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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QLUM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00303

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245455**

2.STATE VENDOR OR MEDICAID NO.
(L2) **673342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - JACKSON**
(L4) **601 WEST JACKSON**
(L5) **JACKSON, MN** (L6) **56143**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/24/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **53** (L18)

13.Total Certified Beds **53** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	53			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 06/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 09/05/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/10/2017
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

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

MDH
Minnesota
Department
of Health

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

MDH
Minnesota
Department
of Health

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).

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

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

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,

Teresa 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=C	"REVISED 2567 as a result of an Informal Dispute Resolution (IDR)" 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:	F 156		3/15/17

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

Electronically Signed | 03/31/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 1 (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State	F 156		

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F 156	Continued From page 2	F 156		

and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for

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F 156	Continued From page 3 information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon	F 156		

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F 156	Continued From page 4	F 156		

admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident

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F 156	Continued From page 5 before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 156		

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F 156	Continued From page 6 Based on interview and record review, the facility failed to ensure the most current Combined Federal and State Bill of Rights (BOR) for Residents in Medicare/Medicaid Certified Skilled Nursing Facilities or Nursing Facilities dated 11/28/16 was provided to the facility residents. This had the potential to affect all 43 residents currently residing in the facility. Findings include: During the initial tour of the facility on 3/6/17 at 11:13 a.m., the Bill of Rights poster hanging on a wall in the facility hallway located between the south and north wings was found by the Director of Nursing to not be the most current BOR which should contain revisions dated 11/28/16. On 3/8/17, at 10:09 a.m. the director of nursing (DON) showed surveyor the Bill of Rights in the facility admission packet given to residents upon admission and confirmed at the time the Combined Federal and Minnesota State Bill of Rights in the admission packet was dated BOR Version had been dated 12/2015. On 3/8/17 at 10:14 a.m. the administrator when asked if he was aware of the most current Bill of Rights dated for the month of 11/2016, stated he was aware there was a more current Bill of Rights. The administrator stated residents had been given the most current BOR but when the BOR given to residents was reviewed it was noted it was not the most current which had been dated 1/2016 and not 11/2017. On 3/8/17, at 2:55 p.m. the administrator stated to surveyor you are right, the most current Bill of Rights is dated 11/2016. The administrator stated	F 156	A new Bill of Rights poster with correct date and information was posted in hallway located between South and North wings. All residents received an updated copy of Resident Rights policy Any time there is a change in Resident Rights facility will notify resident, resident's legal representative or interested family member. All new admission will receive new bill of resident rights. This will be audited by Social services weekly X 4 then monthly X 3 and brought to QAPI for further recommendations.	

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F 156	Continued From page 7 we should have communicated the changes to the residents and we have not done that. The facility Resident Rights Policy dated revised 11/16, Purpose To ensure the resident prompt notification of changes in the resident rights. Policy The location will promptly notify the resident, the resident's legal representative or interested family member when there is a change in resident rights under federal or state law.	F 156		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.	F 167		3/24/17

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F 167	Continued From page 8 (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the location of the current survey results. This had potential to affect all 43 residents, visitors and staff who wished to review this information. Findings include: During the initial tour of the facility on 3/6/17, at 11:35 a.m. the current survey results were observed to be in an 3 ring binder placed in a wall file hanger near the front entrance of the facility. Although the binder included the survey results it was not labeled nor was there a posting to the location. During an interview on 3/7/17, at 7:20 p.m. R38, resident council representative, stated, "Did not know they were available" when asked if R38 knew the location of the CMS2567 with survey results from the last survey. During an interview on 3/8/17, at 10:38 a.m. the administrator verified the survey results were not identified and would be difficult for a resident or visitor to realize the binder in the wall hanger contained the current surveyor results.	F 167	Survey book is labeled and posted at the main entrance to the facility where residents and visitors	
F 170 SS=C	483.10(g)(8)(i)(9)(i)-(iii)(h)(2) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL (g)(8) 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	F 170		3/25/17

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F 170	Continued From page 9 service, including the right to: (i) Privacy of such communications consistent with this section; and (g)(9) communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. (h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure delivery of personal postal mail to residents on Saturdays. This deficient practice had the potential to affect all 43 residents in the facility. Findings include: During interview on 3/8/17 at 9:00 a.m. R38 stated they never get mail delivered on Saturday.	F 170	Post Office was notified to deliver mail on Saturdays. All residents who receive mail on Saturday will be delivered to them Mail was delivered on Saturday 2/25/17 and will continue to be delivered on Saturdays here on out Any Concerns with mail delivery will be	

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F 170	Continued From page 10 During interview on 3/9/17 at 8:42 a.m. registered nurse (RN)-E, activity staff-A and B, stated Saturday mail is never delivered as it stopped when the old administrator was here due to sorting concerns. Interview on 3/9/17 at 9:01 a.m. the administrator was asked about the mail delivery on Saturdays. Administrator stated the mail is delivered to residents every day except Saturday and it has been like that since he was hired due to sorting issues when the past administrator was here. Reviewed the handbook with the administrator, verified the resident handbook revised 10/16 reads on page 27; Your personal mail will be delivered unopened to your room Monday through Saturday, with the exception of holidays. Administrator stated that it is a mistake and agreed 100% that the mail should be delivered on Saturdays. Request of policy regarding mail delivery, none was provided from the facility.	F 170	discussed at resident council, will randomly audit residents regarding mail delivery on Saturdays 2X a month for 3 months and then information obtained discussed at QAPI meeting for further recommendations	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 282	R7 care plan was updated for a	3/31/17

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F 282	Continued From page 11 review, the facility failed to follow the plan of care for 1 of 1 residents (R7) reviewed for non-pressure related skin conditions and failed to follow the care plan for 1 of 3 residents (R49) who was dependent on staff for nail care. Findings include: R7 was observed on 3/6/17, at 3:32 p.m. to have bruises identified on right hand. These bruises were dark purplish in color and varied in size. During an observation of R7's bruises with registered nurse registered nurse (RN)-B on 3/8/17 at 9:51 a.m., R7 was identified to have dark purplish bruises that varied in size on right wrist area. Measurements of the bruises obtained by RN-B at this time and were as noted: Right/wrist: 1) Bruise 2.6 centimeters (cm) by 2 cm 2) Bruise 3.8 cm by 2 cm 3) Bruise 1 cm x 1 cm Review of R7's plan of care with the Last Care plan review completed date of 10/4/14 for skin, (had been updated with information after staff interviewed, 3/8/17) had identified the resident as an actual impairment to the skin integrity due to the use of aspirin. Interventions include; report observations of bruising, weekly skin observation by licensed nurse. Resident needs arm sleeves to protect the skin at all times. Interview on 3/8/17 at 9:47 a.m. with nursing assistant (NA)-B verified R7 has bruises on the right hand and no sleeve protectors were in place. At 9:56 a.m. NA-C stated R7 has bump and bruises, been there for a while, verified no sleeves on.	F 282	non-pressure related skin condition Nurses were educated on process to follow for documenting and monitoring resident skin condition including wearing of arm sleeves as noted on the care plan. Nurse Aides were educated on following R7's care plan to wear arm sleeves. Will audit R7 daily X 1 week to assure arm sleeves are on, then 3 X week for 2 weeks audits will be reviewed by QAPI team for further recommendations. Other residents who have been identified as wearing arm protection will be audited at random weekly for 2 weeks then as determined by QAPI Committee R49 fingernails have been trimmed on both hands All other resident fingernails have been trimmed Nurses and Nurse Aides received education on when nail care should be done, how to mark care record if a resident refuses Audits will be conducted weekly X4, then as determined by QAPI Committee to attain compliance.	

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F 282	Continued From page 12	F 282		

Interview on 3/8/17 at 10:14 a.m. RN-B stated R7 has had bruises for a couple of weeks on right wrist, review of electronic medical record (EMR), confirmed that there is no documentation or monitoring of any bruises on the right wrist for R7 found.

Interview on 3/8/17 at 10:26 a.m. with director of nursing (DON) who explained the process of assessment, monitoring and documenting the bruises. DON said that monitoring and documenting is completed on all residents weekly. DON's expectation would be to follow the care plan.

Request of skin monitoring policy, none was provided by the facility.
R49's care plan print date 3/8/17, indicated bathing: requires one staff assist and personal hygiene: requires one staff assist.

The nursing assistant Kardex report dated 3/8/17, identified R49 required one staff assist for personal hygiene and bathing.

