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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RELC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00575

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245568**
2.STATE VENDOR OR MEDICAID NO.
(L2) **060743600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MARY JANE BROWN**
(L4) **110 SOUTH WALNUT AVENUE**
(L5) **LUVERNE, MN** (L6) **56156**

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 **09/03/2015** (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 **51** (L18)

13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(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 :
Joseph Garvey, HFE NE II 10/05/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/09/2015 (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
07/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 17, 2015

Mr. Philip Samuelson, Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, Minnesota 56156

RE: Project Number S5455026

Dear Mr. Samuelson:

On September 3, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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:

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

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 October 13, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

the deficient practice will not recur;

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 3, 2015 (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 March 3, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Gary Schroeder, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
gary.schroeder@state.mn.us
Telephone: (507) 361-6204

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

(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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278		9/29/15

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

Electronically Signed | 09/29/2015

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

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F 278	Continued From page 1 resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the resident status was accurately reflected on the Minimum Data Set (MDS) assessment for 1 of 1 resident (R17) reviewed for range of motion (ROM) with contractures to the 3rd, 4th, and 5th digits of the left hand. Findings include: On 9/1/15, at 1:25 p.m. R17 was observed seated in her wheelchair (w/c) in bedroom. The 3rd, 4th, and 5th digits of left hand were observed curled inward to the palm of her left hand. When questioned whether she could straighten the identified fingers, R17 stated she was unable and if forced, they would "probably break". R17 was observed to move the 3rd, 4th, and 5th fingertips of the left hand enough to raise them slightly off the palm of her hand while still remaining curled inward. R17 responded that if she moved them any more, it would hurt. R17's quarterly MDS dated 6/23/15, identified R17 had no functional limitations in ROM. However, the occupational therapy (OT) progress and discharge summary dated 12/9/14 identified R17 as having left hand 3rd and 4th digit contractures. The MDS did not accurately reflect	F 278	The MDS for R17 with the ARDs of 12/29/14, 3/30/15 and 6/23/15 were modified to code the limitation of function of the upper extremity. MDS section G400A and G400B were reviewed for all residents identified to have functional range of motion limitations. Education was provided to the RN Case Manager through review of the RAI manual for accurate coding of MDS section G400. Audits will be conducted for accurate functional range of motion coding by comparing the range of motion assessments to the MDS on all signed MDSs for 4 weeks and half of all signed MDSs for 4 weeks by the Director of Nursing or designee. Audits will be reported to the QAPI Committee for review and recommendation. Completion date: September 29, 2015	

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F 278	Continued From page 2 the resident's status at the time of the assessment. When interviewed on 9/3/15, at 11:11 a.m. the MDS coordinator clinical manager (CM)-A stated she had not considered documenting the contracted 3rd, 4th and 5th digits on R17's left hand as a functional limitation on the MDS. CM-A stated R17 was still able to use the left hand even with the 3rd, 4th, and 5th digits curled in and it didn't affect the use of the hand related to activities of daily living. CM-A confirmed that R17 could not voluntarily grasp an object with all the fingers of the left hand and this could limit her functional ability.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		9/29/15

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F 279	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on on observation, interview and document review the facility failed to develop a plan of care which included nutritional interventions for 1 of 2 residents (R21) reviewed who experienced weight loss. Findings include: R21 was admitted to the facility on 3/17/15, and discharged to another skilled nursing facility on 6/1/15. R21 had diagnoses indicated in the physician clinic notes that included: Hypertension, diverticulosis, gastroesophageal reflux, profound dementia with sundowning, anxiety and depression. On admission, 3/17/15, R21 weighed 122 # (pounds), on 4/4/15 weighed 121# and on 5/21/15 weighed 114#. R21 experienced a 7# weight loss or 6.6% of her total body weight in the two months post admission. R21's medical record included a dietician assessment, dated 3/21/15, which identified that R21 had adequate food and fluid for body needs but with a history of insufficient food and fluid. Documentation in the medical record identified a nutritional progress note dated 5/7/15, timed 11:43 a.m. that R21 weighed 113.5 #, a 5% weight loss in the last month. The note further identified R21 was receiving a regular diet. A recommendation in the note indicated R21 should receive calorie dense foods with 8 ounces double strength (DS) chocolate milk BID (twice daily)	F 279	R21 has discharged. All residents with weight loss greater than 5% in 30 days and greater than 10% in 180 days were reviewed on 9-10-15 for appropriate nutrition risk care plans. All licensed nurses were re-educated at a nurses meeting on 9/15/15 on care planning nutrition risk focus, goals, and interventions for residents with weight loss. The DNS was re-educated to document the dietician recommendations in the care plan. All residents will be reviewed for weight loss weekly. Random audits will be completed weekly for 4 weeks and bi-weekly for 4 weeks on 3 residents identified as having an actual weight loss or risk for weight loss for nutrition care plan completion by the Director of Nursing or designee. Audit results will be reported to the QAPI Committee for review and recommendation. Completion date: September 29, 20015	

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 279	Continued From page 4 and between meal snacks. During review of R21's daily meal intake from 5/1/15 thru 6/1/15, the documentation indicated R21 frequently ate 25% or less of her meals and occasionally consumed 26%-50%. The discharge planning documentation dated 6/1/15, indicated: Swallowing/Nutritional Status-(document conditions that affect resident's ability to maintain nutrition and hydration). The notation "None" was documented in this section. No further documentation related to the weight loss experienced during the resident's stay was evident. A physician progress note dated 5/14/15, failed to address any nutrition concerns for R21. R21's care plan, dated 4/2/15, failed to identify any risk factors, goals or interventions for the identified weight loss. The care plan lacked any nutritional concerns. During interview with the director of nursing (DON) on 9/02/15, at 1:49 p.m. she stated she was unable to identify in the record that R21 had a plan of care plan developed after the resident was identified with a 5% weight loss. The DNS verified the dietician had made recommendations for interventions related to weight loss but those interventions were not included in any plan of care. It was also verified R21's nutritional assessment dated 3/21/15, identified that R21 had adequate food and fluid for body needs with a history of insufficient food and fluids.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		9/30/15

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F 282	Continued From page 5 The services provided or arranged by the facility must 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 related to the use of a hand splint for 1 of 1 residents (R17) reviewed for range of motion (ROM), failed to provide personal hygiene/nail care for 1 of 3 residents (R17) reviewed for activities of daily living (ADLS) and failed to provide every 2 hour repositioning per the care plan for 1 of 1 resident (R24) reviewed who was at risk for skin breakdown. Findings include: R17's plan of care dated 6/23/15 included the following: "PERSONAL HYGIENE: Resident requires 1 staff participation with personal hygiene. Resident has contractures of the left hand. "trigger finger"; Provide skin care every AM to keep clean and prevent skin breakdown; and Apply palm protector as resident allows." The occupational therapy (OT) therapist progress and discharge summary note dated 12/9/14 included: "Pt. (patient) fit for L (left) palmar padding/orthotic to prevent skin breakdown resulting from 3rd and 4th digit flexion contracture." The note further indicated: "Caregivers trained on daily wearing schedule with instructions to remove for dressing changes, skin checks, and bathing, to prevent left (L) palmar skin breakdown."	F 282	A new hand splint was made for R17 on 9/3/15. Hand hygiene and nail care was provided to R17 by the Charge Nurse on 9/3/15. The repositioning program for R24 was reviewed by the RN Case Manager on 9/8/15 and changed to reposition every 3 hours based on the Positioning Assessment and Evaluation. No other residents have splints. All residents were observed for clean, trim nails on 9/25/15. All residents were reviewed for at least weakly bath completion. All repositioning programs were re-evaluated by use of the Positioning Assessment and Evaluation by 9/25/15 by the RN Case Manager. Education on the nail care procedure, repositioning procedure, and brace application expectations was provided in a memo to all nursing staff on 9/25/15. Audits for application of splints will be conducted on all residents with splints at various times 3 times per week for 4 weeks and one time per week for 4 weeks by through visualization and documentation of application by the Director of Nursing or Designee. Bathing audits will be completed for all residents weekly for 4 weeks and bi-weekly for 4 weeks by the Director of Nursing or designee. Random nail hygiene audits of	

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	245568	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

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F 282	Continued From page 6 On 8/31/15, at approximately 3:00 p.m. R17 was observed in the dining room with staff and other residents during a social activity. The 3rd, 4th, and 5th digits of R17's left hand were observed to be curled inward towards the palm with no splint device in place. On 9/1/15, at 1:25 p.m. R17 was observed seated in her wheelchair (w/c) in bedroom. The 3rd, 4th, and 5th digits of R17's left hand were observed curled inward toward the palm of her hand, there was no splint device in place. The fingernails on R17's left hand were extremely long. The indentation from the 3rd digit was approximately 1 centimeter deep; the skin was not broken. On 9/1/15, at 7:36 p.m. R17 was observed seated in w/c in her bedroom with the 3rd, 4th, and 5th digits of left hand curled in and no splint device in place. The fingernails on the left hand continued to be long, pressing into the palm of the residents hand leaving skin indentations. On 9/2/15, at 7:44 a.m. nursing assistant (NA)-A was observed assisting R17 with morning (AM) cares. NA-A assisted R17 with personal hygiene and oral care. During the observation R17 was not observed to clean her left hand independently nor was NA-A observed to assist with cleaning the residents left hand or providing nail care. NA-A also did not offer or attempt to obtain a hand splint for R17's left hand. The fingernails on R17's left hand were observed to continue to be long and soiled, pressing into the palm. The resident also continued to have body odor present. During interview immediately following the observation NA-A stated that R17 liked to do as much for herself as she could.	F 282	4 residents will be completed 3 times per week for 4 weeks and weekly for 4 weeks by the Director of Nursing or designee. Random repositioning audits will be completed at various times 3 times per week for 4 weeks and weekly for 4 weeks by Director of Nursing or designee. Audit results will be reported to the QAPI Committee for review and recommendation. Completion date: September 30, 2015.	

