#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID:	RELC	
Fac	Htv ID: 00575	

		10 22 00::111		112 0 111	I BOOK ( BI HOB! ( O I		ruemity ib. occ.re	
MEDICARE/MEDICAID PROVID     (L1) 245568  2.STATE VENDOR OR MEDICAID		3. NAME AND AI (L3) <b>GOOD SAM</b> (L4) <b>110 SOUTH</b>	IARITAN SO	CIETY - M	IARY JANE BROWN	4. TYPE OF ACT  1. Initial  3. Termination	TION: <u>2 (</u> L8)  2. Recertification 4. CHOW	
(L2) <b>060743600</b>		(L5) LUVERNE,	MN		(L6) <b>56156</b>	5. Validation	6. Complaint	
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey A	9. Other fter Complaint	
6. DATE OF SURVEY 09/0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	<b>)3/2015</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR EN	DING DATE: (L35)	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia	nce With		And/Or Approved Waivers O	f The Following Require	ements:	
To (b):			equirements e Based On:		2. Technical Personne 3. 24 Hour RN	6. Scope of		
12.Total Facility Beds	<b>51</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural Si 5. Life Safety Code		oom Size	
13.Total Certified Beds	<b>51</b> (L17)	X B. Not in Con Requireme	npliance with Pro ents and/or Appl			9. Beds/Ro	эш	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
51					<b>3</b> , ( )			
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENC	Y APPROVAL	Date:	
Joseph Garvey, H	Joseph Garvey, HFE NE II 10/05/2015			(L19)	Kamala Fiske-Downing	, Enforcement Sp	ecialist 10/09/2015 (L20)	
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	L OFFICE OR SINGLE S	STATE AGENCY		
19. DETERMINATION OF ELIGIBI	LITY		IPLIANCE WITI	H CIVIL	21. 1. Statement of Fina			
1. Facility is Eligible to	Participate	RIGHTS ACT:			<ol> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol>			
2. Facility is not Eligible	e (L21)							
22. ORIGINAL DATE	23. LTC AGREEI	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	I:	(L30)	
OF PARTICIPATION	BEGINNING		ENDING DA		VOLUNTARY 0		UNTARY	
07/01/1991					01-Merger, Closure	<del></del>	to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburg	sement 06-Fail	to Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminati	on <u>OTHE</u>	<u> </u>	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-1100	rider Status Change	
(L27)	D Di1 C-		(L44)			00-Acti	ve	
. ,	B. Rescind St	aspension Date:	(L45)					
28. TERMINATION DATE:	29	). INTERMEDIARY/			30. REMARKS			
		00140						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAI	DATE				
	(L32)			(L33)	DETERMINATION APP	PROVAL		
						-		



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;

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

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

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

#### DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc\_idr.cfm</a>

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

Kamala Fishe Downing

Health Regulation Division Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 10/05/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245568	B. WING _		09	/03/2015
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN		STREET ADDRESS, CITY, STATE, 2 110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 000		of correction (POC) will serve	F 0	00		
	Department's acce enrolled in ePOC, y at the bottom of the	of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.				
F 278 SS=D	on-site revisit of you validate that substate regulations has been your verification. 483.20(g) - (j) ASS	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with ESSMENT	F 2	78		9/29/15
33=D		ust accurately reflect the				
	A registered nurse each assessment v participation of hea					
	A registered nurse assessment is com	must sign and certify that the pleted.				
		o completes a portion of the sign and certify the accuracy of assessment.				
	willfully and knowin false statement in a subject to a civil mo \$1,000 for each ass willfully and knowin	d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a				
_ABORATOR\	   DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

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

(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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S COMPL	
		245568	B. WING		09/03	3/2015
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN	1	TREET ADDRESS, CITY, STATE, ZIP CODE  10 SOUTH WALNUT AVENUE  .UVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETION DATE
F 278	penalty of not more assessment.  Clinical disagreeme material and false s  This REQUIREMED by: Based on observareview the facility fastatus was accurated bata Set (MDS) as (R17) reviewed for contractures to the left hand.  Findings include:  On 9/1/15, at 1:25 in her wheelchair (vand 5th digits of left inward to the palm questioned whether identified fingers, Fif forced, they would observed to move to the left hand end the palm of her har inward. R17 respons any more, it would R17's quarterly MD	ent does not constitute a statement.  NT is not met as evidenced tion, interview and document ailed to ensure the resident ely reflected on the Minimum sessment for 1 of 1 resident range of motion (ROM) with 3rd, 4th, and 5th digits of the p.m. R17 was observed seated w/c) in bedroom. The 3rd, 4th, t hand were observed curled of her left hand. When r she could straighten the R17 stated she was unable and d "probably break". R17 was the 3rd, 4th, and 5th fingertips ough to raise them slightly off and while still remaining curled nded that if she moved them	F 278	,	enction ere to Case S te y ned gned of	
	However, the occup and discharge sum R17 as having left	pational therapy (OT) progress mary dated 12/9/14 identified hand 3rd and 4th digit				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245568	B. WING			09/	03/2015
	ROVIDER OR SUPPLIER	- MARY JANE BROWN		11	FREET ADDRESS, CITY, STATE, ZIP CODE  0 SOUTH WALNUT AVENUE  UVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279 SS=D	MDS coordinator clishe had not conside contracted 3rd, 4th hand as a functional stated R17 was still with the 3rd, 4th, and didn't affect the use activities of daily livicould not voluntarily fingers of the left has functional ability.  483.20(d), 483.20(k) COMPREHENSIVE A facility must use to develop, review a comprehensive plan. The facility must deplan for each reside objectives and time medical, nursing, and needs that are idental assessment.  The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any selective to the residents due to the residents.	on 9/3/15, at 11:11 a.m. the inical manager (CM)-A stated ered documenting the and 5th digits on R17's left all limitation on the MDS. CM-A able to use the left hand even and 5th digits curled in and it of the hand related to ng. CM-A confirmed that R17 or grasp an object with all the and and this could limit her and and this could limit her and revise the resident's in of care.  Velop a comprehensive care ent that includes measurable tables to meet a resident's ind mental and psychosocial tified in the comprehensive  describe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise exercise of rights under he right to refuse treatment	F2				9/29/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMI	SURVEY PLETED
		245568	B. WING		09/0	03/2015
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN	1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH WALNUT AVENUE .UVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 279	Continued From pa	ige 3	F 279			
	by: Based on on obset document review the plan of care which is interventions for 1 c who experienced w. Findings include: R21 was admitted the discharged to anoth 6/1/15. R21 had disphysician clinic note diverticulosis, gastre dementia with sund depression. On admission, 3/17 (pounds), on 4/4/15 weighed 114#. R2-or 6.6% of her total months post admis R21's medical reco assessment, dated R21 had adequate but with a history of Documentation in the nutritional progress 11:43 a.m. that R21 weight loss in the laidentified R21 was recommendation in receive calorie density.	of 2 residents (R21) reviewed reight loss.  To the facility on 3/17/15, and her skilled nursing facility on agnoses indicated in the less that included: Hypertension, roesophageal reflux, profound downing, anxiety and  T/15, R21 weighed 122 # To weighed 121# and on 5/21/15 To experienced a 7# weight loss body weight in the two		R21 has discharged. All residents with weight loss great 5% in 30 days and greater than 10 180 days were reviewed on 9-10-1 appropriate nutrition risk care plan All licensed nurses were re-educat nurses meeting on 9/15/15 on care planning nutrition risk focus, goals interventions for residents with welloss. The DNS was re-educated to document the dietician recomment in the care plan. All residents will be reviewed for wloss weekly. Random audits will be completed weekly for 4 weeks and bi-weekly for 4 weeks on 3 resider identified as having an actual weig or risk for weight loss for nutrition of plan completion by the Director of or designee. Audit results will be reto the QAPI Committee for review recommendation. Completion date: September 29, 2	% in 5 for s. ed at a e , and ght dations eight e ht loss care Nursing eported and	