R49 was observed on 3/6//17, at 2:12 p.m. to have long uneven fingernails on both hands. R49 at the time stated their fingernails need to be trimmed and had been looking for nail clippers.

On 3/8/17, at 9:41 a.m. registered nurse (RN)-C observed R49's fingernails on both hands and confirmed R49's fingernails were long and uneven. R49 stated to RN-C at the time, "I need them cut." RN-C informed R49 she would obtain some clippers and trim his nails today. RN-C stated fingernails were to be trimmed on the resident bath days. RN-C reviewed R49

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F 282	Continued From page 13 documentation for having received a bath and stated R49 had refused a bath on 3/5/17, but had received a bath on 3/3/17 and 3/1/17. RN-C stated with R49's bathing frequency of three baths per week R49's fingernails should have been trimmed, there was no excuse for R49's nails not to be trimmed. RN-C stated I have been having trouble with staff trimming the resident nails. RN-C stated the facility does not document refusal of nail care. On 3/7/17, a t 5:35 p.m. nursing assistant (NA)-A stated residents generally have their nails trimmed once a week with baths. Activities would trim nails for resident who had their nails painted. NA-A stated the facility does not document specifically nails had been trimmed and when a resident refuses nail care the facility does not document refusal of the care. On 3/8/17, at 9:48 a.m., RN-A stated R49 required extensive (weight bearing assist) assist with hygiene. On 3/8/17, at 2:03 p.m. the director of nursing stated she would expect nails to be trimmed on bath days and if the resident refuses, attempt to do it again. The facility Comprehensive Care Plan and Care Conferences dated revised 11/16, indicated purpose to provide an ongoing method of assessing, implementing, evaluating and updating the resident's care plan to help maintain the resident's highest level of functioning.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		3/31/17

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F 309	Continued From page 14 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and monitor bruising for 1 of 1 residents (R7) and failed to	F 309	R7 care plan was updated for a non-pressure related skin condition (bruising)	

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F 309	Continued From page 15 ensure monitoring and documentation for treatment of a skin tear for 1 of 3 residents (R41) reviewed for non-pressure related skin concerns. Findings include: R7's significant change Minimum Data Set dated 2/10/17 identified R7 as a 12 which is moderately cognitively impaired. On 3/6/17, at 3:32 p.m. R7 observed to have bruises identified on right hand. These bruises were dark purplish in color and varied in size. During an observation of R7's bruises with registered nurse (RN)-B on 3/8/17 at 9:51 a.m., R7 was identified to have dark purplish bruises that varied in size on right wrist area. Measurements of the bruises obtained by RN-B at this time and were as noted: Right/wrist: 1) Bruise 2.6 centimeters (cm) by 2 cm 2) Bruise 3.8 cm by 2 cm 3) Bruise 1 cm x 1 cm Review of R7's current plan of care with the Last Care plan review completed date of 10/4/14 for skin, (had been updated with information after staff interviewed, 3/8/17) had identified the resident as impairment to the skin integrity due to the use of aspirin. Interventions include; report observations of bruising, weekly skin observation by licensed nurse. Resident needs arm sleeves to protect the skin at all times. Review of R7's progress notes dated, 2/4/17 through 3/4/17 did not identify any new skin areas of concern from her weekly skin check on her right wrist.	F 309	Nurses were educated on process to follow for assessing (gathering data)documenting and monitoring resident skin condition on R7 and any other resident who may have a non-pressure related skin condition. Education was given to follow individual resident care plans. Audit will be done weekly X 4 on R7 to assure bruises are healing and any other 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 resident who has skin related condition.	

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F 309	Continued From page 16	F 309		

Interview on 3/8/17 at 9:47 a.m. with nursing assistant (NA)-B while in therapy working with R7 verified she has bruises on the right hand and no sleeve protectors were in place.

At 9:51 a.m., NA-C stated skin issues reported to charge nurse or can place in their computer system, which is an alert to update the nurses if needed. NA-C finds the information on their computer care plans on how to care for the residents, on bath days nurse is notified to complete skin check either in R7's room or shower room.
At 9:56 a.m. NA-C stated R7 has bump and bruises, been there for a while, verified no sleeves on, was not sure what her care plan read, would have to check. At 10:10 a.m., NA-C stated that she checked the care plan and read R7 is supposed to have sleeves on and now knows that she is to have some on.

Interview on 3/8/17 at 10:14 a.m. RN-B asked regarding any knowledge of skin issues. RN-B stated R7 has had bruises for a couple of weeks on right wrist, placed a note in progress notes, bruises monitored weekly. When RN-C was asked about how staff are aware of changes. RN-B said information is communicated to the next shift or expected to read the progress notes.

Interview and record review with RN-B on 3/8/17 at 10:19 a.m. of electronic medical record (EMR) read 3/4/17 had bath day RN-B stated that she forgot to mention bruises and wish we had a better way to monitor bruises. Review of a calendar RN-B stated that sometimes things get wrote in there to monitor or needs updates. Confirmed that there is no documentation or monitoring of any bruises on the right wrist for R7

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F 309	Continued From page 17 found. Interview on 3/8/17 10:26 a.m. with director of nursing (DON) explained the process of assessment, monitoring and documenting the bruises Monitoring is completed on all residents weekly. DON's expectation would be to follow the care plan. R41 was observed on 3/7/17, at 5:25 p.m. R41's right foot second toe had a white dressing in place. The dressing had no date written on it to identify when the dressing had been changed. On 3/8/17 at 9:47 a.m., R41 was observed to be in the therapy room and had sandals on both feet. R41's right foot second toe had a white dressing in place. The dressing had no date written on the dressing to indicate when the dressing had been changed. R41's resident progress notes identified the following: 2/16/17, while transferring resident, right foot second toe bumped a part of the mechanical lift causing small skin tear to second toe, cleansed and applied primapore bandage. 2/19/17, small skin shear noted to right second toe, applied Vaseline and primapore. Site is clean and scab noted. 2/26/17, skin tear to right foot second toe is intact, no active bleeding, new primapore applied. 3/5/17, skin tear noted to right second toe, scabbed over, no redness or drainage noted. Applied Vaseline and primapore. Will continue to monitor. R41's care plan print date 3/8/17, indicated focus: the resident has potential for pressure ulcer development related to altered mental status,	F 309		

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immobility, incontinence. Interventions included inform resident/family of any new area of skin breakdown. Provide pressure redistribution mattress and cushion to wheelchair. Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. The care plan lacked to identify R41 had a skin tear and interventions related to the skin tear.

R41's Medication and Treatment Administration Record (MAR/TAR) dated for the month of 2/2017 and 3/3017, were reviewed and lacked to include documentation of treatment for the skin tear located on R41's right second toe.

On 3/8/17, at 9:23 a.m., RN-B reviewed R41's physician orders and MAR/TAR and stated R41's record lacked a physician order for the treatment to the skin tear and the treatment for the skin tear was not documented on R41's MAR/TAR. RN-B stated if the treatment was not loaded into the physician orders than the treatment would not be on the MAR/TAR. RN-B stated she had changed the dressing for R41's skin tear due to R41 having a bath and the dressing had become wet.

On 3/8/17, at 12:51 p.m., RN-B asked R41 if she and the surveyor could look at the skin tear on his right second toe. R41 replied no. RN-B stated the dressing R41 currently had on his toe had been applied by her this past weekend. RN-B stated the dressing should be changed every three days.

On 3/8/17, at 1:57 p.m., the director of nursing (DON) stated she would expect staff to document the treatment of R41's skin tear on the TAR, to ensure the skin tear was observed and assessed for healing at least every three days and as

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	245455	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 19 needed. A policy for treatment of skin tears was requested but not provided.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R49) who was dependent on staff for meeting activities of daily living (ADLs) had trimmed fingernails. Findings Include: R49 was observed on 3/6//17, at 2:12 p.m. to have long uneven fingernails on both hands. R49 at the time stated the fingernails need to be trimmed and was looking for a nail clippers. On 3/8/17, at 9:41 a.m. registered nurse (RN)-C observed R49's fingernails on both hands and confirmed R49's fingernails were long and uneven. R49 stated to RN-C at the time, "I need them cut." RN-C informed R49 she would obtain some clippers and trim his nails today. RN-C stated fingernails were to be trimmed on the resident bath days. RN-C reviewed R49 documentation for having received a bath and stated R49 had refused a bath on 3/5/17, but had received a bath on 3/3/17 and 3/1/17. RN-C stated with R49's bathing frequency of three	F 312	R49 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.	3/31/17

REVISED

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F 312	Continued From page 20	F 312		

baths per week R49's fingernails should have been trimmed, there was no excuse for R49's nails not to be trimmed. RN-C stated I have been having trouble with staff trimming the resident nails. RN-C stated the facility does not document refusal of nail care.