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F 282	Continued From page 7 On 9/2/15, at 12:21 p.m. R17 was observed seated in w/c in dining room eating her lunch meal. R17's left hand was observed with the 3rd, 4th, and 5th digits curled inward toward the palm with no splint device in place. On 9/3/15, at 8:47 a.m. R17 was observed lying on back in bed sleeping. R17's left hand was observed with the 3rd, 4th, and 5th digits curled inward toward the palm with no splint device in place. Review of R17's quarterly minimum data set (MDS) assessment dated 6/23/15 included a brief interview for mental status (BIMS) score of 4, indicating severe cognitive impairment. The assessment further indicated the resident required extensive assistance with personal hygiene and bathing. When interviewed on 9/2/15, at 12:46 p.m. NA-C stated being unaware if R17 had any kind of a splint device for her left hand as had never seen one. NA-C confirmed working primarily on the east hallway where R17 resides. When interviewed on 9/3/15, at 8:51 a.m. NA-D confirmed R17 had a splint from therapy with velcro that she wore on her left hand. NA-D stated they would put it on R17 when they could find it but many times the resident would "hide it" from staff. NA-D stated R17 was cooperative with staff applying the splint but the resident was able to remove it independently. NA-D attempted to locate the splint in R17's room but was unable to find it. NA-D stated the splint was usually kept in the resident's dresser or on the white bedside table.	F 282		

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When interviewed on 9/3/15, at 9:05 a.m. licensed practical nurse (LPN)-A stated resident's fingernails are to be trimmed on bath day. LPN-A further stated the NA's could also notify nursing if a resident's nails would need to be trimmed prior to bath day or if assistance from nursing was needed. LPN-A stated being unaware R17 had not received a bath since 8/10/15 and was unsure how baths were tracked on the evening shift. LPN-A also stated being unaware that R17's left hand splint was missing. LPN-A observed R17's left hand and confirmed the 3rd, 4th, and 5th digit fingernails were too long causing indentations into the residents skin. LPN-A further confirmed that staff should be offering the left hand splint to R17 to prevent skin breakdown and assist with cleansing the left hand per the plan of care.

When interviewed on 9/3/15, at 9:40 a.m. the director of nursing (DON) stated she would expect nail care to be provided to residents on bath day and as needed. DON stated being unaware (as documented in the medical record) that R17 had not had a bath since 8/10/15. DON stated if the resident is refusing to bathe she would expect the NA's to notify nursing. DON was unsure why R17's bath "did not occur" on 8/28/15 per charting and would check into it. DON observed R17's fingernails on the left hand and confirmed they were too long and acknowledged the deep impressions the 3rd, 4th, and 5th digit nails had left in the residents palm. DON confirmed expectations that nails should be trimmed and assistance given with cleansing of R17's left hand as well as offering use of the left hand splint per the plan of care.
R24's care plan dated 6/9/15, indicated R24 required turning and repositioning every 2 hours

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and as needed to prevent skin-breakdown due to weakness and fatigue from limited physical mobility.

R24's positioning assessment and evaluation dated 5/28/15, indicated R24 required to be repositioned every 2 hours when in bed and a chair to prevent skin breakdown due to weakness and lethargy.

R24's Braden Scale for predicting pressure sore risk dated 6/20/15, scored a 15 indicating R24 was at mild risk for developing a pressure ulcer and the intervention guide included frequent turning every 2 hours.

During continuous observations on 9/1/15, from 3:02 p.m. to 5:22 p.m. (2 hours and 20 minutes), it was noted that R24 remained lying in bed on her back sleeping.

During continuous observation on 9/2/15, from 9:08 a.m. to 12:02 p.m. (2 hours and 54 minutes) it was again noted that R24 remained lying in bed on her back sleeping.

During an interview on 9/2/15, at 1:51 p.m. nursing assistant (NA)-B stated R24 was to be turned and repositioned every 2 hours and confirmed R24 wasn't repositioned within the 2 hour time frame that morning.

Review of the nursing note and treatment record dated 9/2/15, at 9:20 p.m. indicated Calmoseptine Ointment was applied to R24's coccyx area due to skin irritation.

It was observed on 9/3/15, at 9:11 a.m. that NA-B and NA-C changed R24's incontinent pad and

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F 282	Continued From page 10 there were 2 small reddened areas on the inside of R24's buttocks. NA-C confirmed the reddened areas and applied barrier cream. During an interview on 9/3/15, at 9:15 a.m. clinical manager (CM)-A stated she would expect the NAs to turn and reposition R24 every 2 hours as indicated on the care plan and document if R24 refused cares. During an interview on 9/3/15, at 9:24 a.m. the director of nursing (DON) stated R24 should be repositioned every 2 hours as indicated on the care plan and confirmed it was a concern if this wasn't done. Along with the surveyor on 9/3/15, at 9:50 a.m. the DON and licensed practical nurse (LPN)-A observed the reddened areas on R24's buttocks. The DON confirmed R24 had 2 small reddened areas which could lead to skin breakdown and R24 should be repositioned every 2 hours. Review of the facility's Pressure Ulcer Policy dated September 2012, indicated residents will receive appropriate services to promote and maintain skin integrity.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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	F 312		9/29/15

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F 312	Continued From page 11 by: Based on observation, interview and document review the facility failed to provide nail care and personal hygiene/bathing for 1 of 3 residents (R17) reviewed for activities of daily living (ADL's). Findings include: On 9/1/15, at 1:25 p.m. R17 was observed seated in her wheelchair (w/c) in bedroom. The 3rd, 4th, and 5th digits of R17's left hand were observed curled inward toward the palm of her hand. When questioned whether she could straighten the fingers, R 17 stated she was unable and if forced, they would "probably break". R17 was observed to move the 3rd, 4th, and 5th fingertips of the left hand enough to raise them slightly off the palm of her hand while still remaining curled inward. The fingernails on R17's left hand were extremely long. The fingernails on the 3rd, 4th, and 5th digits were approximately 1.5 centimeters in length and observed to be thick, yellowed, and soiled; leaving indentations in the palm of the residents left hand. The indentation from the 3rd digit was approximately 1 centimeter deep; the skin was not broken. On 9/1/15, at 7:36 p.m. R17 was observed seated in w/c in her bedroom; the fingernails on the left hand continued to be long and soiled with the 3rd, 4th, and 5th digits pressing into the palm of the residents hand leaving indentations. The resident also had a strong body odor present. On 9/2/15, at 7:44 a.m. nursing assistant (NA)-A was observed assisting R17 with morning cares. NA-A provided R17 with a clean, wet washcloth to wash her face. NA-A applied R17's support	F 312	Nail care was provided to R17 by the charge nurse on 9/3/15. R17 received a whirlpool with CNA assistance on 9/3/15. All residents were observed for trim and clean nails on 9/25/15. All residents were reviewed for documentation of at least weekly bathing on 9/21/15. Education on the nail care procedure and bathing schedule expectations was provided in a memo to all nursing staff on 9/25/15. Bathing audits will be completed for all residents weekly for 4 weeks and bi-weekly for 4 weeks. Random nail hygiene audits of 4 random residents will be completed 3 times per week for 4 weeks and weekly for 4 weeks by the Director of Nursing or designee. Audit results will be reported to the QAPI Committee for review and recommendation. Completion date: September 29, 2015.	