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245568	B. WING _		09/	03/2015
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN		STREET ADDRESS, CITY, STATE, ZIP CODE  110 SOUTH WALNUT AVENUE  LUVERNE, MN 56156	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	and between meal standards and between meal standards are standards and between meal standards are s	21's daily meal intake from the documentation indicated 25% or less of her meals and med 26%-50%. The discharge ation dated 6/1/15, indicated: nal Status-(document ct resident's ability to maintain ion). The notation "None" was section. No further ted to the weight loss the resident's stay was  25 s note dated 5/14/15, failed to on concerns for R21.  26 ted 4/2/15, failed to identify als or interventions for the iss. The care plan lacked any interventions for the ify in the record that R21 had developed after the resident a 5% weight loss. The DNS in had made recommendations ated to weight loss but those not included in any plan of perified R21's nutritional 3/21/15, identified that R21 and fluid for body needs with	F 27	79		
F 282 SS=D	483.20(k)(3)(ii) SEF	RVICES BY QUALIFIED	F 28	32		9/30/15

	OF DEFICIENCIES OF CORRECTION			SURVEY PLETED		
		245568	B. WING		09/0	3/2015
	PROVIDER OR SUPPLIER	′ - MARY JANE BROWN	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH WALNUT AVENUE .UVERNE, MN 56156	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	The services provi	age 5 ded or arranged by the facility by qualified persons in ach resident's written plan of	F 282			
	by: Based on observareview the facility for review the facility for related to the use of residents (R17) reformed for 1 of 3 residentiates of daily like provide every 2 hoplan for 1 of 1 resident risk for skin breated for skin breated for the factor of	dated 6/23/15 included the NAL HYGIENE: Resident ricipation with personal has contractures of the left er"; Provide skin care every AM prevent skin breakdown; and for as resident allows."  herapy (OT) therapist progress mary note dated 12/9/14 ent) fit for L (left) palmar prevent skin breakdown and 4th digit flexion note further indicated: d on daily wearing schedule remove for dressing changes, eathing, to prevent left (L)		A new hand splint was made for F 9/3/15. Hand hygiene and nail carprovided to R17 by the Charge Nu 9/3/15. The repositioning program was reviewed by the RN Case Ma on 9/8/15 and changed to reposition 3 hours based on the Positioning Assessment and Evaluation.  No other residents have splints. A residents were observed for clean nails on 9/25/15. All residents were reviewed for at least weakly bath completion. All repositioning program were re-evaluated by use of the Positioning Assessment and Evalue 9/25/15 by the RN Case Manager. Education on the nail care proceding repositioning procedure, and brack application expectations was provimemo to all nursing staff on 9/25/15 Audits for application of splints will conducted on all residents with spin various times 3 times per week for weeks and one time per week for by through visualization and documentation of application by the Director of Nursing or Designee. Eaudits will be completed for all residents will be completed for all residents. Page 18 weekly for 4 weeks and bi-weekly weeks by the Director of Nursing or Designee. Random nail hygiene at	e was rse on for R24 nager on every  II , trim e ams uation by ure, e ided in a 15. I be lints at r 4 4 weeks e Bathing idents for 4 or	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245568	B. WING			09/0	03/2015
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN		11	TREET ADDRESS, CITY, STATE, ZIP CODE IO SOUTH WALNUT AVENUE UVERNE, MN 56156	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	On 8/31/15, at approbserved in the din residents during a sand 5th digits of R1 be curled inward to device in place.  On 9/1/15, at 1:25 pin her wheelchair (vand 5th digits of R1 curled inward towar was no splint device R17's left hand wer indentation from the centimeter deep; the On 9/1/15, at 7:36 pin w/c in her bedroed digits of left hand coplace. The fingernato be long, pressing hand leaving skin in On 9/2/15, at 7:44 awas observed assist cares. NA-A assist and oral care. Durinot observed to cle nor was NA-A obsethe residents left hand wer long and soiled, preresident also continuous present. During into present. During into present.	roximately 3:00 p.m. R17 was ing room with staff and other social activity. The 3rd, 4th, 17's left hand were observed to wards the palm with no splint p.m. R17 was observed seated w/c) in bedroom. The 3rd, 4th, 17's left hand were observed rd the palm of her hand, there in place. The fingernails on re extremely long. The e 3rd digit was approximately 1 ne skin was not broken.  p.m. R17 was observed seated om with the 3rd, 4th, and 5th urled in and no splint device in ails on the left hand continued go into the palm of the residents indentations.  a.m. nursing assistant (NA)-A sting R17 with morning (AM) and R17 with personal hygiene ing the observation R17 was an her left hand independently erved to assist with cleaning and or providing nail care. Offer or attempt to obtain a re observed to continue to be desing into the palm. The nued to have body odor rerview immediately following and a stated that R17 liked to do	F 2	82	4 residents will be completed 3 tim week for 4 weeks and weekly for 4 by the Director of Nursing or design Random repositioning audits will be completed at various times 3 times week for 4 weeks and weekly for 4 by Director of Nursing or designee results will be reported to the QAP Committee for review and recommendation.  Completion date: September 30, 2	weeks nee. e s per weeks . Audit	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		LE CONSTRUCTION		E SURVEY PLETED
		245568	B. WING			09/0	03/2015
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN		1	STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	seated in w/c in din meal. R17's left ha 4th, and 5th digits of with no splint device.  On 9/3/15, at 8:47 a on back in bed slee observed with the 3 inward toward the place.  Review of R17's qu (MDS) assessment interview for mental indicating severe of assessment further required extensive hygiene and bathin.  When interviewed of stated being unawas splint device for her one. NA-C confirm east hallway where.  When interviewed of confirmed R17 had velcro that she wor stated they would pfind it but many time.	p.m. R17 was observed ing room eating her lunch and was observed with the 3rd, curled inward toward the palme in place.  a.m. R17 was observed lying eping. R17's left hand was Brd, 4th, and 5th digits curled balm with no splint device in earterly minimum data set a dated 6/23/15 included a brief I status (BIMS) score of 4, cognitive impairment. The indicated the resident assistance with personal ge.  on 9/2/15, at 12:46 p.m. NA-C are if R17 had any kind of a releft hand as had never seen ed working primarily on the	F 2	282	,		
	with staff applying t able to remove it in to locate the splint it to find it. NA-D star	he splint but the resident was dependently. NA-D attempted in R17's room but was unable ted the splint was usually kept esser or on the white bedside					