R49's quarterly Minimum Data Set (MDS) dated 2/2/17, identified required extensive assist of one for personal hygiene and one person physical assist with bathing.

R49's care plan print date 3/8/17, indicated bathing: requires one staff assist and personal hygiene: requires one staff assist.

The nursing assistant Kardex report dated 3/8/17, identified R49 required one staff assist for personal hygiene and bathing,

The facility bath sheet identified R49 received a bath on Sunday day shift, Wednesday and Friday evening,

On 3/7/17, a t 5:35 p.m. nursing assistant (NA)-A stated residents generally have their nails trimmed once a week with baths. Activities would trim nails for resident who had their nails painted. NA-A stated the facility does not document specifically nails had been trimmed and when a resident refuses nail care the facility does not document refusal of the care.

On 3/8/17, at 9:48 a.m., RN-A stated R49 required extensive (weight bearing assist) assist with hygiene.

On 3/8/17, at 2:03 p.m. the director of nursing stated she would expect nails to be trimmed on

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F 312	Continued From page 21 bath days and if the resident refuses, attempt to do it again. The facility policy Nail Care dated revised 5/16, indicated Purpose To keep nails clean and trimmed to promote well-being, to observe nail condition and to prevent nail discomfort.	F 312		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 334		3/31/17

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F 334	Continued From page 22 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure documentation of education was	F 334	R46, R48, R49. documentation provided and resident continued to refuse vaccine.	

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F 334	Continued From page 23 provided for 3 out of 5 residents (R46, R48 and R49) prior to receiving influenza immunization and for 1 of 5 residents (R46) before receiving the pneumococcal immunization. Findings include: R46's Admission Record dated 3/9/17, identified admission date 9/6/16. R46's update immunization record identified immunization: Influenza. Given: refused. Consent Confirmed Date: 10/25/16. Education provided to Resident/Family: no information documented. Pneumococcal Conjugated (PCV13) and (PPSV23). Given: refused. Consent Confirmed Date: 10/24/16. Education provided to Resident/Family: no information documented. R48's Admission Record dated 3/9/17, identified admission date 9/16/16. R48's update immunization record identified immunization: Influenza. Given: consented. Consent Confirmed Date: 10/25/16. Education provided to Resident/Family: no information documented. R49's Admission Record dated 3/8/17, identified admission date 9/20/16. R49's update immunization record identified immunization: Influenza. Given: refused. Consent Confirmed Date: 10/25/16. Education provided to Resident/Family: no information documented. On 3/9/17, at 10:12 a.m., the director of nursing (DON) confirmed education prior to receiving influenza and pneumococcal immunization had not been documented for R46, R48 and R49. The DON stated I would say it was an oversight. The facility policy Immunizations for Residents	F 334	All residents who are provided education on the Influenza and pneumococcal will have a date listed for the information provided in the medical record. This will be audited in Influenza season and on admission for pneumococcal vaccine. Audits will be submitted to the QAPI team for further recommendations.	

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F 334	Continued From page 24 dated revised 11/16, indicated procedure 1. a. Upon admit each resident and/or resident representative will receive the vaccination information sheets for influenza and pneumococcal vaccines. Discuss the benefits and potential side effects of vaccinations with resident and/or resident representative.	F 334		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 441		3/31/17

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F 441	Continued From page 25 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure analysis and surveillance of infections. This had the potential to affect all 43	F 441	Infection Control logs for all residents as applicable, will include a Data sheet where surveillance, education, actions	

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F 441	Continued From page 26 residents, staff and visitors. Findings include: The facility monthly Infection Control Logs were obtained from 7/11/16 through 2/2017. The logs identified for tracking the date, resident name, wing, infection, treatment, nosocomial, C and S (culture and sensitivity) and miscellaneous. The logs identified the following for urinary tract infections: 7/16 - 1 urinary tract infection (UTI), 2 pneumonia, 1 cellulitis, 1 C-diff (stool infection), 1 eye, 1 cystitis 8/16 - 1 UTI, 1 CAP, 1 cellulitis/skin, 1 C-diff, 1 candidiaysis/skin 9/16 - 4 UTI, 1 aspiration pneumonia, 1 conjunctivitis, 1 skin, 1 URI (upper respiratory infection), 1 cystitis/hematuria 10/16 - 1 UTI, 1 congestion/sore throat, 1 congestion/productive cough, 1 bronchitis/nasal congestion, one temperature/leukocytosis 11/16 - 3 UTI, 1 conjunctivitis, 1 C-diff, 1 congestion, cough, 1 skin 12/16 - 3 UTI, 1 cough, 1 pneumonia, 3 skin 1/17 - 3 UTI, 1 URI, 1 sinusitis, 1 tooth, 1 diarrhea, 1 colitis, 1 pneumonia, 1 tooth abscess, 13 gastroenteritis (the log identified 14 with various signs and symptoms of gastroenteritis, extra cleaning by housekeeping, in north rooms, spoke with medical director, kept to one end of facility with consistent staffing keeping residents in rooms, lasted 1 to 2 days) 2/17 - 1 UTI, 2 upper respiratory infections However, the logs failed to include ongoing surveillance and data analysis to help detect unusual or unexpected outcomes and to	F 441	implemented, monitoring of the actions and effectiveness of the actions which are implemented. The data sheets will be reviewed at QAPI meetings to assure compliance and if change is needed if outcomes desired are not obtained.	

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F 441	Continued From page 27 determine the effectiveness of infection prevention and control practices, documentation of observations related to causes of infection and implementing measures to prevent the transmission of infectious agents (except for the month of 1/17 related to gastroenteritis) and what timely training interventions needed to occur to prevent further infections from developing. On 3/9/17, at 10:32 a.m., the director of nursing verified the logs provided by her which included surveillance lacked documentation of education provided to staff, what actions were implemented, monitoring of the actions and effectiveness of the actions implemented. The DON sated the information may be documented in QA (quality assurance notes) or education provided in meetings held. Additional information was provided, but lacked to include surveillance and analysis as above. The facility policy Infection Prevention and Control Program dated revised 11/16, indicated Policy The infection prevention and control program will attempt to meet federal and state regulations for infection control where applicable. The facility policy Infection Monitoring and Exposure Control Surveillance dated revised 3/16, indicated Background Surveillance is an activity that a healthcare institution employs to find, analyze, control and prevent nosocomial infections. Its definition can further include: collection, collation, analysis of data and passing of information to those who need to know and take action. Once a baseline is established then it can be determined where control is needed. procedure 3. Determine the purpose of the data collection, such as a. Obtain baseline. b.	F 441		

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F 441	Continued From page 28 Determine endemic level of specific organisms. c. Perform routine surveillance activities. d. Identify outbreaks. e. Prevent spread.	F 441		
F 492 SS=D	483.70(b)(c) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD (b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. (c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 492	R55 their demand bill was reviewed at	3/31/17

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F 492	Continued From page 29 facility failed to stop billing for daily stay during the appeals process for 1 of 1 resident (R55) who requested a demand bill. Findings included: R55's record reflects the facility issued the SNF (Skilled Nursing Facility) Determination of Continued Stay on 12/28/16. The SNF indicated R55 had met goals and no longer required skilled level of care. The notice indicated R55 no longer qualified as covered under Medicare beginning 12/31/16 and was signed by R55's beneficiary/representative on 11/12/17. On 3/8/17, at 1:26 p.m., registered nurse (RN)-A stated R55's beneficiary/representative: must have written the wrong date when singing the form. The form identified R55's beneficiary/representative was given verbal notice via phone on 12/29/16. The SNF identified the marked option was marked for "I do want my bill for service I continue to receive to be submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted. You are not required to pay for services which could be covered by Medicare until a Medicare decision has been made." Accounting records reflect payments were received for R55 on 2/16/17 for $1641.68 and on 2/28/17 for $1420.00, confirmed by office manager (OF)-C. On 3/8/17, at 1:37 p.m., OF-C stated it looks like they did not stop billing during the period the resident wanted services reviewed by intermediary. OF-C stated the SNF was scanned into the computer system and the corporate office (who is responsible for billing) should be aware R55 had requested a demand bill.	F 492	corporate level and R55 should not have been billed R55 and any other resident who requests a demand bill of rights will be audited on facility level to assure payment is not requested. Audits will be conducted monthly X2 then reviewed at QAPI for further recommendations	

