET ADDRESS, CITY, STATE, ZIP CODE D1 WEST JACKSON ACKSON, MN 56143		
(X4) ID PREFIX T <b>A</b> G	(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
	fire alarm system h 9.6.1.6  FINDINGS INCLUI  On facility tour betw 03/7/2017, docume the Out of Service System does not h contact information  This deficient pract Maintenance Direct NFPA 101 Sprinkle  Sprinkler System - Where the sprinkle extent and duration determined, areas inspected and risks recommendations or designated reprodepartment and ott jurisdiction have be sprinkler system is hours in a 24-hour of the building affe approved fire watc system has been r 18.3.5.1, 19.3.5.1, This STANDARD Based on docume	cted by the shutdown until the las been returned to service.  DE:  Ween 2:00 PM and 5:00 PM on entation review revealed that Policy for the Fire Alarm ave current Staff/Fire Marshal I.  Lice was verified by the Facility tor.  It System - Out of Service  Out of Service  It system is impaired, the in of the impairment has been or buildings involved are are determined, are submitted to management esentative, and the fire her authorities having the notified. Where the out of service for more than 10 period, the building or portion cted are evacuated or an his provided until the sprinkler	K 346	K 354 The out of service fire sprinkler po	olicy has	3/31/17
		nkler Out of Service Policy. The could affect 44 out of 44		been updated as of 3/13/17 to inc State Fire Marshals□ contact info and the 10 hours out of service up have been done.	rmation	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	IPLE CONSTRUCTION IG <b>01 - Main Building 01</b>	COMPLETED		
		245455	B. WING _		03/0	7/2017
	PROVIDER OR SUPPLIER	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 354	Sprinkler System - Where the sprinkle extent and duration determined, areas inspected and risks recommendations or designated repredepartment and oth jurisdiction have be sprinkler system is 10 hours in a 24-ho portion of the buildi an approved fire was sprinkler system has	Out of Service r system is impaired, the of the impairment has been or buildings involved are are determined, are submitted to management esentative, and the fire her authorities having een notified. Where the out of service for more than our period, the building or ng affected are evacuated or atch is provided until the as been returned to service. 9.7.5, 15.5.2 (NFPA 25)	K 35	54		
K 363 SS=F	03/07/2017, docume the Out of Service System does not he contact information time needs to be up.  This deficient pract Maintenance Direct NFPA 101 Corridor Corridor - Doors 2012 EXISTING Doors protecting correquired enclosure hazardous areas so as those constructions to the Output Doors wood, or capations are so as those constructions wood, or capations are so as the Output Doors wood, or capations are so as the Output Doors wood, or capations are so as the Output Doors wood, or capations are so as the Output Doors wood, or capations are so as the Output Doors wood, or capations with the Output Doors with the	ice was verified by the Facility tor.	K 3	63	·-	3/31/17