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F 282	licensed practical in fingernails are to be further stated the Na resident's nails we to bath day or if associated. LPN-A stanot received a bath how baths were trated thand splint was misleft hand and confir fingernails were too the residents skin. staff should be offer to prevent skin breadleansing the left hand and confirmed they are too bath day and as neunaware (as documentat R17 had not has stated if the resider would expect the Name was unsure why R18/28/15 per charting DON observed R17 and confirmed they acknowledged the and 5th digit nails in DON confirmed expertined and assist R17's left hand as whand splint per the R24's care plan day	on 9/3/15, at 9:05 a.m. furse (LPN)-A stated resident's at trimmed on bath day. LPN-A IA's could also notify nursing if ould need to be trimmed prior sistance from nursing was ated being unaware R17 had a since 8/10/15 and was unsure cked on the evening shift. Deing unaware that R17's left sing. LPN-A observed R17's med the 3rd, 4th, and 5th digit of long causing indentations into LPN-A further confirmed that wring the left hand splint to R17 akdown and assist with and per the plan of care.  On 9/3/15, at 9:40 a.m. the (DON) stated she would be provided to residents on reded. DON stated being mented in the medical record) and a bath since 8/10/15. DON at is refusing to bathe she IA's to notify nursing. DON 17's bath "did not occur" on g and would check into it. 7's fingernails on the left hand of were too long and deep impressions the 3rd, 4th, and left in the residents palm. Dectations that nails should be ance given with cleansing of well as offering use of the left	F 2	282			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION		E SURVEY PLETED
		245568	B. WING			09/0	03/2015
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN		11	REET ADDRESS, CITY, STATE, ZIP CODE  0 SOUTH WALNUT AVENUE  JVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	and as needed to p weakness and fatig mobility.  R24's positioning as dated 5/28/15, indic repositioned every chair to prevent skin and lethargy.  R24's Braden Scale risk dated 6/20/15, was at mild risk for and the intervention turning every 2 hou.  During continuous 3:02 p.m. to 5:22 p. it was noted that R2 her back sleeping.  During continuous 9:08 a.m. to 12:02 pit was again noted to nher back sleepin.  During an interview nursing assistant (Nurned and reposition confirmed R24 was hour time frame that the skin irritation.	revent skin-breakdown due to the from limited physical assessment and evaluation cated R24 required to be 2 hours when in bed and a nobreakdown due to weakness a for predicting pressure sore scored a 15 indicating R24 developing a pressure ulcer a guide included frequent rs.  Observations on 9/1/15, from limit. (2 hours and 20 minutes), 24 remained lying in bed on on the form of the following in bed and limits and 54 minutes) and R24 remained lying in bed and limits and stated R24 was to be oned every 2 hours and sin't repositioned within the 2	F 2	82			
		R24's incontinent pad and					

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F 282 F 312 SS=D	there were 2 small of R24's buttocks. areas and applied by During an interview manager (CM)-A st NAs to turn and repindicated on the carrefused cares.  During an interview director of nursing (repositioned every scare plan and confine wasn't done.  Along with the survet the DON and licens observed the redder The DON confirmed areas which could I R24 should be repositioned every state and the pool of the facility dated September 2 receive appropriate maintain skin integrated was 25(a)(3) ADL CONTRES A resident who is undaily living receives	reddened areas on the inside NA-C confirmed the reddened parrier cream.  on 9/3/15, at 9:15 a.m. clinical ated she would expect the position R24 every 2 hours as the plan and document if R24.  on 9/3/15, at 9:24 a.m. the DON) stated R24 should be 2 hours as indicated on the red it was a concern if this eyor on 9/3/15, at 9:50 a.m. seed practical nurse (LPN)-A and areas on R24's buttocks. If R24 had 2 small reddened ead to skin breakdown and positioned every 2 hours.  ey's Pressure Ulcer Policy on 12, indicated residents will services to promote and city.  EARE PROVIDED FOR	F 28			9/29/15
	This REQUIREMEN	NT is not met as evidenced				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			E SURVEY IPLETED
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F 312	by: Based on observareview the facility fipersonal hygiene/b(R17) reviewed for (ADL's).  Findings include: On 9/1/15, at 1:25 in her wheelchair (and 5th digits of Ricurled inward toward the fingers, R 17 storced, they would observed to move of the left hand end the palm of her hainward. The finger extremely long. Thand 5th digits were in length and obsesoiled; leaving ind residents left hand digit was approximate skin was not broke. On 9/1/15, at 7:36 in w/c in her bedrohand continued to 4th, and 5th digits residents hand lear also had a strong brown of the left hand digits are sidents hand lear also had a strong brown of the learn of	tion, interview and document ailed to provide nail care and bathing for 1 of 3 residents activities of daily living  p.m. R17 was observed seated w/c) in bedroom. The 3rd, 4th, 17's left hand were observed rd the palm of her hand. whether she could straighten tated she was unable and if "probably break". R17 was the 3rd, 4th, and 5th fingertips ough to raise them slightly off and while still remaining curled nails on R17's left hand were be fingernails on the 3rd, 4th, approximately 1.5 centimeters are to be thick, yellowed, and entations in the palm of the continued to the indentation from the 3rd ately 1 centimeter deep; the n.  p.m. R17 was observed seated om; the fingernails on the left be long and soiled with the 3rd, pressing into the palm of the ving indentations. The resident	F 31	Nail care was provided to charge nurse on 9/3/15. Rt whirlpool with CNA assistar All residents were observed clean nails on 9/25/15. All reviewed for documentation weekly bathing on 9/21/15. Education on the nail care bathing schedule expectati provided in a memo to all n 9/25/15.  Bathing audits will be compresidents weekly for 4 weekloi-weekly for 4 weeks. Ran hygiene audits of 4 random be completed 3 times per weeks and weekly for 4 we Director of Nursing or designesults will be reported to the Committee for review and recommendation.  Completion date: Septemb	17 received a nice on 9/3/15. If for trim and residents were in of at least procedure and ons was sursing staff on oleted for all ks and idom nail in residents will week for 4 reks by the gnee. Audit ne QAPI	