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stockings then obtained additional towels and washcloths to assist R17 with washing up for the day. NA-A provided R17 with a clean washcloth and prompted R17 to wash upper body. NA-A washed the resident's back and R17 dried herself with the towel provided. NA-A then assisted R17 with dressing her upper body, assisted her to standing position, provided peri-care, dressed her lower half and assisted her to the w/c. NA-A then assisted R17 with personal hygiene and oral care. During the observation, R17 did not wash/clean her left hand nor did NA-A assist with washing the resident's left hand, nor provide nail care. The fingernails on R17's left hand were noted to remain long and soiled, pressing into the palm. It was noted that body odor remained evident after completion of morning cares.

During interview immediately following the observation on 9/2/15, NA-A stated that R17 liked to do as much for herself as possible. NA-A confirmed that he assisted with washing R17's back and peri-care as R17 independently completed the remaining personal cares.

On 9/3/15, at 8:47 a.m. R17 was observed lying supine in bed asleep. R17's left hand was observed with the 3rd, 4th, and 5th digits curled inward toward the palm and the fingernails remained long, untrimmed and dirty.

Review of R17's quarterly Minimum Data Set (MDS) assessment dated 6/23/15, included a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The assessment further indicated the resident required extensive assistance with personal hygiene and bathing.

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The plan of care dated 6/23/15, indicated R17 required one staff participation with bathing and personal hygiene and included the following: "PERSONAL HYGIENE: Resident requires 1 staff participation with personal hygiene. Resident has contractures of the left hand "trigger finger"; Provide skin care every AM to keep clean and prevent skin breakdown; apply palm protector as resident allows."

Review of the documentation on the follow up question report dated 8/4/15 thru 9/3/15, related to bathing, it indicated R17 received a whirlpool bath on 8/7/15 and 8/10/15. The report further indicated on 8/17/15 "resident refused" a bath, and on 8/27/15 the bath "did not occur". Documentation was lacking to indicate the resident had refused the bath.

When interviewed on 9/2/15, at 1:30 p.m. R17 stated she was unsure whether she ever wore anything on her left hand to prevent her fingers from pressing into her palm. When asked if R17 would allow staff to trim her fingernails on the left hand, she responded affirmatively.

When interviewed on 9/3/15, at 9:05 a.m. licensed practical nurse (LPN)-A stated resident's fingernails were to be trimmed on bath day. LPN-A further stated the NA's could also notify nursing if a resident's nails would need to be trimmed prior to bath day or if assistance from nursing was needed. LPN-A stated being unaware R17 had not received a bath since 8/10/15 and was unsure how baths were tracked when scheduled on the evening shift.
LPN-A observed R17's fingernails on the left hand and confirmed they were too long and were causing indentations into the skin. LPN-A asked

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F 312	Continued From page 14 R17 if she would allow her nails to be trimmed and R17 indicated she would. LPN-A further confirmed that staff should be providing assistance with washing R17's left hand during cares as she was unable. When interviewed on 9/3/15, at 9:40 a.m. the director of nursing (DON) stated she would expect nail care to be provided to residents on bath day and as needed. DON stated being unaware (as documented in the medical record) that R17 had not been bathed since 8/10/15. DON stated if the resident refused bathing she expected the NA's to notify nursing staff. The DON was unsure why R17's bath "did not occur" on 8/28/15 as charted and would follow up. The DON observed R17's fingernails on the left hand and confirmed they were too long and acknowledged the deep impressions the 3rd, 4th, and 5th digit nails had left in the resident's palm. DON confirmed she expected staff to trim nails and help with cleansing of R17's left hand.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314		9/30/15

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F 314	Continued From page 15 Based on observation, interview and document review the facility failed to provide timely repositioning for 1 of 1 resident (R24) reviewed who was identified at risk for pressure ulcer development based on skin and positioning assessments. Findings include: R24's significant change Minimum Data Set (MDS) assessment dated 6/8/15, identified R24 with a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. The MDS further identified R24 required extensive assistance of 2 staff with bed mobility, transfers, toileting, and locomotion and was at risk for the development of pressure ulcers. It identified that R24 was on a turning and repositioning program. R24's positioning assessment and evaluation dated 5/28/15, indicated R24 required to be repositioned every 2 hours when in bed and a chair to prevent skin breakdown due to weakness and lethargy. R24's Braden Scale for predicting pressure sore risk dated 6/20/15, scored a 15 indicating R24 was at mild risk for developing a pressure ulcer and the intervention guide included frequent turning every 2 hours. R24's care plan dated 6/9/15, indicated R24 required turning and repositioning every 2 hours and as needed to prevent skin-breakdown due to weakness and fatigue from limited physical mobility. During continuous observations on 9/1/15, from	F 314	F 314 The repositioning program for R24 was reviewed by the RN Case Manager on 9/8/15. The reposition program was changed to reposition every 3 hours after completion of the Positioning Assessment and Evaluation UDA. Staff was updated of the change through a care plan alert to CNA and nursing dashboard. All repositioning programs were re-evaluated by 9/25/15 by the RN Case Manager. Education on the repositioning procedure was provided in a memo to all nursing staff on 9/25/15. Random repositioning audits will be completed at various times 3 times per week for 4 weeks and weekly for 4 weeks by Director of Nursing or designee. Audit results will be reported to the QAPI Committee for review and recommendation. Completion date: September 30, 2015.	

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3:02 p.m. to 5:22 p.m. (2 hours and 20 minutes), it was noted that R24 remained lying in bed on her back sleeping.

During continuous observation on 9/2/15, from 9:08 a.m. to 12:02 p.m. (2 hours and 54 minutes) it was again noted that R24 remained lying in bed on her back sleeping.

During an interview on 9/2/15, at 1:51 p.m. nursing assistant (NA)-B stated R24 was to be turned and repositioned every 2 hours and confirmed R24 wasn't repositioned within the 2 hour time frame that morning.

Review of the nursing note and treatment record dated 9/2/15, at 9:20 p.m. indicated Calmoseptine Ointment was applied to R24's coccyx area due to skin irritation.

It was observed on 9/3/15, at 9:11 a.m. that NA-B and NA-C changed R24's incontinent pad and there were 2 small reddened areas on the inside of R24's buttocks. NA-C confirmed the reddened areas and applied barrier cream.

During an interview on 9/3/15, at 9:15 a.m. clinical manager (CM)-A stated she would expect the NAs to turn and reposition R24 every 2 hours as indicated on the care plan and document if R24 refused cares.

During an interview on 9/3/15, at 9:24 a.m. the director of nursing (DON) stated R24 should be repositioned every 2 hours as indicated on the care plan and confirmed it was a concern if this wasn't done.

Along with the surveyor on 9/3/15, at 9:50 a.m.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 17 the DON and licensed practical nurse (LPN)-A observed the reddened areas on R24's buttocks. The DON confirmed R24 had 2 small reddened areas which could lead to skin breakdown and R24 should be repositioned every 2 hours. Review of the facility's Pressure Ulcer Policy dated September 2012, indicated residents will receive appropriate assessments and services to promote and maintain skin integrity. Review of the facility's Wound and Pressure Ulcer Management dated May 2015, indicated the program should include a comprehensive management program to prevent development of a pressure ulcer or other skin conditions (Braden, following interventions identified on care plan, nutritional intervention, specialty surfaces, etc.).	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to apply a hand splint to maintain and/or prevent further decrease in range of motion (ROM) for 1 of 1 resident (R17) reviewed with limited range of motion.	F 318	A new hand splint was made and applied on 9/3/15. An extra splint was made. No other residents have hand splints. All charge nurses were educated to make splint application and removal a documentable care plan intervention at a	9/30/15

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F 318	Continued From page 18 Findings include: On 8/31/15, at approximately 3:00 p.m. R17 was observed in the dining room with staff and other residents during a social activity. The 3rd, 4th and 5th digits of R17's left hand were observed to be curled inward towards the palm with no splint device in place. On 9/1/15, at 1:25 p.m. R17 was observed seated in her wheelchair (w/c) in her bedroom. The 3rd, 4th, and 5th digits of R17's left hand were observed curled inward toward the palm of her hand. When questioned by the surveyor if R17 could straighten the fingers; she stated not being able to and if forced to they would "probably break". R17 was observed to move the 3rd, 4th, and 5th fingertips of the left hand enough to raise them slightly off the palm of her hand while still remaining curled inward. R17 stated if she moved them any more, it would hurt. On 9/1/15, at 7:36 p.m. R17 was observed seated in w/c in her bedroom with the 3rd, 4th, and 5th digits of left hand curled in and no splint device in place. On 9/2/15, at 7:44 a.m. nursing assistant (NA)-A was observed assisting R17 with morning (AM) cares. NA-A completed personal hygiene and oral care but did not offer or attempt to obtain a hand splint for R17's left hand. On 9/2/15, at 12:21 p.m. R17 was observed seated in w/c in dining room eating her lunch meal. R17's left hand was observed with the 3rd, 4th, and 5th digits curled inward toward the palm with no evidence of a splint device.	F 318	nurses meeting on 9/18/15. All nursing staff were re-educated on the brace application procedure in a nursing memo dated 9/25/15. Audits for application of splints through visualization and documentation of placement will be conducted on all residents with splints at various times 3 times per week for 4 weeks and one time per week for 4 weeks by the Director of Nursing or designee. Audit Results will be reported to the QAPI Committee for review and recommendation. Completion date: September 30, 2015.	