Event ID: QLUM21

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245455	B. WING			03/07/2017	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY			60	REET ADDRESS, CITY, STATE, ZIP CODE  1 WEST JACKSON  ACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 363	passage of smoke means suitable for There is no impedi doors. Clearance to floor covering is not latches are prohibit corridor doors and or combustible matcomplying with 7.2 devices that release pulled are permitted of unlimited height meeting 19.3.6.3.6 Door frames shall or other materials the smoke compart window assemblies sprinklered comparestrictions in area frames in window a 19.3.6.3, 42 CFR frank 485 Show in REMARK protection ratings, etc.  This STANDARD Based on observation frames in window a semble sprinklered comparestrictions in area frames in window and 485 Show in REMARK protection ratings, etc.  This STANDARD Based on observation of the compare door openings were in the deficient practice of the compared to ensure door openings were in the compared to ensure door openings were door	only required to resist the . Doors shall be provided with a keeping the door closed. ment to the closing of the between bottom of door and of exceeding 1 inch. Roller ted by CMS regulations on rooms containing flammable terials. Powered doors .1.9 are permissible. Hold open se when the door is pushed or ed. Nonrated protective plates are permitted. Dutch doors are permitted. be labeled and made of steel in compliance with 8.3, unless the time that is sprinklered. Fixed fire is are allowed per 8.3. In retrements there are no or fire resistance of glass or	K	863	K 363 A door inspection template has be added to our audits as of 3/20/17 ensure our smoke doors are inspeand documented to ensure compl with the Annual Fire and Smoke Einspection.	to ected iance	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		245455	B. WING			03/07/2017		
	GOOD SAMARITAN SOCIETY - JACKSON			STREET ADDRESS, CITY, STATE, 601 WEST JACKSON JACKSON, MN 56143	ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE  THE APPROPRIATE	(X5) COMPLETION DATE		
K 363	core wood, or cap 20 minutes. Door compartments are passage of smoke a means suitable There is no imped doors. Clearance floor covering is re latches are prohit corridor doors and or combustible m complying with 7. devices that releas pulled are permitt of unlimited heigh meeting 19.3.6.3. Door frames shal or other materials the smoke compa window assemblic sprinklered comp restrictions in are frames in window 19.3.6.3, 42 CFR and 485 Show in REMARI protection ratings etc.  FINDINGS INCLU On facility tour be 03/07/2017, documented duri Door Inspection p	sted of 1-3/4 inch solid-bonded table of resisting fire for at least as in fully sprinklered smoke to only required to resist the endors shall be provided with for keeping the door closed. It diment to the closing of the between bottom of door and not exceeding 1 inch. Roller bited by CMS regulations on the drooms containing flammable atterials. Powered doors 2.1.9 are permissible. Hold open use when the door is pushed or lead. Nonrated protective plates at are permitted. Dutch doors 6 are permitted. Dutch doors 6 are permitted. I be labeled and made of steel in compliance with 8.3, unless artment is sprinklered. Fixed fire less are allowed per 8.3. In artments there are no a or fire resistance of glass or assemblies.  Parts 403, 418, 460, 482, 483, KS details of doors such as fire, automatics closing devices,  JDE:  Stween 2:00 PM and 5:00 PM on mentation review revealed that and information is being the Annual Fire and Smoke over NFPA 80.	K3	363				
	I his deficient pra	ctice was verified by the Facility	1					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G <b>01 - MAIN BUILDING 01</b>		(X3) DATE SURVEY COMPLETED	
		245455	B. WING _		03/0	7/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	) BE	(X5) COMPLETION DATE
	Evacuation and Real There is a written patients and for the an emergency. Employees are peinformed with their copy of the plan is operator or with sebasic response reand provides for a components per 1 18.7.1.1 through 1 18.7.2.3, 19.7.1.1 19.7.2.2, 19.7.2.3 This STANDARD Based on docume the Facility failed to Relocation Plan ac Code. This deficier 44 residents  Evacuation and Real There is a written patients and for the patients and for the nemergency. Employees are peinformed with their copy of the plan is telephone operator addresses the bas per 18/19.7.2.1.2 a safety plan components. Through 1	elocation Plan blan for the protection of all eir evacuation in the event of riodically instructed and kept duties under the plan, and a readily available with telephone curity. The plan addresses the quired of staff per 18/19.7.2.1.2 Il of the fire safety plan 8/19.2.2. 8.7.1.3, 18.7.2.1.2, 18.7.2.2, through 19.7.1.3, 19.7.2.1.2, is not met as evidenced by: entation review and interview, o maintain a Evacuation and ecording to the 2012 Life Safety at practice could affect 44 of the	K 36		has nclude	3/31/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			COMPLETED	
		245455	B, WING			03/0	07/2017
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - JACKSON			STREET ADDRESS, CITY, STATE, ZIP CODI 601 WEST JACKSON JACKSON, MN 56143			Ē	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 711	Continued From pa	DE:	K	711			
	03/07/2017, docum Facility Fire Emerg	veen 2:00 PM and 5:00 PM on nentation review revealed the ency Plan needs to be updated quirements in the 2012 Life A 101, 19.7.2.2)					
K 920 SS=F	Maintenance Directorica NFPA 101 Electrica	ice was verified by the Facility tor.  al Equipment - Power Cords	K	920			3/31/17
	Extension Cords Power strips in a pused for componer patient-care-related (PCREE) assemble by qualified person 10.2.3.6. Power st may not be used for electronics), excep rooms that do not of PCREE meet UL 1 strips for non-PCR (outside of vicinity) care rooms, power standards. All power precautions. Extension cords us immediately upon which it was install 10.2.4. 10.2.3.6 (NFPA 99)	atient care vicinity are only atient care vicinity are only atient care vicinity are only at of movable delectrical equipment as that have been assembled and meet the conditions of the patient care vicinity or non-PCREE (e.g., personal at in long-term care resident use PCREE. Power strips for 363A or UL 60601-1. Power EE in the patient care rooms meet UL 1363. In non-patient a strips meet other UL are strips are used with general asion cords are not used as a wiring of a structure. Seed temporarily are removed completion of the purpose for ed and meets the conditions of 0, 10.2.4 (NFPA 99), 400-8 D) (NFPA 70), TIA 12-5					