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F 312	washcloths to assist day. NA-A provided and prompted R17 washed the resider with the towel provision, plower half and assist assisted R17 with puring the observation on R17's remain long and so was noted that bod completion of morn During interview im observation on 9/2/to do as much for hoseleted the remained that he aback and peri-care completed the remained long, until Review of R17's que (MDS) assessment Brief Interview for M4, indicating severe assessment further	sined additional towels and st R17 with washing up for the d R17 with a clean washcloth to wash upper body. NA-A at's back and R17 dried herself ded. NA-A then assisted R17 pper body, assisted her to provided peri-care, dressed her sted her to the w/c. NA-A then assisted her to the w/c. NA-A then assist with washing the personal hygiene and oral care. The steff hand were noted to siled, pressing into the palm. It yodor remained evident after sing cares.  In example of the washing R17 in the palm of the pa	F 312			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG			E SURVEY PLETED
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F 312	The plan of care darequired one staff presonal hygiene as "PERSONAL HYGI participation with personal hygiene as "PERSONAL HYGI participation with participation with personal hygiene as "PERSONAL HYGI participat	ted 6/23/15, indicated R17 articipation with bathing and and included the following: ENE: Resident requires 1 staff ersonal hygiene. Resident has left hand "trigger finger"; very AM to keep clean and down; apply palm protector as mentation on the follow up ed 8/4/15 thru 9/3/15, related ed R17 received a whirlpool 8/10/15. The report further 5 "resident refused" a bath, bath "did not occur". Is lacking to indicate the did the bath.  In 9/2/15, at 1:30 p.m. R17 ure whether she ever wore hand to prevent her fingers her palm. When asked if R17 trim her fingernails on the left ed affirmatively.  In 9/3/15, at 9:05 a.m. urse (LPN)-A stated resident's be trimmed on bath day. It is nails would need to be the day or if assistance from did. LPN-A stated being not received a bath since issure how baths were tracked	F3	12			

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3)  A. BUILDING			X3) DATE SURVEY COMPLETED	
	245568	B. WING _		09/	03/2015	
PROVIDER OR SUPPLIER	- MARY JANE BROWN		STREET ADDRESS, CITY, STATE, ZIP CODE  110 SOUTH WALNUT AVENUE  LUVERNE, MN 56156			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI	) BE	(X5) COMPLETION DATE	
R17 if she would all and R17 indicated so confirmed that staff assistance with was cares as she was unwhen interviewed of director of nursing (expect nail care to both day and as neunaware (as document that R17 had not be DON stated if the reexpected the NA's to DON was unsure woon 8/28/15 as chart DON observed R17 and confirmed they acknowledged the cand 5th digit nails hoon confirmed she and help with clean 483.25(c) TREATM PREVENT/HEAL P  Based on the compresident, the facility who enters the facil does not develop prindividual's clinical of they were unavoidal pressure sores recesservices to promote prevent new sores in the same sores in the s	low her nails to be trimmed she would. LPN-A further should be providing shing R17's left hand during nable.  In 9/3/15, at 9:40 a.m. the DON) stated she would be provided to residents on eded. DON stated being nented in the medical record) been bathed since 8/10/15. Sesident refused bathing she to notify nursing staff. The shy R17's bath "did not occur" ed and would follow up. The "s fingernails on the left hand were too long and deep impressions the 3rd, 4th, ad left in the resident's palm. Se expected staff to trim nails sing of R17's left hand. ENT/SVCS TO RESSURE SORES  Irrehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and from developing.				9/30/15	
by:	NT IS NOT MET AS EVIDENCED					
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From pa R17 if she would all and R17 indicated s confirmed that staff assistance with was cares as she was u  When interviewed of director of nursing ( expect nail care to b bath day and as ne- unaware (as docum that R17 had not be DON stated if the re expected the NA's t DON was unsure w on 8/28/15 as chart DON observed R17 and confirmed they acknowledged the or and 5th digit nails h DON confirmed she and help with clean 483.25(c) TREATM PREVENT/HEAL P  Based on the comp resident, the facility who enters the facil does not develop po individual's clinical of they were unavoidal pressure sores reces services to promote prevent new sores in  This REQUIREMENT	AMARITAN SOCIETY - MARY JANE BROWN  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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. 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.	PROVIDER OR SUPPLIER  AMARITAN SOCIETY - MARY JANE BROWN  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  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This REQUIREMENT is not met as evidenced	PROVIDER OR SUPPLIER  MARRITAN SOCIETY - MARY JANE BROWN  SUMMARY STATEMENT OF DEFICIENCIES (LEACH DEFICIENCY MARY JANE BROWN)  SUMMARY STATEMENT OF DEFICIENCIES (LEACH DEFICIENCY MARY JANE BROWN)  CONTINUED FOR ILSC IDENTIFYING INFORMATION)  CONTINUED FOR USE IDENTIFYING INFORMATION)  CONTINUED FOR DATE OF CORRECTION PRIEFIX TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  TAG  TO THE APPROPRIATE DEFICIENCY  TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  TAG  TO THE APPROPRIATE DEFICIENCY  TAG  TO THE APPROPRIATE DEFICIENCY  TAG  TO STATE THE APPROPRIATE DEFICIENCY  TAG  TO STATE THE APPROPRIATE DEFICIENCY  TAG  TO STATE THE APPROPRIATE DEFICIENCY  TAG  TO SUMMARY STATEMENT OF DEFICIENCIES ID.  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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245568	B. WING		_   (	9/03/2015
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN		STREET ADDRESS, CITY, STA 110 SOUTH WALNUT AVEN LUVERNE, MN 56156	ATE, ZIP CODE	
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F 314	Based on observareview the facility for repositioning for 1 who was identified development base assessments.  Findings include:  R24's significant ch (MDS) assessment with a Brief Intervies score of 3, indicatir impairment. The Norequired extensive mobility, transfers, was at risk for the culcers. It identified repositioning program R24's positioning program R24's positioning and ated 5/28/15, indicated 5/28/	tion, interview and document alled to provide timely of 1 resident (R24) reviewed at risk for pressure ulcer d on skin and positioning mange Minimum Data Set to date 6/8/15, identified R24 ew for Mental Status (BIMS) and severe cognitive MDS further identified R24 assistance of 2 staff with bed toileting, and locomotion and development of pressure that R24 was on a turning and am.  Assessment and evaluation cated R24 required to be 2 hours when in bed and a in breakdown due to weakness de for predicting pressure sore scored a 15 indicating R24 developing a pressure ulcer in guide included frequent	F3	F 314 The repositioning previewed by the RN 9/8/15. The reposition changed to reposition completion of the Polyand Evaluation UDA the change through CNA and nursing day All repositioning progre-evaluated by 9/28 Manager. Education on the rewas provided in a most staff on 9/25/15. Random repositioning completed at variou week for 4 weeks as	Case Manager on on program was on every 3 hours after ositioning Assessme A. Staff was updated a care plan alert to ashboard.  grams were 5/15 by the RN Case positioning proceduratemo to all nursing audits will be s times 3 times per and weekly for 4 weeking or designee. Audited to the QAPI we and	nt of e