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F 318	Continued From page 19	F 318		

On 9/3/15, at 8:47 a.m. R17 was observed lying supine in bed asleep. R17's left hand was observed with the 3rd, 4th, and 5th digits curled inward toward the palm with no splint device in place.

The occupational therapy (OT) therapist progress and discharge summary note dated 12/9/14 included: "Pt. (patient) fit for L (left) palmar padding/orthotic to prevent skin breakdown resulting from 3rd and 4th digit flexion contracture." The note further indicated: "Caregivers trained on daily wearing schedule with instructions to remove for dressing changes, skin checks, and bathing, to prevent left (L) palmar skin breakdown."

Review of R17's quarterly Minimum Data Set (MDS) assessment dated 6/23/15, included a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment.

R17's plan of care dated 6/23/15 included the following: "PERSONAL HYGIENE: Resident requires 1 staff participation with personal hygiene. Resident has contractures of the left hand; "trigger finger"; Provide skin care every AM to keep clean and prevent skin breakdown; apply palm protector as resident allows."

When interviewed on 9/2/15, at 12:46 p.m. NA-C stated being unaware whether R17 had any kind of a splint device for her left hand as had never seen one. NA-C confirmed working primarily on the east hallway where R17 resides.

When interviewed on 9/2/15, at 1:30 p.m. R17 stated being unsure of ever wearing anything on her left hand to prevent her fingers from pressing

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F 318	Continued From page 20 into her palm. When interviewed on 9/3/15, at 8:51 a.m. NA-D confirmed R17 had a splint from therapy with velcro that she wore on her left hand. NA-D stated they would put it on R17 when they could locate the splint, but many times the resident would "hide it" from staff. NA-D stated R17 was cooperative with staff applying the splint but R17 was able to remove it independently. NA-D attempted to locate the splint in R17's room but was unable to find it. NA-D stated the splint was usually kept in the resident's dresser and/or on the white bedside table. When interviewed on 9/3/15, at 9:05 a.m. licensed practical nurse (LPN)-A stated being unaware that R17's left hand splint was missing. LPN-A further confirmed that staff should be offering the left hand splint to R17. When interviewed on 9/3/15, at 9:40 a.m. the director of nursing confirmed she would expect staff to offer the use of the left hand splint to R17 per the plan of care. When interviewed on 9/3/15, at 10:26 a.m. the physical therapist (PT) stated being unaware that R17's splint was missing and to his knowledge therapy had not been notified if the splint needed to be replaced. PT stated that he manages the therapy department and would have notified if a replacement needed to be ordered.	F 318		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a	F 325		9/29/15

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F 325	Continued From page 21 resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary nutritional needs based on comprehensive assessment for 1 of 3 residents (R21) reviewed for weight loss. Findings include: R21 was admitted to the facility on 3/17/15, and discharged to another skilled nursing facility on 6/1/15. R21 had diagnoses indicated in the physician clinic notes that included: Hypertension, diverticulosis, hypothyroidism, gastroesophageal reflux, hyperlipidemia, profound dementia with sundowning, anxiety, depression and asthma. On admission, 3/17/15, R21 weighed 122 # (pounds), on 4/4/15 weighed 121# and on 5/21/15 weighed 114#. R21 experienced a 7# weight loss or 6.6% of her total body weight in the two months post admission. R21's medical record included a dietician assessment, dated 3/21/15, which identified that R21 had adequate food and fluid for body needs but with a history of insufficient food and fluid.	F 325	R21 has discharged. All residents with weight loss greater than 5% in 30 days and greater than 10% in 180 days were reviewed on 9/10/15 for appropriate nutrition risk care plans. All licensed nurses re-educated on 9/15/15 on care planning nutrition risk focus, goals, and interventions for residents with weight loss. The dietician will be notified of newly reported weight loss by nursing for evaluation and care plan development. Random audits will be completed weekly for 4 weeks and bi-weekly for 4 weeks on 3 residents identified as having an actual weight loss or risk for weight loss for nutrition care plan completion by the Director of Nursing or designee. Audit results will be reported to the QAPI Committee for review and recommendation. Completion date: September 29, 20015	

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F 325	Continued From page 22	F 325		

Documentation in the medical record identified a nutritional progress note dated 5/7/15, timed 11:43 a.m. that R21 weighed 113.5 #, a 5% weight loss in the last month. The note further identified R21 was receiving a regular diet. A recommendation in the note indicated R21 should receive calorie dense foods with 8 ounces double strength (DS) chocolate milk BID (twice daily) and between meal snacks.

During review of R21's daily meal intake from 5/1/15 thru 6/1/15, the documentation indicated R21 frequently ate 25% or less of her meals and occasionally consumed 26%-50%. The discharge planning documentation dated 6/1/15, indicated: Swallowing/Nutritional Status-(document conditions that affect resident's ability to maintain nutrition and hydration). The notation "None" was documented in this section. No further documentation related to the weight loss experienced during the resident's stay was evident.

A physician progress note dated 5/14/15, failed to address any nutrition concerns for R21.

R21's care plan, dated 4/2/15, failed to identify any risk factors, goals or interventions for the identified weight loss. The care plan lacked any nutritional concerns.

During interview with the director of nursing (DON) on 9/02/15, at 1:49 p.m. she stated she was unable to identify in the record that R21 had a plan of care plan developed after the resident was identified with a 5% weight loss. The DNS verified the dietician had made recommendations for interventions for weight loss but those

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F 325	Continued From page 23 interventions were not included in any care planning. It was also verified R21's nutritional assessment dated 3/21/15, identified that R21 had adequate food and fluid for body needs with a history of insufficient food and fluids.	F 325		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on September 01, 2015. At the time of this survey, Building 01 of Good Samaritan Society Mary J. Brown was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 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 St., Suite 145 St. Paul, MN 55101-5145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/25/2015

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 Facsimile: 651-215-0525, or By email to: Marian.Whitney@state.mn.us and 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. Building 01 of Good Samaritan Society Mary J. Brown was constructed as follows: The original building was constructed in 1959, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1965, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1987, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 3rd Addition was constructed in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire	K 000		

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K 000	Continued From page 2 department notification. The facility has a capacity of 51 beds and had a census of 49 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility had a corridor door which was held open improperly and was not in conformance with NFPA 101 (2000) Chapter 19, Section 19.2.2.2.6 and Chapter 7, Section 7.2.1.8. In a fire emergency, this deficient practice could adversely affect 10 of 49 residents.	K 021	By coordinating with a contractor the facility ensured the installation of magnetic door holders, which would auto-release the doors to the Activity and Therapy rooms when the fire alarm is activated. This correction was implemented and completed by 9/11/15 under the direction of the facility Director of Maintenance,	9/11/15

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K 021	Continued From page 3 FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 09/01/2015, it was observed that the Activity Room and Therapy Room was improperly held-open with a two-piece magnetic door hold open device, which was not electrically interconnected with the building fire alarm system to release upon activation of the fire alarm system. This finding was confirmed with the chief building engineer (DW)at the time of discovery.	K 021	Don Weinkauf.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1.	K 029	The facility, by coordinating with a contractor, ensured that a new door for the nurses station being used for oxygen storage has been ordered. The new door will have an automatic door closer that will latch appropriately and will be compliant with fire rating requirements. The 45	10/20/15

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K 029	Continued From page 4 Findings include: On facility tour between 9:00 AM and 12:00 PM on 09/01/2015, observation revealed that the following was found: 1. The Oxygen Storage Room door does not have an automatic door closer This finding was confirmed with the chief building engineer (DW)at the time of discovery.	K 029	minute fire rating will be noted on a metal plate which will be visible upon inspection. The facility Director of Maintenance, Don Weinkauf, who is responsible for the oversight of this measure, estimates that the door will be delivered by the middle of October 2015, with the installation being completed by 10/20/15.	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. Findings include: On facility tour between 9:00 AM and 12:00 PM	K 050	The facility Director of Maintenance will ensure that moving forward, beginning with the next quarterly required fire drills, that fire drills occur as required and especially at randomized and unexpected times with sufficient lags in the time of day that drills occur. The Facility Director of Maintenance will delegate responsibility for the performance of fire drills in the	9/25/15