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F 492	Continued From page 30 The facility policy Medicare Part A Non-Coverage Notifications dated revised 1/17, indicated Policy The provider will follow the regulations to issuance of the notice of non-coverage on the continued stay in order to appropriately inform beneficiaries of demand bill rights. Procedure Specific Delivery Issues If the beneficiary disagrees and asks you to submit a demand bill to the MAC, you may not require, request or accept deposit or other payment from the beneficiary for the services until the MAC makes an initial determination that the services are not covered by Medicare.	F 492		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QLUM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00303

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245455**

2. STATE VENDOR OR MEDICAID NO. (L2) **673342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - JACKSON**
(L4) **601 WEST JACKSON**
(L5) **JACKSON, MN** (L6) **56143**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/09/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

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

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

12.Total Facility Beds **57** (L18)

13.Total Certified Beds **57** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	57			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, HFE NE II 04/05/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/10/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **04/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting	F 156		3/15/17

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

Electronically Signed | 03/31/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 1 personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42	F 156		

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F 156	Continued From page 2 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:	F 156		

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F 156	Continued From page 3 (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and	F 156		

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F 156	Continued From page 4 regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the	F 156		

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F 156	Continued From page 5 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the most current Combined Federal and State Bill of Rights (BOR) for Residents in Medicare/Medicaid Certified Skilled Nursing Facilities or Nursing Facilities dated	F 156	A new Bill of Rights poster with correct date and information was posted in hallway located between South and North wings.	

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F 156	Continued From page 6 11/28/16 was provided to the facility residents. This had the potential to affect all 43 residents currently residing in the facility. Findings include: During the initial tour of the facility on 3/6/17 at 11:13 a.m., the Bill of Rights poster hanging on a wall in the facility hallway located between the south and north wings was found by the Director of Nursing to not be the most current BOR which should contain revisions dated 11/28/16. On 3/8/17, at 10:09 a.m. the director of nursing (DON) showed surveyor the Bill of Rights in the facility admission packet given to residents upon admission and confirmed at the time the Combined Federal and Minnesota State Bill of Rights in the admission packet was dated BOR Version had been dated 12/2015. On 3/8/17 at 10:14 a.m. the administrator when asked if he was aware of the most current Bill of Rights dated for the month of 11/2016, stated he was aware there was a more current Bill of Rights. The administrator stated residents had been given the most current BOR but when the BOR given to residents was reviewed it was noted it was not the most current which had been dated 1/2016 and not 11/2017. On 3/8/17, at 2:55 p.m. the administrator stated to surveyor you are right, the most current Bill of Rights is dated 11/2016. The administrator stated we should have communicated the changes to the residents and we have not done that. The facility Resident Rights Policy dated revised 11/16, Purpose To ensure the resident prompt	F 156	All residents received an updated copy of Resident Rights policy Any time there is a change in Resident Rights facility will notify resident, resident's legal representative or interested family member. All new admission will receive new bill of resident rights. This will be audited by Social services weekly X 4 then monthly X 3 and brought to QAPI for further recommendations.	

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F 156	Continued From page 7 notification of changes in the resident rights. Policy The location will promptly notify the resident, the resident's legal representative or interested family member when there is a change in resident rights under federal or state law.	F 156		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 167	Survey book is labeled and posted at the	3/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - JACKSON	601 WEST JACKSON JACKSON, MN 56143

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F 167	Continued From page 8 review, the facility failed to post the location of the current survey results. This had potential to affect all 43 residents, visitors and staff who wished to review this information. Findings include: During the initial tour of the facility on 3/6/17, at 11:35 a.m. the current survey results were observed to be in an 3 ring binder placed in a wall file hanger near the front entrance of the facility. Although the binder included the survey results it was not labeled nor was there a posting to the location. During an interview on 3/7/17, at 7:20 p.m. R38, resident council representative, stated, "Did not know they were available" when asked if R38 knew the location of the CMS2567 with survey results from the last survey. During an interview on 3/8/17, at 10:38 a.m. the administrator verified the survey results were not identified and would be difficult for a resident or visitor to realize the binder in the wall hanger contained the current surveyor results.	F 167	main entrance to the facility where residents and visitors	
F 170 SS=E	483.10(g)(8)(i)(9)(i)-(iii)(h)(2) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL (g)(8) 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, including the right to: (i) Privacy of such communications consistent with this section; and	F 170		3/25/17

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F 170	Continued From page 9 (g)(9) communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. (h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure delivery of personal postal mail to residents on Saturdays. This deficient practice had the potential to affect all 43 residents in the facility. Findings include: During interview on 3/8/17 at 9:00 a.m. R38 stated they never get mail delivered on Saturday. During interview on 3/9/17 at 8:42 a.m. registered nurse (RN)-E, activity staff-A and B, stated Saturday mail is never delivered as it stopped when the old administrator was here due to sorting concerns.	F 170	Post Office was notified to deliver mail on Saturdays. All residents who receive mail on Saturday will be delivered to them Mail was delivered on Saturday 2/25/17 and will continue to be delivered on Saturdays here on out Any Concerns with mail delivery will be discussed at resident council, will randomly audit residents regarding mail delivery on Saturdays 2X a month for 3 months and then information obtained discussed at QAPI meeting for further	

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F 170	Continued From page 10 Interview on 3/9/17 at 9:01 a.m. the administrator was asked about the mail delivery on Saturdays. Administrator stated the mail is delivered to residents every day except Saturday and it has been like that since he was hired due to sorting issues when the past administrator was here. Reviewed the handbook with the administrator, verified the resident handbook revised 10/16 reads on page 27; Your personal mail will be delivered unopened to your room Monday through Saturday, with the exception of holidays. Administrator stated that it is a mistake and agreed 100% that the mail should be delivered on Saturdays. Request of policy regarding mail delivery, none was provided from the facility.	F 170	recommendations	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 280		3/31/17

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F 280	Continued From page 11 (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 280		

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F 280	Continued From page 12 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to revise the care plan for pain for the administration of as needed (PRN) pain medications for 1 of 5 residents (R49) reviewed for medication use. Findings include: R49 on 3/8/17, at 8:44 a.m., was laid in bed and registered nurse (RN)-C tried to encourage R49 to arise for breakfast. R49 complained of pain in his leg. RN-C asked R49 if she would like some Tylenol and R49 said yes. RN-C then left R49's room to obtain the Tylenol. RN-C stated to surveyor R40 had pain in his left lower leg and he will be giving Tylenol before getting up. It was	F 280	Resident R49 care plan was updated to reflect non-pharmalogical intervention prior to any pain administration All other residents care plans have been reviewed to assure any PRN pain medications have non-pharmalogical interventions listed on their care plans Nurses have been re-educated on updating care plans as resident needs or status changes. Residents who have PRN orders for pain medication will be audited Q 2 weeks X 2 to assure non-pharmalogical interventions	

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F 280	Continued From page 13 noted that RN-C had not offered non-pharmacological intervention before giving Tylenol medication. R49's current care plan failed to address pain so not interventions were developed which at a minimum should have included non-pharmacological interventions to manage pain. R49's Medication Review Report identified an order for Acetaminophen (Tylenol) 500 mg (milligrams) every six hours as needed for pain or fever, start date 9/20/16. Review of the R49's medication administration records (MAR) dated September 2016 through March 2017 revealed: September 2016 received Tylenol PRN two times for right shoulder pain, no non-pharmacological interventions offered prior to administration. October 2016 received Tylenol PRN seven times for cramps legs, generalized pain. Left knee pain. No non--pharmacological interventions offered prior to administration six out of seven times. December 2016 received Tylenol PRN six times for generalized pain. No non-pharmacological interventions offered prior to administration. January 2017 received Tylenol PRN one time for generalized pain. No non-pharmacological interventions offered prior to administration. February 2017 received Tylenol PRN one time for generalized pain. No non-pharmacological interventions offered prior to administration. March 2017 received Tylenol PRN one time for leg cramps. No non-pharmacological interventions offered prior to administration. On 3/8/17, at 9:48 a.m., RN-A confirmed R49's	F 280	have been attempted prior to giving pain medication. These results will be reviewed at the QAPI meeting for further recommendations to assure compliance is sustained.	