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		245568	B. WING		<del></del>	09/0	03/2015
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN		110 S	ET ADDRESS, CITY, STATE, ZIP CODE SOUTH WALNUT AVENUE ERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	3:02 p.m. to 5:22 p it was noted that R2 her back sleeping.  During continuous 9:08 a.m. to 12:02 it was again noted on her back sleeping.  During an interview nursing assistant (Naturned and reposition confirmed R24 was hour time frame that Review of the nursidated 9/2/15, at 9:2 Ointment was applied to skin irritation.  It was observed on and NA-C changed there were 2 small of R24's buttocks, areas and applied to R24's buttocks, areas and applied to Louring an interview manager (CM)-A st NAs to turn and regindicated on the carefused cares.  During an interview director of nursing repositioned every care plan and confiwasn't done.	c.m. (2 hours and 20 minutes), 24 remained lying in bed on 24 remained lying in bed on 25 p.m. (2 hours and 54 minutes) that R24 remained lying in bed ag. 25 on 9/2/15, at 1:51 p.m. NA)-B stated R24 was to be oned every 2 hours and on't repositioned within the 2 at morning.  In gnote and treatment record 20 p.m. indicated Calmoseptine ed to R24's coccyx area due 26 p.m. that NA-B R24's incontinent pad and reddened areas on the inside NA-C confirmed the reddened	F3	14			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY IPLETED
		245568	B. WING		09/	03/2015
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN	1	TREET ADDRESS, CITY, STATE, ZIP CODE  10 SOUTH WALNUT AVENUE  LUVERNE, MN 56156	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318 SS=D	the DON and licens observed the redder The DON confirme areas which could I R24 should be reported. Review of the facility dated September 2 receive appropriate promote and maint. Review of the facility Ulcer Management program should incommanagement program should incompare a pressure ulcer or following intervention. IN RANGE OF MO Based on the compresident, the facility with a limited range appropriate treatments.	sed practical nurse (LPN)-A ened areas on R24's buttocks. d R24 had 2 small reddened ead to skin breakdown and ositioned every 2 hours.  by's Pressure Ulcer Policy 012, indicated residents will assessments and services to ain skin integrity.  by's Wound and Pressure dated May 2015, indicated the dude a comprehensive am to prevent development of other skin conditions (Braden, ons identified on care plan, ion, specialty surfaces, etc.). EASE/PREVENT DECREASE TION  by the prevent development of a must ensure that a resident end of motion receives ent and services to increase dor to prevent further	F 314			9/30/15
	by: Based on observareview the facility famaintain and/or pre	NT is not met as evidenced tion, interview and document ailed to apply a hand splint to event further decrease in range or 1 of 1 resident (R17) ed range of motion.		A new hand splint was made and a on 9/3/15. An extra splint was mad No other residents have hand splin All charge nurses were educated to splint application and removal a documentable care plan intervention	e. ts. o make	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED			
		245568	B. WING		09/	03/2015
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN		STREET ADDRESS, CITY, STATE, ZIF 110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 318	Findings include:  On 8/31/15, at approbserved in the dirresidents during a and 5th digits of Ribe curled inward to device in place.  On 9/1/15, at 1:25 in her wheelchair (4th, and 5th digits observed curled inhand. When quest could straighten the able to and if force break". R17 was and 5th fingertips of them slightly off the remaining curled inmoved them any more on 9/1/15, at 7:36 in w/c in her bedrodigits of left hand oplace.  On 9/2/15, at 7:44 was observed assicares. NA-A comporal care but did no hand splint for R17.  On 9/2/15, at 12:21 seated in w/c in dirmeal. R17's left has	roximately 3:00 p.m. R17 was hing room with staff and other social activity. The 3rd, 4th 17's left hand were observed to owards the palm with no splint p.m. R17 was observed seated w/c) in her bedroom. The 3rd, of R17's left hand were ward toward the palm of her tioned by the surveyor if R17 e fingers; she stated not being d to they would "probably observed to move the 3rd, 4th, of the left hand enough to raise e palm of her hand while still hward. R17 stated if she hore, it would hurt.  p.m. R17 was observed seated om with the 3rd, 4th, and 5th curled in and no splint device in a.m. nursing assistant (NA)-A sting R17 with morning (AM) bleted personal hygiene and obt offer or attempt to obtain a "'s left hand.  I p.m. R17 was observed hing room eating her lunch and was observed with the 3rd, curled inward toward the palm	F 3	nurses meeting on 9/18/1 staff were re-educated on application procedure in a dated 9/25/15.  Audits for application of systia visualization and docume placement will be conduct residents with splints at vistimes per week for 4 week per week for 4 weeks by the Nursing or designee. Aud reported to the QAPI Commendat Completion date: Septem	the brace a nursing memo plints through ntation of ted on all arious times 3 ks and one time the Director of it Results will be nmittee for ion.	