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GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**110 SOUTH WALNUT AVENUE LUVERNE, MN 56156**

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K 050	Continued From page 5 on 09/01/2015, the review of the fire drill documentation for the past 12 months (August 2014 to September 2015) revealed the drills for the following shifts did not not sufficiently vary the times that the drills were conducted: a. day-1000, 1300, 1500, and 1330 hours b. evening - 1900, 1500, 1600, and 1500 hours c. night -0500, 2300, 0100, and 2345 hours This finding was confirmed with the chief building engineer (DW)at the time of discovery.	K 050	case of drills occurring during the night shift.	
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based observation and staff interview, the facility failed to properly install Emergency Generators in accordance with the requirements at NFPA 99 (1999 edition) and NFPA 110 (1999 edition). In a fire or other emergency, this deficient practice could adversely affect all 49 residents.. FINDINGS INCLUDE:	K 144	The facility has confirmed that the annunciator panel has an audible alarm on it. The Director of Maintenance will coordinate the relocation of the annunciator panel to a location that is staffed 24 hours a day with Cummins, the organization that services the generator, and/or an electrician as necessary. This	10/9/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/01/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**110 SOUTH WALNUT AVENUE** **LUVERNE, MN 56156**

(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
K 144	Continued From page 6 On facility tour between 9:00 AM and 12:00 PM on 09/01/2015, during an inspection of the emergency generator annunciator panel it was determined that the annunciator panel was not located in a manned 24 hour staff area. It also could not be determined that the panel had an audible alarm that would alert staff in the event of generator trouble. This finding was confirmed with the chief building engineer (DW)at the time of discovery.	K 144	will be completed in approximately two weeks, by 10/9/15.	
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 9:00 AM and 12:00 PM on 09/01/2015, observation and documentation	K 154	To become compliant with this standard, the facility now has a documented procedure located in the Emergency Procedures binder titled ¿Fire Protection Systems Out of Service.¿ This document outlines the protocol for implementing a fire watch procedure in the event that the sprinkler system is out of commission for a period of 4 hours or more within a 24 hour period. This deficiency was immediately corrected after surveyors	9/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/01/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**110 SOUTH WALNUT AVENUE LUVERNE, MN 56156**

(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
K 154	Continued From page 7 reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This finding was confirmed with the chief building engineer (DW)at the time of discovery.	K 154	exited the facility. The current Fire Watch Protocol is based on resources provided by the State of MN Fire Marshal. In the event that the Director of Maintenance is not present to institute a fire watch, this duty will be that of the Facility Administrator.	
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 9:00 AM and 12:00 PM on 09/01/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This finding was confirmed with the chief building engineer (DW)at the time of discovery.	K 155	To become compliant with this standard, the facility now has a documented procedure located in the Emergency Procedures binder titled ¿Fire Protection Systems Out of Service.¿ This document outlines the protocol for implementing a fire watch procedure in the event that the fire alarm system is out of commission for a period of 4 hours or more within a 24 hour period. This deficiency was immediately corrected after surveyors exited the facility. The current Fire Watch Protocol is based on resources provided by the State of MN Fire Marshal. In the event that the Director of Maintenance is not present to institute a fire watch, this duty will be that of the Facility	9/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/01/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**110 SOUTH WALNUT AVENUE** **LUVERNE, MN 56156**

(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
K 155	Continued From page 8	K 155	Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**09/01/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**110 SOUTH WALNUT AVENUE LUVERNE, MN 56156**

(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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on September 01, 2015. At the time of this survey, Building 02 of Good Samaritan Society Mary J. Brown was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 18 New 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 St., Suite 145 St. Paul, MN 55101-5145	K 000	EPOC	

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

Electronically Signed | 09/25/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**09/01/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**110 SOUTH WALNUT AVENUE LUVERNE, MN 56156**

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K 000	Continued From page 1 Facsimile: 651-215-0525, or By email to: Marian.Whitney@state.mn.us and 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. Building 02 of Good Samaritan Society Mary J. Brown consists of the 2011 building addition, which includes a new main entrance, offices, conference room and beauty shop. Building 02 is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II (111) construction. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 51 beds and had a census of 49 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**09/01/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**110 SOUTH WALNUT AVENUE LUVERNE, MN 56156**

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K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. Findings include: On facility tour between 9:00 AM and 12:00 PM on 09/01/2015, the review of the fire drill documentation for the past 12 months (August 2014 to September 2015) revealed the drills for the following shifts did not not sufficiently vary the times that the drills were conducted: a. day-1000, 1300, 1500, and 1330 hours b. evening - 1900, 1500, 1600, and 1500 hours c. night -0500, 2300, 0100, and 2345 hours This finding was confirmed with the chief building engineer (DW)at the time of discovery.	K 050	The facility Director of Maintenance will ensure that moving forward, beginning with the next quarterly required fire drills, that fire drills occur as required and especially at randomized and unexpected times with sufficient lags in the time of day that drills occur. The Facility Director of Maintenance will delegate responsibility for the performance of fire drills in the case of drills occurring during the night shift.	9/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**09/01/2015**

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K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based observation and staff interview, the facility failed to properly install Emergency Generators in accordance with the requirements at NFPA 99 (1999 edition) and NFPA 110 (1999 edition). In a fire or other emergency, this deficient practice could adversely affect all 49 residents.. FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 09/01/2015, during an inspection of the emergency generator announciator panel it was determined that the annunciator panel was not located in a manned 24 hour staff area. It also could not be determined that the panel had an audible alarm that would alert staff in the event of generator trouble. This finding was confirmed with the chief building engineer (DW)at the time of discovery.	K 144	The facility has confirmed that the annunciator panel has an audible alarm on it. The Director of Maintenance will coordinate the relocation of the annunciator panel to a location that is staffed 24 hours a day with Cummins, the organization that services the generator, and/or an electrician as necessary. This will be completed in approximately two weeks, by 10/9/15.	10/9/15
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left	K 154		9/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**09/01/2015**

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K 154	Continued From page 4 unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 9:00 AM and 12:00 PM on 09/01/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This finding was confirmed with the chief building engineer (DW)at the time of discovery.	K 154	To become compliant with this standard, the facility now has a documented procedure located in the Emergency Procedures binder titled ¿Fire Protection Systems Out of Service.¿ This document outlines the protocol for implementing a fire watch procedure in the event that the sprinkler system is out of commission for a period of 4 hours or more within a 24 hour period. This deficiency was immediately corrected after surveyors exited the facility. The current Fire Watch Protocol is based on resources provided by the State of MN Fire Marshal. In the event that the Director of Maintenance is not present to institute a fire watch, this duty will be that of the Facility Administrator.	
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period,	K 155	To become compliant with this standard, the facility now has a documented	9/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**09/01/2015**

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K 155	Continued From page 5 the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 9:00 AM and 12:00 PM on 09/01/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This finding was confirmed with the chief building engineer (DW)at the time of discovery.	K 155	procedure located in the Emergency Procedures binder titled ¿Fire Protection Systems Out of Service.¿ This document outlines the protocol for implementing a fire watch procedure in the event that the fire alarm system is out of commission for a period of 4 hours or more within a 24 hour period. This deficiency was immediately corrected after surveyors exited the facility. The current Fire Watch Protocol is based on resources provided by the State of MN Fire Marshal. In the event that the Director of Maintenance is not present to institute a fire watch, this duty will be that of the Facility Administrator.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
September 17, 2015

Mr. Philip Samuelson, Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, Minnesota 56156

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5455026

Dear Mr. Samuelson:

The above facility was surveyed on August 31, 2015 through September 3, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00575	A. BUILDING: _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BF	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00575	A. BUILDING: _____ B. WING _____	09/03/2015

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On August 31st, September 1st, 2nd and 3rd surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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GOOD SAMARITAN SOCIETY - MARY JANE BF	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on on observation, interview and document review the facility failed to develop a plan of care which included nutritional interventions for 1 of 2 residents (R21) reviewed who experienced weight loss. Findings include: R21 was admitted to the facility on 3/17/15, and discharged to another skilled nursing facility on 6/1/15. R21 had diagnoses indicated in the physician clinic notes that included: Hypertension, diverticulosis, gastroesophageal reflux, profound dementia with sundowning, anxiety and depression. On admission, 3/17/15, R21 weighed 122 #	2 560	No POC Needed	9/29/15