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F 280	Continued From page 14	F 280		

current care plan lacked to address pain with interventions. RN-A stated sometimes if managed generalized pain here and there we do not always care plan for pain control, unless more of a focus. I do not care plan pain if I do not think chronic or acute pain. RN-A stated she had not picked up on anything in R49's notes regarding leg pain. At 2:56 p.m., RN-A stated when R49 was first admitted R49's care plan addressed pain due to fracture. RN-A stated pain was removed from R49's care plan in November 2016, because a fracture had resolved. The care plan provided by RN-A for November 2016 identified Focus: resolved, the resident has fracture of right arm post fall (date initiated 9/20/16 and date resolved 11/22/16).

On 3/8/17, at 1:57 p.m., the director of nursing (DON) stated she would expect pain to be addressed with interventions, including non-pharmacological interventions on R49's care plan, if R49 was having pain. The DON stated she would expect non-pharmacological measures to be offered before administration of PRN pain medications unless it was documented that non-pharmacological interventions do not work for the resident.

The facility policy Non-Pharmacological Pain Interventions, dated 2/2017, indicated purpose to use non-pharmacological interventions as identified by the resident to promote comfort. Non-pharmacological interventions should be attempted first; however, in the event they are not successful, they may be combined with pharmacological regimen. Be sure to ask the resident what has worked for him or her in the past.

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F 280	Continued From page 15 The facility Comprehensive Care Plan and Care Conferences dated revised 11/16, indicated procedure 8. c. In addition to updates during a care plan review, care plans must be revised as the resident's needs/status changes.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for 1 of 1 residents (R7) reviewed for non-pressure related skin conditions and failed to follow the care plan for 1 of 3 residents (R49) who was dependent on staff for nail care. Findings include: R7 was observed on 3/6/17, at 3:32 p.m. to have bruises identified on right hand. These bruises were dark purplish in color and varied in size. During an observation of R7's bruises with registered nurse registered nurse (RN)-B on 3/8/17 at 9:51 a.m., R7 was identified to have dark purplish bruises that varied in size on right wrist area. Measurements of the bruises obtained by RN-B at this time and were as noted: Right/wrist:	F 282	R7 care plan was updated for a non-pressure related skin condition Nurses were educated on process to follow for documenting and monitoring resident skin condition including wearing of arm sleeves as noted on the care plan. Nurse Aides were educated on following R7's care plan to wear arm sleeves. Will audit R7 daily X 1 week to assure arm sleeves are on, then 3 X week for 2 weeks audits will be reviewed by QAPI team for further recommendations. Other residents who have been identified as wearing arm protection will be audited at random weekly for 2 weeks then as determined by QAPI Committee R49 fingernails have been trimmed on both hands All other resident fingernails have been	3/31/17

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F 282	Continued From page 16 1) Bruise 2.6 centimeters (cm) by 2 cm 2) Bruise 3.8 cm by 2 cm 3) Bruise 1 cm x 1 cm Review of R7's plan of care with the Last Care plan review completed date of 10/4/14 for skin, (had been updated with information after staff interviewed, 3/8/17) had identified the resident as an actual impairment to the skin integrity due to the use of aspirin. Interventions include; report observations of bruising, weekly skin observation by licensed nurse. Resident needs arm sleeves to protect the skin at all times. Interview on 3/8/17 at 9:47 a.m. with nursing assistant (NA)-B verified R7 has bruises on the right hand and no sleeve protectors were in place. At 9:56 a.m. NA-C stated R7 has bump and bruises, been there for a while, verified no sleeves on. Interview on 3/8/17 at 10:14 a.m. RN-B stated R7 has had bruises for a couple of weeks on right wrist, review of electronic medical record (EMR), confirmed that there is no documentation or monitoring of any bruises on the right wrist for R7 found. Interview on 3/8/17 at 10:26 a.m. with director of nursing (DON) who explained the process of assessment, monitoring and documenting the bruises. DON said that monitoring and documenting is completed on all residents weekly. DON's expectation would be to follow the care plan. Request of skin monitoring policy, none was provided by the facility. R49's care plan print date 3/8/17, indicated	F 282	trimmed Nurses and Nurse Aides received education on when nail care should be done, how to mark care record if a resident refuses Audits will be conducted weekly X4, then as determined by QAPI Committee to attain compliance.	

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bathing: requires one staff assist and personal hygiene: requires one staff assist.

The nursing assistant Kardex report dated 3/8/17, identified R49 required one staff assist for personal hygiene and bathing.

R49 was observed on 3/6//17, at 2:12 p.m. to have long uneven fingernails on both hands. R49 at the time stated their fingernails need to be trimmed and had been looking for nail clippers.

On 3/8/17, at 9:41 a.m. registered nurse (RN)-C observed R49's fingernails on both hands and confirmed R49's fingernails were long and uneven. R49 stated to RN-C at the time, "I need them cut." RN-C informed R49 she would obtain some clippers and trim his nails today. RN-C stated fingernails were to be trimmed on the resident bath days. RN-C reviewed R49 documentation for having received a bath and stated R49 had refused a bath on 3/5/17, but had received a bath on 3/3/17 and 3/1/17. RN-C stated with R49's bathing frequency of three baths per week R49's fingernails should have been trimmed, there was no excuse for R49's nails not to be trimmed. RN-C stated I have been having trouble with staff trimming the resident nails. RN-C stated the facility does not document refusal of nail care.

On 3/7/17, a t 5:35 p.m. nursing assistant (NA)-A stated residents generally have their nails trimmed once a week with baths. Activities would trim nails for resident who had their nails painted. NA-A stated the facility does not document specifically nails had been trimmed and when a resident refuses nail care the facility does not document refusal of the care.

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F 282	Continued From page 18 On 3/8/17, at 9:48 a.m., RN-A stated R49 required extensive (weight bearing assist) assist with hygiene. On 3/8/17, at 2:03 p.m. the director of nursing stated she would expect nails to be trimmed on bath days and if the resident refuses, attempt to do it again. The facility Comprehensive Care Plan and Care Conferences dated revised 11/16, indicated purpose to provide an ongoing method of assessing, implementing, evaluating and updating the resident's care plan to help maintain the resident's highest level of functioning.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including	F 309		3/31/17

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F 309	Continued From page 19 but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and monitor bruising for 1 of 1 residents (R7) and failed to ensure monitoring and documentation for treatment of a skin tear for 1 of 3 residents (R41) reviewed for non-pressure related skin concerns. Findings include: R7's significant change Minimum Data Set dated 2/10/17 identified R7 as a 12 which is moderately cognitively impaired. On 3/6/17, at 3:32 p.m. R7 observed to have bruises identified on right hand. These bruises were dark purplish in color and varied in size. During an observation of R7's bruises with registered nurse (RN)-B on 3/8/17 at 9:51 a.m., R7 was identified to have dark purplish bruises that varied in size on right wrist area. Measurements of the bruises obtained by RN-B at this time and were as noted:	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 resident skin condition on R7 and any other resident who may have a non-pressure related skin condition. Education was given to follow individual resident care plans. Audit will be done weekly X 4 on R7 to assure bruises are healing and any other 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 resident who has skin related condition.	

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F 309	Continued From page 20 Right/wrist: 1) Bruise 2.6 centimeters (cm) by 2 cm 2) Bruise 3.8 cm by 2 cm 3) Bruise 1 cm x 1 cm Review of R7's current plan of care with the Last Care plan review completed date of 10/4/14 for skin, (had been updated with information after staff interviewed, 3/8/17) had identified the resident as impairment to the skin integrity due to the use of aspirin. Interventions include; report observations of bruising, weekly skin observation by licensed nurse. Resident needs arm sleeves to protect the skin at all times. Review of R7's progress notes dated, 2/4/17 through 3/4/17 did not identify any new skin areas of concern from her weekly skin check on her right wrist. Interview on 3/8/17 at 9:47 a.m. with nursing assistant (NA)-B while in therapy working with R7 verified she has bruises on the right hand and no sleeve protectors were in place. At 9:51 a.m., NA-C stated skin issues reported to charge nurse or can place in their computer system, which is an alert to update the nurses if needed. NA-C finds the information on their computer care plans on how to care for the residents, on bath days nurse is notified to complete skin check either in R7's room or shower room. At 9:56 a.m. NA-C stated R7 has bump and bruises, been there for a while, verified no sleeves on, was not sure what her care plan read, would have to check. At 10:10 a.m., NA-C stated that she checked the care plan and read R7 is supposed to have sleeves on and now knows that	F 309		