STATEMENT OF AND PLAN OF C					X3) DATE SURVEY COMPLETED		
		245568	B. WING			09/	03/2015
	OVIDER OR SUPPLIER	- MARY JANE BROWN		110	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH WALNUT AVENUE VERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
O stock in plant of the part o	upine in bed asleed been one. NA-C contacted being unsured.	a.m. R17 was observed lying ap. R17's left hand was ard, 4th, and 5th digits curled balm with no splint device in the property of the property	F3	18			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245568	B. WING		09/	03/2015	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN		STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE LUVERNE, MN 56156	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 318	confirmed R17 had velcro that she work stated they would plocate the splint, but would "hide it" from cooperative with state was able to remove attempted to locate was unable to find it usually kept in their the white bedside to the white b	on 9/3/15, at 8:51 a.m. NA-D a splint from therapy with e on her left hand. NA-D but it on R17 when they could at many times the resident staff. NA-D stated R17 was aff applying the splint but R17 it independently. NA-D the splint in R17's room but t. NA-D stated the splint was resident's dresser and/or on able.  On 9/3/15, at 9:05 a.m. urse (LPN)-A stated being left hand splint was missing. The that staff should be d splint to R17.  On 9/3/15, at 9:40 a.m. the confirmed she would expect to of the left hand splint to R17 at 10:26 a.m. the PT) stated being unaware that ssing and to his knowledge an notified if the splint needed stated that he manages the that and would have notified if a do to be ordered. N NUTRITION STATUS DABLE	F3			9/29/15	
	Based on a residen assessment, the fa	t's comprehensive cility must ensure that a					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245568	B. WING		09/0	3/2015
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN	1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH WALNUT AVENUE .UVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	status, such as boo unless the resident demonstrates that (2) Receives a ther nutritional problem.	otable parameters of nutritional ly weight and protein levels, 's clinical condition this is not possible; and apeutic diet when there is a	F 325			
	by: Based on observareview the facility fareview the facility facilit	tion, interview and document ailed to provide the necessary ased on comprehensive f 3 residents (R21) reviewed to the facility on 3/17/15, and ner skilled nursing facility on agnoses indicated in the est that included: Hypertension, thyroidism, gastroesophageal nia, profound dementia with y, depression and asthma.  7/15, R21 weighed 122 # weighed 121# and on 5/21/15 I experienced a 7# weight loss body weight in the two sion.  rd included a dietician 3/21/15, which identified that food and fluid for body needs insufficient food and fluid.		R21 has discharged. All residents with weight loss greate 5% in 30 days and greater than 10° 180 days were reviewed on 9/10/18 appropriate nutrition risk care plans. All licensed nurses re-educated on 9/15/15 on care planning nutrition recus, goals, and interventions for residents with weight loss. The diet will be notified of newly reported we loss by nursing for evaluation and oplan development. Random audits will be completed we for 4 weeks and bi-weekly for 4 we 3 residents identified as having an weight loss or risk for weight loss for nutrition care plan completion by the Director of Nursing or designee. Au results will be reported to the QAPI Committee for review and recommendation. Completion date: September 29, 26	% in 5 for 5. isk iician eight care veekly eks on actual or ee udit	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245568	B. WING			09/	03/2015
	PROVIDER OR SUPPLIER	Y - MARY JANE BROWN		1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH WALNUT AVENUE .UVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	nutritional progres 11:43 a.m. that R2 weight loss in the lidentified R21 was recommendation i receive calorie derive derive derive derive derive derive calorie derive calorie derive calorie derive calorie derive derive derive derive derive calorie derive calorie derive de	the medical record identified a s note dated 5/7/15, timed 1 weighed 113.5 #, a 5% last month. The note further is receiving a regular diet. A in the note indicated R21 should use foods with 8 ounces double colate milk BID (twice daily) I snacks.  R21's daily meal intake from the documentation indicated 25% or less of her meals and umed 26%-50%. The discharge station dated 6/1/15, indicated: conal Status-(document ect resident's ability to maintain ation). The notation "None" was a section. No further ated to the weight loss g the resident's stay was  R25's note dated 5/14/15, failed to ion concerns for R21.  Rated 4/2/15, failed to identify oals or interventions for the loss. The care plan lacked any	F3	325			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245568	B. WING		09/	03/2015	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN	•	STREET ADDRESS, CITY, STATE, ZIP COI 110 SOUTH WALNUT AVENUE LUVERNE, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 325	interventions were planning. It was als assessment dated	not included in any care so verified R21's nutritional 3/21/15, identified that R21 and fluid for body needs with	F3	25			

F5568024

PRINTED: 09/30/2015 **FORM APPROVED** OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 245568 09/01/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 110 SOUTH WALNUT AVENUE GOOD SAMARITAN SOCIETY - MARY JANE BROWN LUVERNE, MN 56156 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 **INITIAL COMMENTS** K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on 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

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

TITLE

09/25/2015

(X6) DATE

**Electronically Signed** 

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

Facility ID: 00575

PRINTED: 09/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED	
		245568	B. WING			09/	01/2015	
	PROVIDER OR SUPPLIER	- MARY JANE BROWN		STREET ADDRESS, CITY, STATE, ZIP CODE  110 SOUTH WALNUT AVENUE  LUVERNE, MN 56156				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	Κ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 3rd Addition was constructed in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction;		K 000					
	detection in the corr	ire alarm system with smoke ridors and spaces open to the nonitored for automatic fire						