Facility ID: 00303

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A, BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245455	B. WING		03/	07/2017
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - JACKSON			STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 920	Based on observable delectrical Equipm Extension Cords Power strips in a used for compon patient-care-relat (PCREE) assembly qualified personal to the compon patient of the com	is not met as evidenced by: vation and interview, the Facility vith 10.2.4.  9), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5. This could affect 44 of the 44  ment - Power Cords and patient care vicinity are only ents of movable ed electrical equipment bles that have been assembled onnel and meet the conditions of strips in the patient care vicinity for non-PCREE (e.g., personal ept in long-term care resident t use PCREE. Power strips for 1363A or UL 60601-1. Power REE in the patient care rooms y) meet UL 1363. In non-patient er strips meet other UL ower strips are used with general ension cords are not used as a ded wiring of a structure. used temporarily are removed in completion of the purpose for alled and meets the conditions of 19), 10.2.4 (NFPA 99), 400-8 16(D) (NFPA 70), TIA 12-5	K 920	K 920 Extension cord was removed activity room. The power strips removed, electrical boxes add building was audited for comp were reminded about extensic educated at Safety committee 3/28/2017.	s were also led and the liance. Staff on cords and	

Facility ID: 00303

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01		COMPLETED	
		245455	B. WING		03	/07/2017	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - JACKSON				STREET ADDRESS, CITY, STATE, ZIP 601 WEST JACKSON JACKSON, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
K 920	2.)Observation during power strip being up in the family room wobserved plugged in the chapel storage chargers for three splugged into a power strip being up in the chapel storage chargers for three splugged into a power strip being up in the chapel storage chargers for three splugged into a power strip being up in the chapel storage chargers for three splugged into a power strip being up in the chapel storage chargers for three splugged into a power strip being up in the chapel storage chargers for three splugged into a power strip being up in the family room with the chapel storage chargers for three splugged into a power strip being up in the family room with the chapel storage chargers for three splugged into a power strip being up in the chapel storage chargers for three splugged into a power strip being up in the chapel storage chargers for three splugged into a power strip being up in the chapel storage chargers for three splugged into a power strip being up in the chapel storage chargers for three splugged into a power strip being up in the chapel storage chargers for three splugged into a power strip being up in the chapel storage chargers for three splugged into a power strip being up in the chapel storage chargers for three splugged into a power strip being up in the chapel storage chargers for three splugged into a power strip being up in the chapel storage chargers for three splugged into a power strip being up in the chapel storage chargers for three splugged into a power strip being up in the chapel strip three splugged into a power strip being up in the chapel strip three splugged into a power splugged into a power strip three splugged into a power strip three splugged into a power strip three splugged into a power splugged into a power strip three splugged into a power splug	ing used as a source of fixed om.  ing the inspection revealed a sed as a source of fixed wiring where a refrigerator was into a power strip.  ring the inspection revealed a ised as a source of fixed wiring ge room where the battery floor machines were observed fer strip.	KS	920			