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GOOD SAMARITAN SOCIETY - JACKSON	601 WEST JACKSON JACKSON, MN 56143

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F 309	Continued From page 21 she is to have some on. Interview on 3/8/17 at 10:14 a.m. RN-B asked regarding any knowledge of skin issues. RN-B stated R7 has had bruises for a couple of weeks on right wrist, placed a note in progress notes, bruises monitored weekly. When RN-C was asked about how staff are aware of changes. RN-B said information is communicated to the next shift or expected to read the progress notes. Interview and record review with RN-B on 3/8/17 at 10:19 a.m. of electronic medical record (EMR) read 3/4/17 had bath day RN-B stated that she forgot to mention bruises and wish we had a better way to monitor bruises. Review of a calendar RN-B stated that sometimes things get wrote in there to monitor or needs updates. Confirmed that there is no documentation or monitoring of any bruises on the right wrist for R7 found. Interview on 3/8/17 10:26 a.m. with director of nursing (DON) explained the process of assessment, monitoring and documenting the bruises Monitoring is completed on all residents weekly. DON's expectation would be to follow the care plan. R41 was observed on 3/7/17, at 5:25 p.m. R41's right foot second toe had a white dressing in place. The dressing had no date written on it to identify when the dressing had been changed. On 3/8/17 at 9:47 a.m., R41 was observed to be in the therapy room and had sandals on both feet. R41's right foot second toe had a white dressing in place. The dressing had no date written on the dressing to indicate when the dressing had been changed.	F 309		

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R41's resident progress notes identified the following:
2/16/17, while transferring resident, right foot second toe bumped a part of the mechanical lift causing small skin tear to second toe, cleansed and applied primapore bandage.
2/19/17, small skin shear noted to right second toe, applied Vaseline and primapore. Site is clean and scab noted.
2/26/17, skin tear to right foot second toe is intact, no active bleeding, new primapore applied.
3/5/17, skin tear noted to right second toe, scabbed over, no redness or drainage noted. Applied Vaseline and primapore. Will continue to monitor.

R41's care plan print date 3/8/17, indicated focus: the resident has potential for pressure ulcer development related to altered mental status, immobility, incontinence. Interventions included inform resident/family of any new area of skin breakdown. Provide pressure redistribution mattress and cushion to wheelchair. Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. The care plan lacked to identify R41 had a skin tear and interventions related to the skin tear.

R41's Medication and Treatment Administration Record (MAR/TAR) dated for the month of 2/2017 and 3/3017, were reviewed and lacked to include documentation of treatment for the skin tear located on R41's right second toe.

On 3/8/17, at 9:23 a.m., RN-B reviewed R41's physician orders and MAR/TAR and stated R41's record lacked a physician order for the treatment

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F 309	Continued From page 23 to the skin tear and the treatment for the skin tear was not documented on R41's MAR/TAR. RN-B stated if the treatment was not loaded into the physician orders than the treatment would not be on the MAR/TAR. RN-B stated she had changed the dressing for R41's skin tear due to R41 having a bath and the dressing had become wet. On 3/8/17, at 12:51 p.m., RN-B asked R41 if she and the surveyor could look at the skin tear on his right second toe. R41 replied no. RN-B stated the dressing R41 currently had on his toe had been applied by her this past weekend. RN-B stated the dressing should be changed every three days. On 3/8/17, at 1:57 p.m., the director of nursing (DON) stated she would expect staff to document the treatment of R41's skin tear on the TAR, to ensure the skin tear was observed and assessed for healing at least every three days and as needed. A policy for treatment of skin tears was requested but not provided.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R49) who was dependent on staff for meeting activities of daily living (ADLs) had trimmed fingernails.	F 312	R49 fingernails have been trimmed on both hands All other resident who needed nail care were cleaned and trimmed	3/31/17

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F 312	Continued From page 24 Findings Include: R49 was observed on 3/6//17, at 2:12 p.m. to have long uneven fingernails on both hands. R49 at the time stated the fingernails need to be trimmed and was looking for a nail clippers. On 3/8/17, at 9:41 a.m. registered nurse (RN)-C observed R49's fingernails on both hands and confirmed R49's fingernails were long and uneven. R49 stated to RN-C at the time, "I need them cut." RN-C informed R49 she would obtain some clippers and trim his nails today. RN-C stated fingernails were to be trimmed on the resident bath days. RN-C reviewed R49 documentation for having received a bath and stated R49 had refused a bath on 3/5/17, but had received a bath on 3/3/17 and 3/1/17. RN-C stated with R49's bathing frequency of three baths per week R49's fingernails should have been trimmed, there was no excuse for R49's nails not to be trimmed. RN-C stated I have been having trouble with staff trimming the resident nails. RN-C stated the facility does not document refusal of nail care. R49's quarterly Minimum Data Set (MDS) dated 2/2/17, identified required extensive assist of one for personal hygiene and one person physical assist with bathing. R49's care plan print date 3/8/17, indicated bathing: requires one staff assist and personal hygiene: requires one staff assist. The nursing assistant Kardex report dated 3/8/17, identified R49 required one staff assist for personal hygiene and bathing,	F 312	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.	

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F 312	Continued From page 25 The facility bath sheet identified R49 received a bath on Sunday day shift, Wednesday and Friday evening, On 3/7/17, a t 5:35 p.m. nursing assistant (NA)-A stated residents generally have their nails trimmed once a week with baths. Activities would trim nails for resident who had their nails painted. NA-A stated the facility does not document specifically nails had been trimmed and when a resident refuses nail care the facility does not document refusal of the care. On 3/8/17, at 9:48 a.m., RN-A stated R49 required extensive (weight bearing assist) assist with hygiene. On 3/8/17, at 2:03 p.m. the director of nursing stated she would expect nails to be trimmed on bath days and if the resident refuses, attempt to do it again. The facility policy Nail Care dated revised 5/16, indicated Purpose To keep nails clean and trimmed to promote well-being, to observe nail condition and to prevent nail discomfort.	F 312		
F 315 SS=E	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 315		3/31/17

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F 315	Continued From page 26 (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) 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. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure documentation of three signs and symptoms of urinary tract infection before using an antibiotic medication for 4 out of 4 residents (R5, R8, R13 and R62) and failed to ensure culture results for 3 of 4 residents (R5, R8 and R62) related to urinary tract infections (UTI) reviewed for antibiotic use. Findings include:	F 315	Residents R5, R8, R13, and R62 labs and urine specimans were ordered by physicians nurses completed the symptomology they saw with the resident after residents were seen by physician. Residents R5, R8, R13, R62 and any other residents identified receiving antibiotics for a urinary tract infection will be audited X 1 month to assure 3 signs	

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F 315	Continued From page 27 The facility infection control logs and resident records identified the following: R5 was on infection control log dated 1/8/17, with urinary tract infection (UTI), treatment Levaquin (antibiotic). Nosocomial yes, UA (urine analysis) obtained in ER (emergency room) C and S (culture and sensitivity): no information documented. The log, R5's record and Infection Control Reporting Form lacked documentation of three signs and symptoms. R5's physician orders identified 1/10/17 discontinue Levaquin 250 mg (milligrams) daily for UTI, start Macrodantin (antibiotic) 100 mg twice daily for seven days. R5's medication administration record (MAR) dated 1/17, identified R5 had received Levaquin and Macrodantin as ordered. The log and R5's record lacked culture results. Culture results were obtained from the clinic after surveyor had requested them on 3/9/17. R8 was on infection control log dated 12/21/16, UTI, treatment Levaquin. Nosocomial yes. C and S: no culture. Misc. (miscellaneous): doctor felt she needed. R8's physician orders identified order on 12/20/16 UA one time only for hallucinations and repeat falls. An order on 12/21/16 identified Levaquin 250 mg daily for 10 days. R8's MAR dated 12/16 identified the Levaquin was given as ordered. The log and R8's record lacked three signs and symptoms and culture results. R13 was on infection control log dated 11/25/16, UTI, treatment Cefdinir (antibiotic). Nosocomial yes. C and S: no information documented. R13 MAR dated 11/16 identified R13 had received Cefdinir 300 mg twice daily for UTI. The log and	F 315	and symptoms of UTI are obtained or as indicated by their physician. Audits will be completed on all resident X 1 month identified with a UTI, then audits will be reviewed by QAPI for further recommendations.	