Facility ID: 00575

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245568	B. WING			09/	01/2015
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN		110	REET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH WALNUT AVENUE JVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 000	capacity of 51 beds time of the survey.	tion. The facility has a and had a census of 49 at	K	000			
K 021 SS=D	Any door in an exit passageway, stairway		K 021				9/11/15
	hazardous area end devices arranged to	al exit, smoke barrier or closure is held open only by a automatically close all such roughout the facility upon	or only by all such				ANA CONTRACTOR AND CO
	a) the required mar	nual fire alarm system;					
	smoke passing thro	b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and					on transmission and a superioran
	c) the automatic sp 19.2.2.2.6, 7.2.1.8.	rinkler system, if installed. 2	ed.				Notes and annual partial parti
	Based on observate facility had a corridor improperly and was NFPA 101 (2000) Cand Chapter 7, Second	s not met as evidenced by: tion and staff interview, the or door which was held open is not in conformance with hapter 19, Section 19.2.2.2.6 tion 7.2.1.8. In a fire ficient practice could adversely dents.			By coordinating with a contractor of facility ensured the installation of n door holders, which would auto-rel the doors to the Activity and Thera rooms when the fire alarm is active. This correction was implemented a completed by 9/11/15 under the direction of the facility Director of Maintenar	nagnetic ease py ated. and rection	

PRINTED: 09/30/2015 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0930-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				PLE CONSTRUCTION IG <b>01 - MAIN BUILDING 01</b>		E SURVEY PLETED
		245568	B. WING _		09/0	01/2015
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN		STREET ADDRESS, CITY, STATE, ZIP CO 110 SOUTH WALNUT AVENUE LUVERNE, MN 56156	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 021	On facility tour betwon 09/01/2015, it we Room and Therapy held-open with a two open device, which interconnected with to release upon actions.	<del>-</del>	K 02	Don Weinkauf.		
K 029 SS=D	engineer (DW)at the NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 prothe approved autoroption is used, the other spaces by sm doors. Doors are stield-applied protection.	onfirmed with the chief building the time of discovery. FETY CODE STANDARD  construction (with ¾ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and telf-closing and non-rated or tive plates that do not exceed bottom of the door are	K 02			10/20/15
	Based on observated facility failed to mai partitions and doors	s not met as evidenced by: tion and staff interview, the ntain smoke-resisting s in accordance with the ents of 2000 NFPA 101,		The facility, by coordinating contractor, ensured that a nather nurses station being use storage has been ordered, will have an automatic door latch appropriately and will the with fire rating requirements	ew door for ed for oxygen The new door closer that will be compliant	

Event ID: RELC21

PRINTED: 09/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL` A. BUILDI		(X3) DATE SURVEY COMPLETED			
		245568	B. WING			09/	01/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- MARY JANE BROWN	STREET ADDRESS, CITY, STATE, ZIP CODE  110 SOUTH WALNUT AVENUE  LUVERNE, MN 56156				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	Κ.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 029	On facility tour betwon 09/01/2015, obs	ween 9:00 AM and 12:00 PM servation revealed that the d:	К0	29	minute fire rating will be noted on a plate which will be visible upon insp. The facility Director of Maintenance Weinkauf, who is responsible for the oversight of this measure, estimate the door will be delivered by the mit October 2015, with the installation completed by 10/20/15.	pection. e, Don ne es that ddle of	
K 050 SS=D	engineer (DW)at the NFPA 101 LIFE SA Fire drills are held a varying conditions, The staff is familiar that drills are part of Responsibility for passigned only to conqualified to exercise conducted between	onfirmed with the chief building the time of discovery.  AFETY CODE STANDARD  at unexpected times under at least quarterly on each shift. It with procedures and is aware of established routine. It will be a shift of the conducting drills is competent persons who are the leadership. Where drills are in 9 PM and 6 AM a coded by be used instead of audible.	KΟ	₹ 050			9/25/15
	Based on docume interview, the facilit were conducted on staff under varying required by 2000 N Findings include:	s not met as evidenced by: ntation review and staff by failed to assure fire drills ce per shift per quarter for all times and conditions as IFPA 101, Section 19.7.1.2.	,	AND THE PROPERTY OF THE PROPER	The facility Director of Maintenance ensure that moving forward, begins with the next quarterly required fire that fire drills occur as required and especially at randomized and unex times with sufficient lags in the time that drills occur. The Facility Direct Maintenance will delegate respons for the performance of fire drills in	ning drills, depected of day tor of dilty	