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2 560	Continued From page 3 (pounds), on 4/4/15 weighed 121# and on 5/21/15 weighed 114#. R21 experienced a 7# weight loss or 6.6% of her total body weight in the two months post admission. R21's medical record included a dietician assessment, dated 3/21/15, which identified that R21 had adequate food and fluid for body needs but with a history of insufficient food and fluid. Documentation in the medical record identified a nutritional progress note dated 5/7/15, timed 11:43 a.m. that R21 weighed 113.5 #, a 5% weight loss in the last month. The note further identified R21 was receiving a regular diet. A recommendation in the note indicated R21 should receive calorie dense foods with 8 ounces double strength (DS) chocolate milk BID (twice daily) and between meal snacks. During review of R21's daily meal intake from 5/1/15 thru 6/1/15, the documentation indicated R21 frequently ate 25% or less of her meals and occasionally consumed 26%-50%. The discharge planning documentation dated 6/1/15, indicated: Swallowing/Nutritional Status-(document conditions that affect resident's ability to maintain nutrition and hydration). The notation "None" was documented in this section. No further documentation related to the weight loss experienced during the resident's stay was evident. A physician progress note dated 5/14/15, failed to address any nutrition concerns for R21. R21's care plan, dated 4/2/15, failed to identify any risk factors, goals or interventions for the identified weight loss. The care plan lacked any nutritional concerns.	2 560		

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2 560	Continued From page 4 During interview with the director of nursing (DON) on 9/02/15, at 1:49 p.m. she stated she was unable to identify in the record that R21 had a plan of care plan developed after the resident was identified with a 5% weight loss. The DNS verified the dietician had made recommendations for interventions related to weight loss but those interventions were not included in any plan of care. It was also verified R21's nutritional assessment dated 3/21/15, identified that R21 had adequate food and fluid for body needs with a history of insufficient food and fluids. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure the policy and procedures are reviewed, revised as needed, staff trained and systems assessed, monitored and evaluated to assure the comprehensive plan of care is developed and lists measurable objectives and timetables to meet each residents individual needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	2 565	No Written POC Needed	9/29/15

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2 565	Continued From page 5	2 565		

review the facility failed to follow the plan of care related to the use of a hand splint for 1 of 1 residents (R17) reviewed for range of motion (ROM), failed to provide personal hygiene/nail care for 1 of 3 residents (R17) reviewed for activities of daily living (ADLS) and failed to provide every 2 hour repositioning per the care plan for 1 of 1 resident (R24) reviewed who was at risk for skin breakdown.

Findings include:

R17's plan of care dated 6/23/15 included the following: "PERSONAL HYGIENE: Resident requires 1 staff participation with personal hygiene. Resident has contractures of the left hand. "trigger finger"; Provide skin care every AM to keep clean and prevent skin breakdown; and Apply palm protector as resident allows."

The occupational therapy (OT) therapist progress and discharge summary note dated 12/9/14 included: "Pt. (patient) fit for L (left) palmar padding/orthotic to prevent skin breakdown resulting from 3rd and 4th digit flexion contracture." The note further indicated: "Caregivers trained on daily wearing schedule with instructions to remove for dressing changes, skin checks, and bathing, to prevent left (L) palmar skin breakdown."

On 8/31/15, at approximately 3:00 p.m. R17 was observed in the dining room with staff and other residents during a social activity. The 3rd, 4th, and 5th digits of R17's left hand were observed to be curled inward towards the palm with no splint device in place.

On 9/1/15, at 1:25 p.m. R17 was observed seated in her wheelchair (w/c) in bedroom. The 3rd, 4th,

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2 565	Continued From page 6	2 565		

and 5th digits of R17's left hand were observed curled inward toward the palm of her hand, there was no splint device in place. The fingernails on R17's left hand were extremely long. The indentation from the 3rd digit was approximately 1 centimeter deep; the skin was not broken.

On 9/1/15, at 7:36 p.m. R17 was observed seated in w/c in her bedroom with the 3rd, 4th, and 5th digits of left hand curled in and no splint device in place. The fingernails on the left hand continued to be long, pressing into the palm of the residents hand leaving skin indentations.

On 9/2/15, at 7:44 a.m. nursing assistant (NA)-A was observed assisting R17 with morning (AM) cares. NA-A assisted R17 with personal hygiene and oral care. During the observation R17 was not observed to clean her left hand independently nor was NA-A observed to assist with cleaning the residents left hand or providing nail care. NA-A also did not offer or attempt to obtain a hand splint for R17's left hand. The fingernails on R17's left hand were observed to continue to be long and soiled, pressing into the palm. The resident also continued to have body odor present. During interview immediately following the observation NA-A stated that R17 liked to do as much for herself as she could.

On 9/2/15, at 12:21 p.m. R17 was observed seated in w/c in dining room eating her lunch meal. R17's left hand was observed with the 3rd, 4th, and 5th digits curled inward toward the palm with no splint device in place.

On 9/3/15, at 8:47 a.m. R17 was observed lying on back in bed sleeping. R17's left hand was observed with the 3rd, 4th, and 5th digits curled inward toward the palm with no splint device in

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2 565	Continued From page 7 place. Review of R17's quarterly minimum data set (MDS) assessment dated 6/23/15 included a brief interview for mental status (BIMS) score of 4, indicating severe cognitive impairment. The assessment further indicated the resident required extensive assistance with personal hygiene and bathing. When interviewed on 9/2/15, at 12:46 p.m. NA-C stated being unaware if R17 had any kind of a splint device for her left hand as had never seen one. NA-C confirmed working primarily on the east hallway where R17 resides. When interviewed on 9/3/15, at 8:51 a.m. NA-D confirmed R17 had a splint from therapy with velcro that she wore on her left hand. NA-D stated they would put it on R17 when they could find it but many times the resident would "hide it" from staff. NA-D stated R17 was cooperative with staff applying the splint but the resident was able to remove it independently. NA-D attempted to locate the splint in R17's room but was unable to find it. NA-D stated the splint was usually kept in the resident's dresser or on the white bedside table. When interviewed on 9/3/15, at 9:05 a.m. licensed practical nurse (LPN)-A stated resident's fingernails are to be trimmed on bath day. LPN-A further stated the NA's could also notify nursing if a resident's nails would need to be trimmed prior to bath day or if assistance from nursing was needed. LPN-A stated being unaware R17 had not received a bath since 8/10/15 and was unsure how baths were tracked on the evening shift. LPN-A also stated being unaware that R17's left hand splint was missing. LPN-A observed R17's	2 565		

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2 565	Continued From page 8	2 565		

left hand and confirmed the 3rd, 4th, and 5th digit fingernails were too long causing indentations into the residents skin. LPN-A further confirmed that staff should be offering the left hand splint to R17 to prevent skin breakdown and assist with cleansing the left hand per the plan of care.

When interviewed on 9/3/15, at 9:40 a.m. the director of nursing (DON) stated she would expect nail care to be provided to residents on bath day and as needed. DON stated being unaware (as documented in the medical record) that R17 had not had a bath since 8/10/15. DON stated if the resident is refusing to bathe she would expect the NA's to notify nursing. DON was unsure why R17's bath "did not occur" on 8/28/15 per charting and would check into it. DON observed R17's fingernails on the left hand and confirmed they were too long and acknowledged the deep impressions the 3rd, 4th, and 5th digit nails had left in the residents palm. DON confirmed expectations that nails should be trimmed and assistance given with cleansing of R17's left hand as well as offering use of the left hand splint per the plan of care.

R24's care plan dated 6/9/15, indicated R24 required turning and repositioning every 2 hours and as needed to prevent skin-breakdown due to weakness and fatigue from limited physical mobility.

R24's positioning assessment and evaluation dated 5/28/15, indicated R24 required to be repositioned every 2 hours when in bed and a chair to prevent skin breakdown due to weakness and lethargy.