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F 315	Continued From page 28 R13's record lacked three signs and symptoms to justify the use of an antibiotic. R62 was on infection control log dated 9/2/16, UTI, treatment Levaquin. Nosocomial yes. C and S: no information documented. R62's physician orders identified 9/2/16 Levaquin 250 mg daily for seven days. Urine culture pending. R62's MAR dated 9/16 identified R62 had received the Levaquin as ordered. The log and R62's record lacked three signs and symptoms and culture results. Culture results were obtained from the clinic after surveyor had requested them on 3/9/17. On 3/9/17, at 10:32 a.m., the director of nursing (DON) verified the infection control logs lacked to include documentation of three signs and symptoms and culture results as above for UTI's. The DON stated we have been having trouble with getting culture results from the clinic. A policy for UTI's was requested, but not provided.	F 315		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F 329		3/31/17

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F 329	Continued From page 29 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to offer and document non-pharmacological interventions attempted prior to the administration of as needed (PRN) pain medications for 1 of 5 residents (R49) reviewed for medication use. Findings include: R49's Admission record dated 3/8/17, identified diagnosis of osteoarthritis. R49's quarterly	F 329	Resident R49 care plan was updated to reflect non-pharmalogical intervention prior to any pain administration All other residents care plans have been reviewed to assure any PRN pain medications have non-pharmalogical interventions listed on their care plans Nurses have been re-educated on updating care plans as resident needs or	

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F 329	Continued From page 30 Minimum Data Set (MDS) dated 2/2/17, indicated R49 had moderately impaired cognition and had no pain. On 3/8/17, at 8:44 a.m., R49 was laid in bed and registered nurse (RN)-C tried to encourage R49 to arise for breakfast. R49 complained of pain in his leg. RN-C asked R49 if he would like some Tylenol. RN-C then left R49's room to obtain the Tylenol. RN-C stated to surveyor R40 had pain in his left lower leg and she will be giving him Tylenol and R49 said he would get up after he gets pain pills. No non-pharmacological intervention was offered to R49 for complaints of leg pain. R49's Medication Review Report identified an order for Acetaminophen (Tylenol) 500 mg (milligrams) every six hours as needed for pain or fever, start date 9/20/16. Review of the R49's medication administration records (MAR) dated September 2016 through March 2017 revealed: September 2016 received Tylenol PRN two times for right shoulder pain, no non-pharmacological interventions offered prior to administration. October 2016 received Tylenol PRN seven times for cramps legs, generalized pain. Left knee pain. No non--pharmacological interventions offered prior to administration six out of seven times. December 2016 received Tylenol PRN six times for generalized pain. No non-pharmacological interventions offered prior to administration. January 2017 received Tylenol PRN one time for generalized pain. No non-pharmacological interventions offered prior to administration. February 2017 received Tylenol PRN one time for generalized pain. No non-pharmacological	F 329	status changes Residents who have PRN orders for pain medication will be audited Q 2 weeks X 2 to assure non-pharmalogical interventions have been attempted prior to giving pain medication. Audit results will be reviewed at the QAPI meeting for further recommendations to assure compliance is sustained.	

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interventions offered prior to administration. March 2017 received Tylenol PRN one time for leg cramps. No non-pharmacological interventions offered prior to administration.

R49's Pain Data Collection effective date 2/2/17, indicated Pain management: received non-medication intervention for pain, no. Received PRN pain medications or was offered and declined, no.

On 3/8/17, at 9:48 a.m., registered nurse (RN)-A confirmed R49's current care plan lacked to address pain with interventions. RN-A stated sometimes if managed generalized pain here and there do not always care plan pain, unless more of a focus. I do not care plan pain if I do not think chronic or acute pain. RN-A stated she had not picked up on anything in R49's notes regarding leg pain. At 2:56 p.m., RN-A stated when R49 was first admitted R49's care plan addressed pain due to fracture. RN-A stated pain was removed from R49's care plan in November 2016, because the fracture had resolved. The care plan provided by RN-A for November 2016 identified Focus: resolved, the resident has fracture of right arm post fall (date initiated 9/20/16 and date resolved 11/22/16).

On 3/8/17, at 1:57 p.m., the director of nursing (DON) stated she would expect pain to be addressed with interventions, including non-pharmacological interventions on R49's care plan, if R49 was having pain. The DON stated she would expect non-pharmacological measures to be offered before administration of PRN pain medications unless it was documented that non-pharmacological interventions do not work for the resident.

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F 329	Continued From page 32 The facility policy Non-Pharmacological Pain Interventions, dated 2/17, indicated purpose to use non-pharmacological interventions as identified by the resident to promote comfort. Non-pharmacological interventions should be attempted first; however, in the event they are not successful, they may be combined with pharmacological regimen. Be sure to ask the resident what has worked for him or her in the past.	F 329		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 334		3/31/17

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was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-

(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 34 contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure documentation of education was provided for 3 out of 5 residents (R46, R48 and R49) prior to receiving influenza immunization and for 1 of 5 residents (R46) before receiving the pneumococcal immunization. Findings include: R46's Admission Record dated 3/9/17, identified admission date 9/6/16. R46's update immunization record identified immunization: Influenza. Given: refused. Consent Confirmed Date: 10/25/16. Education provided to Resident/Family: no information documented. Pneumococcal Conjugated (PCV13) and (PPSV23). Given: refused. Consent Confirmed Date: 10/24/16. Education provided to Resident/Family: no information documented. R48's Admission Record dated 3/9/17, identified admission date 9/16/16. R48's update immunization record identified immunization: Influenza. Given: consented. Consent Confirmed Date: 10/25/16. Education provided to Resident/Family: no information documented. R49's Admission Record dated 3/8/17, identified admission date 9/20/16. R49's update immunization record identified immunization: Influenza. Given: refused. Consent Confirmed Date: 10/25/16. Education provided to Resident/Family: no information documented. On 3/9/17, at 10:12 a.m., the director of nursing (DON) confirmed education prior to receiving	F 334	R46, R48, R49. documentation provided and resident continued to refuse vaccine. All residents who are provided education on the Influenza and pneumococcal will have a date listed for the information provided in the medical record. This will be audited in Influenza season and on admission for pneumococcal vaccine. Audits will be submitted to the QAPI team for further recommendations.	

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F 334	Continued From page 35 influenza and pneumococcal immunization had not been documented for R46, R48 and R49. The DON stated I would say it was an oversight. The facility policy Immunizations for Residents dated revised 11/16, indicated procedure 1. a. Upon admit each resident and/or resident representative will receive the vaccination information sheets for influenza and pneumococcal vaccines. Discuss the benefits and potential side effects of vaccinations with resident and/or resident representative.	F 334		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the	F 441		3/31/17

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F 441	Continued From page 36 facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their	F 441		

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F 441	Continued From page 37 program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure analysis and surveillance of infections. This had the potential to affect all 43 residents, staff and visitors. Findings include: The facility monthly Infection Control Logs were obtained from 7/11/16 through 2/2017. The logs identified for tracking the date, resident name, wing, infection, treatment, nosocomial, C and S (culture and sensitivity) and miscellaneous. The logs identified the following for urinary tract infections: 7/16 - 1 urinary tract infection (UTI), 2 pneumonia, 1 cellulitis, 1 C-diff (stool infection), 1 eye, 1 cystitis 8/16 - 1 UTI, 1 CAP, 1 cellulitis/skin, 1 C-diff, 1 candidiaysis/skin 9/16 - 4 UTI, 1 aspiration pneumonia, 1 conjunctivitis, 1 skin, 1 URI (upper respiratory infection), 1 cystitis/hematuria 10/16 - 1 UTI, 1 congestion/sore throat, 1 congestion/productive cough, 1 bronchitis/nasal congestion, one temperature/leukocytosis 11/16 - 3 UTI, 1 conjunctivitis, 1 C-diff, 1 congestion, cough, 1 skin 12/16 - 3 UTI, 1 cough, 1 pneumonia, 3 skin 1/17 - 3 UTI, 1 URI, 1 sinusitis, 1 tooth, 1 diarrhea, 1 colitis, 1 pneumonia, 1 tooth abscess, 13 gastroenteritis (the log identified 14 with various signs and symptoms of gastroenteritis, extra cleaning by housekeeping, in north rooms, spoke with medical director, kept to one end of facility with consistent staffing keeping residents	F 441	Infection Control logs for all residents as applicable, will include a Data sheet where surveillance, education, actions implemented, monitoring of the actions and effectiveness of the actions which are implemented. The data sheets will be reviewed at QAPI meetings to assure compliance and if change is needed if outcomes desired are not obtained.	