R24's Braden Scale for predicting pressure sore risk dated 6/20/15, scored a 15 indicating R24

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2 565	Continued From page 9 was at mild risk for developing a pressure ulcer and the intervention guide included frequent turning every 2 hours. During continuous observations on 9/1/15, from 3:02 p.m. to 5:22 p.m. (2 hours and 20 minutes), it was noted that R24 remained lying in bed on her back sleeping. During continuous observation on 9/2/15, from 9:08 a.m. to 12:02 p.m. (2 hours and 54 minutes) it was again noted that R24 remained lying in bed on her back sleeping. During an interview on 9/2/15, at 1:51 p.m. nursing assistant (NA)-B stated R24 was to be turned and repositioned every 2 hours and confirmed R24 wasn't repositioned within the 2 hour time frame that morning. Review of the nursing note and treatment record dated 9/2/15, at 9:20 p.m. indicated Calmoseptine Ointment was applied to R24's coccyx area due to skin irritation. It was observed on 9/3/15, at 9:11 a.m. that NA-B and NA-C changed R24's incontinent pad and there were 2 small reddened areas on the inside of R24's buttocks. NA-C confirmed the reddened areas and applied barrier cream. During an interview on 9/3/15, at 9:15 a.m. clinical manager (CM)-A stated she would expect the NAs to turn and reposition R24 every 2 hours as indicated on the care plan and document if R24 refused cares. During an interview on 9/3/15, at 9:24 a.m. the director of nursing (DON) stated R24 should be repositioned every 2 hours as indicated on the	2 565		

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2 565	Continued From page 10 care plan and confirmed it was a concern if this wasn't done. Along with the surveyor on 9/3/15, at 9:50 a.m. the DON and licensed practical nurse (LPN)-A observed the reddened areas on R24's buttocks. The DON confirmed R24 had 2 small reddened areas which could lead to skin breakdown and R24 should be repositioned every 2 hours. Review of the facility's Pressure Ulcer Policy dated September 2012, indicated residents will receive appropriate services to promote and maintain skin integrity. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility develops care plans according to the residents individualized needs. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance with providing cares as directed by the care plan.. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. .	2 565		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:	2 840		9/29/15

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2 840	Continued From page 11 B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors.	2 840		

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2 840	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide personal hygiene/bathing for 1 of 3 residents (R17) reviewed for activities of daily living (ADL's). Findings include: On 9/1/15, at 1:25 p.m. R17 was observed seated in her wheelchair (w/c) in bedroom. The 3rd, 4th, and 5th digits of R17's left hand were observed curled inward toward the palm of her hand. On 9/1/15, at 7:36 p.m. R17 was observed seated in w/c in her bedroom and a strong body odor present. On 9/2/15, at 7:44 a.m. nursing assistant (NA)-A was observed assisting R17 with morning cares. NA-A provided R17 with a clean, wet washcloth to wash her face. NA-A applied R17's support stockings then obtained additional towels and washcloths to assist R17 with washing up for the day. NA-A provided R17 with a clean washcloth and prompted R17 to wash upper body. NA-A washed the resident's back and R17 dried herself with the towel provided. NA-A then assisted R17 with dressing her upper body, assisted her to standing position, provided peri-care, dressed her lower half and assisted her to the w/c. NA-A then assisted R17 with personal hygiene and oral care. During the observation, R17 did not wash/clean her left hand nor did NA-A assist with washing the resident's left hand. It was noted that body odor remained evident after completion of morning cares. During interview immediately following the observation on 9/2/15, NA-A stated that R17 liked	2 840	No Written POC Needed	

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2 840	Continued From page 13 to do as much for herself as possible. NA-A confirmed that he assisted with washing R17's back and peri-care as R17 independently completed the remaining personal cares. Review of R17's quarterly Minimum Data Set (MDS) assessment dated 6/23/15, included a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The assessment further indicated the resident required extensive assistance with personal hygiene and bathing. The plan of care dated 6/23/15, indicated R17 required one staff participation with bathing and included the following: "PERSONAL HYGIENE: Resident requires 1 staff participation with personal hygiene. Provide skin care every AM to keep clean and prevent skin breakdown." Review of the documentation on the follow up question report dated 8/4/15 thru 9/3/15, related to bathing, it indicated R17 received a whirlpool bath on 8/7/15 and 8/10/15. The report further indicated on 8/17/15 "resident refused" a bath, and on 8/27/15 the bath "did not occur". Documentation was lacking to indicate the resident had refused the bath. When interviewed on 9/3/15, at 9:05 a.m. licensed practical nurse (LPN)-A stated being unaware R17 had not received a bath since 8/10/15 and was unsure how baths were tracked when scheduled on the evening shift. When interviewed on 9/3/15, at 9:40 a.m. the director of nursing (DON) stated being unaware per the medical record that R17 had not had a bath since 8/10/15. DON stated if the resident is refusing to bathe she would expect the NA's to	2 840		

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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) COMPLETE DATE
2 840	Continued From page 14 notify nursing. DON was unsure why R17's bath "did not occur" on 8/28/15 per charting and would check into it. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review policies and procedures and revise as needed, to assure residents are free from offensive odors. A bathing plan could be developed as part of each resident's plan of care. The DON could conduct audits to assure each resident is being bathed as needed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide nail care for 1 of 3 residents (R17) reviewed for activities of daily living (ADL's). Findings include: On 9/1/15, at 1:25 p.m. R17 was observed seated in her wheelchair (w/c) in bedroom. The 3rd, 4th, and 5th digits of R17's left hand were observed	2 860	No Written POC Needed	9/29/15

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2 860	Continued From page 15	2 860		

curled inward toward the palm of her hand. The fingernails on R17's left hand were extremely long. The fingernails on the 3rd, 4th, and 5th digits were approximately 1.5 centimeters in length and observed to be thick, yellowed, and soiled; leaving indentations in the palm of the residents left hand. The indentation from the 3rd digit was approximately 1 centimeter deep; the skin was not broken.

On 9/1/15, at 7:36 p.m. R17 was observed seated in w/c in her bedroom; the fingernails on the left hand continued to be long and soiled with the 3rd, 4th, and 5th digits pressing into the palm of the residents hand leaving indentations.

On 9/2/15, at 7:44 a.m. nursing assistant (NA)-A was observed assisting R17 with morning cares. During the observation, R17 did not wash/clean her left hand nor did NA-A assist with washing the resident's left hand, nor provide nail care. The fingernails on R17's left hand were noted to remain long and soiled, pressing into the palm.

On 9/3/15, at 8:47 a.m. R17 was observed lying supine in bed asleep. R17's left hand was observed with the 3rd, 4th, and 5th digits curled inward toward the palm and the fingernails remained long, untrimmed and dirty.

Review of R17's quarterly Minimum Data Set (MDS) assessment dated 6/23/15, included a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The assessment further indicated the resident required extensive assistance with personal hygiene.

The plan of care dated 6/23/15, indicated R17 required one staff participation with personal

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2 860	Continued From page 16 hygiene and included the following: "PERSONAL HYGIENE: Resident requires 1 staff participation with personal hygiene. Resident has contractures of the left hand "trigger finger"; When interviewed on 9/2/15, at 1:30 p.m. R17 was asked if she would allow staff to trim her fingernails on the left hand, she responded affirmatively. When interviewed on 9/3/15, at 9:05 a.m. licensed practical nurse (LPN)-A stated resident's fingernails were to be trimmed on bath day. LPN-A further stated the NA's could also notify nursing if a resident's nails would need to be trimmed prior to bath day or if assistance from nursing was needed. LPN-A observed R17's fingernails on the left hand and confirmed they were too long and were causing indentations into the skin. LPN-A asked R17 if she would allow her [LPN-A]to trim her nails and R17 indicated she would. When interviewed on 9/3/15, at 9:40 a.m. the director of nursing (DON) stated she would expect nail care to be provided to residents on bath day and as needed. DON observed R17's fingernails on the left hand and confirmed they were too long and acknowledged the deep impressions the 3rd, 4th, and 5th digit nails had left in the residents palm. DON confirmed expectations that nails should be trimmed. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could in-service all staff on performing activities of daily living including finger nail care for residents. The director of nursing or designee could schedule audits to monitor for compliance.	2 860		

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2 860	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to apply a hand splint to maintain and/or prevent further decrease in range of motion (ROM) for 1 of 1 resident (R17) reviewed with limited range of motion. Findings include: On 8/31/15, at approximately 3:00 p.m. R17 was observed in the dining room with staff and other residents during a social activity. The 3rd, 4th and 5th digits of R17's left hand were observed to be curled inward towards the palm with no splint device in place. On 9/1/15, at 1:25 p.m. R17 was observed seated	2 895	No Written POC Needed	9/29/15

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2 895	Continued From page 18	2 895		

in her wheelchair (w/c) in her bedroom. The 3rd, 4th, and 5th digits of R17's left hand were observed curled inward toward the palm of her hand. When questioned by the surveyor if R17 could straighten the fingers; she stated not being able to and if forced to they would "probably break". R17 was observed to move the 3rd, 4th, and 5th fingertips of the left hand enough to raise them slightly off the palm of her hand while still remaining curled inward. R17 stated if she moved them any more, it would hurt.

On 9/1/15, at 7:36 p.m. R17 was observed seated in w/c in her bedroom with the 3rd, 4th, and 5th digits of left hand curled in and no splint device in place.

On 9/2/15, at 7:44 a.m. nursing assistant (NA)-A was observed assisting R17 with morning (AM) cares. NA-A completed personal hygiene and oral care but did not offer or attempt to obtain a hand splint for R17's left hand.

On 9/2/15, at 12:21 p.m. R17 was observed seated in w/c in dining room eating her lunch meal. R17's left hand was observed with the 3rd, 4th, and 5th digits curled inward toward the palm with no evidence of a splint device.

On 9/3/15, at 8:47 a.m. R17 was observed lying supine in bed asleep. R17's left hand was observed with the 3rd, 4th, and 5th digits curled inward toward the palm with no splint device in place.

The occupational therapy (OT) therapist progress and discharge summary note dated 12/9/14 included: "Pt. (patient) fit for L (left) palmar padding/orthotic to prevent skin breakdown resulting from 3rd and 4th digit flexion

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2 895	Continued From page 19	2 895		

contracture." The note further indicated: "Caregivers trained on daily wearing schedule with instructions to remove for dressing changes, skin checks, and bathing, to prevent left (L) palmar skin breakdown."

Review of R17's quarterly Minimum Data Set (MDS) assessment dated 6/23/15, included a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment.

R17's plan of care dated 6/23/15 included the following: "PERSONAL HYGIENE: Resident requires 1 staff participation with personal hygiene. Resident has contractures of the left hand; "trigger finger"; Provide skin care every AM to keep clean and prevent skin breakdown; apply palm protector as resident allows."

When interviewed on 9/2/15, at 12:46 p.m. NA-C stated being unaware whether R17 had any kind of a splint device for her left hand as had never seen one. NA-C confirmed working primarily on the east hallway where R17 resides.

When interviewed on 9/2/15, at 1:30 p.m. R17 stated being unsure of ever wearing anything on her left hand to prevent her fingers from pressing into her palm.

When interviewed on 9/3/15, at 8:51 a.m. NA-D confirmed R17 had a splint from therapy with velcro that she wore on her left hand. NA-D stated they would put it on R17 when they could locate the splint, but many times the resident would "hide it" from staff. NA-D stated R17 was cooperative with staff applying the splint but R17 was able to remove it independently. NA-D attempted to locate the splint in R17's room but was unable to find it. NA-D stated the splint was

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2 895	Continued From page 20 usually kept in the resident's dresser and/or on the white bedside table. When interviewed on 9/3/15, at 9:05 a.m. licensed practical nurse (LPN)-A stated being unaware that R17's left hand splint was missing. LPN-A further confirmed that staff should be offering the left hand splint to R17. When interviewed on 9/3/15, at 9:40 a.m. the director of nursing confirmed she would expect staff to offer the use of the left hand splint to R17 per the plan of care. When interviewed on 9/3/15, at 10:26 a.m. the physical therapist (PT) stated being unaware that R17's splint was missing and to his knowledge therapy had not been notified if the splint needed to be replaced. PT stated that he manages the therapy department and would have notified if a replacement needed to be ordered. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk of a decline in range of motion. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be	2 905		9/29/15

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2 905	Continued From page 21 positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely repositioning for 1 of 1 resident (R24) reviewed who was identified at risk for pressure ulcer development based on skin and positioning assessments. Findings include: R24's significant change Minimum Data Set (MDS) assessment dated 6/8/15, identified R24 with a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. The MDS further identified R24 required extensive assistance of 2 staff with bed mobility, transfers, toileting, and locomotion and was at risk for the development of pressure ulcers. It identified that R24 was on a turning and repositioning program. R24's positioning assessment and evaluation dated 5/28/15, indicated R24 required to be repositioned every 2 hours when in bed and a chair to prevent skin breakdown due to weakness and lethargy. R24's Braden Scale for predicting pressure sore risk dated 6/20/15, scored a 15 indicating R24	2 905	No Written POC Needed	

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2 905	Continued From page 22 was at mild risk for developing a pressure ulcer and the intervention guide included frequent turning every 2 hours. R24's care plan dated 6/9/15, indicated R24 required turning and repositioning every 2 hours and as needed to prevent skin-breakdown due to weakness and fatigue from limited physical mobility. During continuous observations on 9/1/15, from 3:02 p.m. to 5:22 p.m. (2 hours and 20 minutes), it was noted that R24 remained lying in bed on her back sleeping. During continuous observation on 9/2/15, from 9:08 a.m. to 12:02 p.m. (2 hours and 54 minutes) it was again noted that R24 remained lying in bed on her back sleeping. During an interview on 9/2/15, at 1:51 p.m. nursing assistant (NA)-B stated R24 was to be turned and repositioned every 2 hours and confirmed R24 wasn't repositioned within the 2 hour time frame that morning. Review of the nursing note and treatment record dated 9/2/15, at 9:20 p.m. indicated Calmoseptine Ointment was applied to R24's coccyx area due to skin irritation. It was observed on 9/3/15, at 9:11 a.m. that NA-B and NA-C changed R24's incontinent pad and there were 2 small reddened areas on the inside of R24's buttocks. NA-C confirmed the reddened areas and applied barrier cream. During an interview on 9/3/15, at 9:15 a.m. clinical manager (CM)-A stated she would expect the NAs to turn and reposition R24 every 2 hours as	2 905		

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2 905	Continued From page 23 indicated on the care plan and document if R24 refused cares. During an interview on 9/3/15, at 9:24 a.m. the director of nursing (DON) stated R24 should be repositioned every 2 hours as indicated on the care plan and confirmed it was a concern if this wasn't done. Along with the surveyor on 9/3/15, at 9:50 a.m. the DON and licensed practical nurse (LPN)-A observed the reddened areas on R24's buttocks. The DON confirmed R24 had 2 small reddened areas which could lead to skin breakdown and R24 should be repositioned every 2 hours. Review of the facility's Pressure Ulcer Policy dated September 2012, indicated residents will receive appropriate assessments and services to promote and maintain skin integrity. Review of the facility's Wound and Pressure Ulcer Management dated May 2015, indicated the program should include a comprehensive management program to prevent development of a pressure ulcer or other skin conditions (Braden, following interventions identified on care plan, nutritional intervention, specialty surfaces, etc.). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could train all staff on ensuring each resident receives turning and repositioning assistance according to their assessed need. The DON or designee could then perform observational audits to determine compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 905		

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2 965	Continued From page 24	2 965		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure that assessed nutritional approaches were implemented and monitored for effectiveness to prevent further weight loss for 1 of 2 residents (R21) reviewed who experienced unplanned weight loss. Findings include: R21 was admitted to the facility on 3/17/15, and discharged to another skilled nursing facility on 6/1/15. R21 had diagnoses indicated in the physician clinic notes that included: Hypertension, diverticulosis, hypothyroidism, gastroesophageal reflux, hyperlipidemia, profound dementia with sundowning, anxiety, depression and asthma. On admission, 3/17/15, R21 weighed 122 # (pounds), on 4/4/15 weighed 121# and on 5/21/15 weighed 114#. R21 experienced a 7# weight loss or 6.6% of her total body weight in the two months post admission. R21's medical record included a dietician	2 965	No Written POC Needed	9/29/15

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2 965	Continued From page 25 assessment, dated 3/21/15, which identified that R21 had adequate food and fluid for body needs but with a history of insufficient food and fluid. Documentation in the medical record identified a nutritional progress note dated 5/7/15, timed 11:43 a.m. that R21 weighed 113.5 #, a 5% weight loss in the last month. The note further identified R21 was receiving a regular diet. A recommendation in the note indicated R21 should receive calorie dense foods with 8 ounces double strength (DS) chocolate milk BID (twice daily) and between meal snacks. During review of R21's daily meal intake from 5/1/15 thru 6/1/15, the documentation indicated R21 frequently ate 25% or less of her meals and occasionally consumed 26%-50%. The discharge planning documentation dated 6/1/15, indicated: Swallowing/Nutritional Status-(document conditions that affect resident's ability to maintain nutrition and hydration). The notation "None" was documented in this section. No further documentation related to the weight loss experienced during the resident's stay was evident. A physician progress note dated 5/14/15, failed to address any nutrition concerns for R21. R21's care plan, dated 4/2/15, failed to identify any risk factors, goals or interventions for the identified weight loss. The care plan lacked any nutritional concerns. During interview with the director of nursing (DON) on 9/02/15, at 1:49 p.m. she stated she was unable to identify in the record that R21 had a plan of care developed after the resident was identified with a 5% weight loss. The DNS verified	2 965		

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2 965	Continued From page 26 the dietician had made recommendations for nutritional interventions related to the unplanned weight loss but the interventions were not included in any care planning. It was also verified that R21's nutritional assessment dated 3/21/15, identified that R21 had adequate food and fluid for body needs with a history of insufficient food and fluids. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise current policies and procedures related to weight loss and residents nutritionally at risk. The administrator or designee could educate responsible staff on the policy changes as well as audit to ensure all current recommendations are being carried out within the dietary department. The administrator or designee could conduct audits for compliance and review with the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		