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F 441	Continued From page 38 in rooms, lasted 1 to 2 days) 2/17 - 1 UTI, 2 upper respiratory infections However, the logs failed to include ongoing surveillance and data analysis to help detect unusual or unexpected outcomes and to determine the effectiveness of infection prevention and control practices, documentation of observations related to causes of infection and implementing measures to prevent the transmission of infectious agents (except for the month of 1/17 related to gastroenteritis) and what timely training interventions needed to occur to prevent further infections from developing. On 3/9/17, at 10:32 a.m., the director of nursing verified the logs provided by her which included surveillance lacked documentation of education provided to staff, what actions were implemented, monitoring of the actions and effectiveness of the actions implemented. The DON sated the information may be documented in QA (quality assurance notes) or education provided in meetings held. Additional information was provided, but lacked to include surveillance and analysis as above. The facility policy Infection Prevention and Control Program dated revised 11/16, indicated Policy The infection prevention and control program will attempt to meet federal and state regulations for infection control where applicable. The facility policy Infection Monitoring and Exposure Control Surveillance dated revised 3/16, indicated Background Surveillance is an activity that a healthcare institution employs to find, analyze, control and prevent nosocomial infections. Its definition can further include:	F 441		

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F 441	Continued From page 39 collection, collation, analysis of data and passing of information to those who need to know and take action. Once a baseline is established then it can be determined where control is needed. procedure 3. Determine the purpose of the data collection, such as a. Obtain baseline. b. Determine endemic level of specific organisms. c. Perform routine surveillance activities. d. Identify outbreaks. e. Prevent spread.	F 441		
F 492 SS=D	483.70(b)(c) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD (b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. (c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45	F 492		3/31/17

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F 492	Continued From page 40 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to stop billing for daily stay during the appeals process for 1 of 1 resident (R55) who requested a demand bill. Findings included: R55's record reflects the facility issued the SNF (Skilled Nursing Facility) Determination of Continued Stay on 12/28/16. The SNF indicated R55 had met goals and no longer required skilled level of care. The notice indicated R55 no longer qualified as covered under Medicare beginning 12/31/16 and was signed by R55's beneficiary/representative on 11/12/17. On 3/8/17, at 1:26 p.m., registered nurse (RN)-A stated R55's beneficiary/representative: must have written the wrong date when singing the form. The form identified R55's beneficiary/representative was given verbal notice via phone on 12/29/16. The SNF identified the marked option was marked for "I do want my bill for service I continue to receive to be submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted. You are not required to pay for services which could be covered by Medicare until a Medicare decision has been made." Accounting records reflect payments were received for R55 on 2/16/17 for $1641.68 and on 2/28/17 for $1420.00, confirmed by office manager (OF)-C. On 3/8/17, at 1:37 p.m., OF-C stated it looks like they did not stop billing during the period the	F 492	R55 their demand bill was reviewed at corporate level and R55 should not have been billed R55 and any other resident who requests a demand bill of rights will be audited on facility level to assure payment is not requested. Audits will be conducted monthly X2 then reviewed at QAPI for further recommendations	

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F 492	Continued From page 41 resident wanted services reviewed by intermediary. OF-C stated the SNF was scanned into the computer system and the corporate office (who is responsible for billing) should be aware R55 had requested a demand bill. The facility policy Medicare Part A Non-Coverage Notifications dated revised 1/17, indicated Policy The provider will follow the regulations to issuance of the notice of non-coverage on the continued stay in order to appropriately inform beneficiaries of demand bill rights. Procedure Specific Delivery Issues If the beneficiary disagrees and asks you to submit a demand bill to the MAC, you may not require, request or accept deposit or other payment from the beneficiary for the services until the MAC makes an initial determination that the services are not covered by Medicare.	F 492		

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	245455	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/07/2017**

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GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON** **JACKSON, MN 56143**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society Jackson was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to:	K 000	EPOC	

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Jackson was constructed as follows: The original building was constructed in 1956, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type I(332) construction; The 1st Addition was constructed in 1965, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type I(332) construction; The 2nd Addition was constructed in 1976, is one-story, has a partial basement, is fully fire sprinklered protected and was determined to be of Type I(332) construction; The 3rd Addition was constructed in 1996, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type I(332) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the	K 000		

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K 000	Continued From page 2 corridors, which is monitored for automatic fire department notification. The facility has a capacity of 57 beds and had a census of 44 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=E	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. The deficient practice could affect 44 out of 44 residents. Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily	K 345	K 345 The DACT system will be tested during all fire drills and documented. The documentation will be audited for the next quarter ending on 5/30/17 by the environmental services director to ensure compliance.	3/31/17

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K 345	Continued From page 3 available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25. FINDINGS INCLUDE: On facility tour between 2:00 PM and 5:00 PM on 03/07/2016, documentation reviewed revealed that the DACT System was not tested during the 2016 fire drills conducted on the night shift. This deficient practice was verified by the Facility Maintenance Director.	K 345		
K 346 SS=E	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Alarm Out of Service Policy. The deficient practice could affect 44 out of 44 residents. Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all	K 346	K 346 The out of service fire policy for the fire alarm system has been updated to include the State Fire Marshal□s contact information as of 3/13/17.	3/31/17

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K 346	Continued From page 4 parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 FINDINGS INCLUDE: On facility tour between 2:00 PM and 5:00 PM on 03/7/2017, documentation review revealed that the Out of Service Policy for the Fire Alarm System does not have current Staff/Fire Marshal contact information. This deficient practice was verified by the Facility Maintenance Director.	K 346		
K 354 SS=E	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Sprinkler Out of Service Policy. The deficient practice could affect 44 out of 44 residents.	K 354	K 354 The out of service fire sprinkler policy has been updated as of 3/13/17 to include the State Fire Marshals□ contact information and the 10 hours out of service updates have been done.	3/31/17

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GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON** **JACKSON, MN 56143**

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K 354	Continued From page 5 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) FINDINGS INCLUDE: On facility tour between 2:00 PM and 5:00 PM on 03/07/2017, documentation review revealed that the Out of Service Policy for the Fire Sprinkler System does not have current Staff/ Fire Marshal contact information and the 10 hour out of service time needs to be updated. This deficient practice was verified by the Facility Maintenance Director.	K 354		
K 363 SS=F	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke	K 363		3/31/17

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	245455	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/07/2017**

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K 363	Continued From page 6 compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to ensure doors protecting corridor openings were in operable condition. This deficient practice could affect 44 of the 44 residents. Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such	K 363	K 363 A door inspection template has been added to our audits as of 3/20/17 to ensure our smoke doors are inspected and documented to ensure compliance with the Annual Fire and Smoke Door Inspection.	

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	245455	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/07/2017**

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K 363	Continued From page 7 as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. FINDINGS INCLUDE: On facility tour between 2:00 PM and 5:00 PM on 03/07/2017, documentation review revealed that not all the required information is being documented during the Annual Fire and Smoke Door Inspection per NFPA 80. This deficient practice was verified by the Facility	K 363		

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K 363	Continued From page 8 Maintenance Director.	K 363		
K 711 SS=E	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to maintain a Evacuation and Relocation Plan according to the 2012 Life Safety Code.This deficient practice could affect 44 of the 44 residents Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3	K 711	K 711 Our facilities emergency fire plan has been updated as of 3/20/2017 to include all the new requirements of the 2012 LSC.	3/31/17

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K 711	Continued From page 9 FINDINGS INCLUDE: On facility tour between 2:00 PM and 5:00 PM on 03/07/2017, documentation review revealed the Facility Fire Emergency Plan needs to be updated to include all the requirements in the 2012 Life Safety Code. (NFPA 101, 19.7.2.2) This deficient practice was verified by the Facility Maintenance Director.	K 711		
K 920 SS=F	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K 920		3/31/17

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K 920	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to comply with 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5.This deficient practice could affect 44 of the 44 residents. Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 FINDINGS INCLUDE: On facility tour between 2:00 PM and 5:00 PM on 03/07/2017, the following was revealed: 1.)Observation during the inspection revealed an	K 920	K 920 Extension cord was removed from the activity room. The power strips were also removed, electrical boxes added and the building was audited for compliance. Staff were reminded about extension cords and educated at Safety committee on 3/28/2017.	

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K 920	Continued From page 11 extension cord being used as a source of fixed wiring in activity room. 2.)Observation during the inspection revealed a power strip being used as a source of fixed wiring in the family room where a refrigerator was observed plugged into a power strip. 3.) Observation during the inspection revealed a power strip being used as a source of fixed wiring in the chapel storage room where the battery chargers for three floor machines were observed plugged into a power strip. These deficient practices were verified by the Facility Maintenance Director.	K 920		