Event ID: RELC21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER SUPPLIER  (X2) MARK OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - MARY JANE BROWN  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MILST BE PRECEDED BY FIULL TAG (EACH DEFICIENCY MILST BE PRECEDED BY FIULL CROSS-REFERENCED TO THE APPROF DEFICIENCY)  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:  K 144 SS=E  K 144 SS=E  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.		***************************************	& MEDICAID SERVICES	(VO) MILLS	TIDLE CONSTRUCTION		E SURVEY
AMME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - MARY JANE BROWN  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 144  SS=E  Generators are inspected weekly and exercised under load for 30 minutes per month in				1 ' '			PLETED
GOOD SAMARITAN SOCIETY - MARY JANE BROWN    Martin			245568	B. WING			01/2015
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICE OF THE APPR			- MARY JANE BROWN	110 SOUTH WALNUT AVENUE			
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 144 SS=E  Generators are inspected weekly and exercised under load for 30 minutes per month in	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
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.  NFPA 101 LIFE SAFETY CODE STANDARD  K 144 SS=E  Generators are inspected weekly and exercised under load for 30 minutes per month in	K 050	on 09/01/2015, the documentation for t 2014 to September the following shifts	review of the fire drill the past 12 months (August 2015) revealed the drills for did not not sufficiently vary the		case of drills occurring durin	g the night	
engineer (DW)at the time of discovery.  K 144  NFPA 101 LIFE SAFETY CODE STANDARD  SS=E  Generators are inspected weekly and exercised under load for 30 minutes per month in		b. evening - 190 hours c. night -0500, 2	2300, 0100, and 2345 hours				
		engineer (DW)at th NFPA 101 LIFE SA Generators are insp under load for 30 m	re time of discovery. FETY CODE STANDARD  pected weekly and exercised hinutes per month in	K 1	44		10/9/15
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  The facility has confirmed that the annunciator panel has an audible on it. The Director of Maintenance coordinate the relocation of the annunciator panel to a location that staffed 24 hours a day with Cummorganization that services the gen		Based observation failed to properly instance with the (1999 edition) and I fire or other emerge	and staff interview, the facility stall Emergency Generators in e requirements at NFPA 99 NFPA 110 (1999 edition). In a ency, this deficient practice		annunciator panel has an au on it. The Director of Mainte coordinate the relocation of annunciator panel to a locat staffed 24 hours a day with	udible alarm enance will the ion that is Cummins, the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245568	B. WING		09/	01/2015
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN		STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
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K 154 SS=D	On facility tour betwon 09/01/2015, durently determined that the located in a manner could not be determined that the located in a manner audible alarm that generator trouble.  This finding was concended in the service for more of service for more of the authority and the building is watch system is prunprotected by the	ween 9:00 AM and 12:00 PM ring an inspection of the stor announciator panel it was a annunciator panel was not ad 24 hour staff area. It also mined that the panel had an would alert staff in the event of the staff of the confirmed with the chief building the time of discovery.  WEETY CODE STANDARD automatic sprinkler system is nore than 4 hours in a 24-hour y having jurisdiction is notified, evacuated or an approved fire ovided for all parties left shutdown until the sprinkler eturned to service. 9.7.6.1	K 14	will be completed in approximatel weeks, by 10/9/15.	y two	9/2/15
	Where a required out of service for meriod, the authoritiand the building is watch system is prunprotected by the system has been referred.  On facility tour beto	s not met as evidenced by: automatic sprinkler system is nore than 4 hours in a 24-hour y having jurisdiction is notified, evacuated or an approved fire ovided for all parties left shutdown until the sprinkler eturned to service. 9.7.6.1  ween 9:00 AM and 12:00 PM servation and documentation		To become compliant with this st the facility now has a documented procedure located in the Emerger Procedures binder titled ¿Fire Procedures binder titled ¿Fire Procedures out of Service. ¿This doutlines the protocol for implementation of the event sprinkler system is out of commis a period of 4 hours or more within hour period. This deficiency was immediately corrected after surve	d ncy occument occument offing a that the sion for a 24	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''	LTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		245568	B. WING			09/01/2015	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN		STREET ADDRESS, CITY, STATE, ZIP C 110 SOUTH WALNUT AVENUE LUVERNE, MN 56156	ODE		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETION DATE	
K 154 K 155 SS=D	reviewed revealed plan for the out of sprinkler system.  This finding was congineer (DW)at the NFPA 101 LIFE SAWhere a required for service for more than the authority having building is evacuate provided for all par	that there was not a single service plan for the fire onfirmed with the chief building the time of discovery. AFETY CODE STANDARD fire alarm system is out of an 4 hours in a 24-hour period, g jurisdiction is notified, and the ed or an approved fire watch is ties left unprotected by the fire alarm system has been		exited the facility. The curred Protocol is based on resour by the State of MN Fire Marevent that the Director of Minot present to institute a fireduty will be that of the Facility Administrator.	ces provided shal. In the aintenance is watch, this	9/2/15	
	Where a required service for more the the authority having building is evacuate provided for all particular shutdown until the returned to service.  On facility tour betwon 09/01/2015, observiewed revealed plan for the out of seystem.	s not met as evidenced by: fire alarm system is out of an 4 hours in a 24-hour period, g jurisdiction is notified, and the ed or an approved fire watch is ties left unprotected by the fire alarm system has been 9.6.1.8  veen 9:00 AM and 12:00 PM servation and documentation that there was not a single service plan for the fire alarm		To become compliant with the facility now has a docum procedure located in the En Procedures binder titled ¿Fi Systems Out of Service. ¿ Toutlines the protocol for implier watch procedure in the fire alarm system is out of ca period of 4 hours or more hour period. This deficiency immediately corrected after exited the facility. The curred Protocol is based on resour by the State of MN Fire Markevent that the Director of Market in the present to institute a fired duty will be that of the Facility.	nented nergency ire Protection This document olementing a event that the commission for within a 24 y was surveyors ent Fire Watch ces provided whal. In the aintenance is e watch, this		

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB MO	. 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G <b>01 - MAIN BUILDING 01</b>	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		245568	B. WING		09/	01/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE			
			LUVERNE, MN 56156		·		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
K 155	Continued From pa	ge 8	K 15	5 Administrator.		POR NAMES AND ADDRESS OF THE PORT OF THE P	
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PRINTED: 09/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** 

(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2011 ADDITION (X3) DATE SURVEY COMPLETED

245568

B. WING

09/01/2015

	PROVIDER OR SUPPLIER  AMARITAN SOCIETY - MARY JANE BROWN	1	STREET ADDRESS, CITY, STATE, ZIP CODE  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	K 000			
	FIRE SAFETY				
	THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.				
	UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.				
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on 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.		EPOC		
	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	si			
ABORATOR'	Y DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	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.

Facility ID: 00575

PRINTED: 09/30/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION 02 - 2011 ADDITION	(X3) DATE SURVEY COMPLETED	
		245568	B. WING			09/	01/2015
	PROVIDER OR SUPPLIER	' - MARY JANE BROWN		11	TREET ADDRESS, CITY, STATE, ZIP CODE IO SOUTH WALNUT AVENUE UVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 000	Continued From pa Facsimile: 651-21	_	KO	00			The second secon
	By email to: Marian.Whitney@s Angela.Kappenma						TO COLOR TO THE TOTAL THE TOTAL TO THE TOTAL TOTAL TO THE
		PRRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:					
	A description of to correct the defic	what has been, or will be, done lency.	1				
	2. The actual, or pr	roposed, completion date.	***				
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency.					
	Brown consists of the which includes a necessary conference room a one-story in height	d Samaritan Society Mary J. the 2011 building addition, ew main entrance, offices, and beauty shop. Building 02 is , has no basement, is fully fire and was determined to be of ruction.					
	detection in the coll corridors, which is department notifica	fire alarm system with smoke rridors and spaces open to the monitored for automatic fire ation. The facility has a s and had a census of 49 at					
	The requirement a	t 42 CFR, Subpart 483.70(a) is					

CENT	ERS FOR MEDICARI	E & MEDICAID SERVICES				0930-0391
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G <b>02 - 2011 ADDITION</b>		E SURVEY PLETED
		245568	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		ı
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 050 SS=E	Fire drills are held varying conditions. The staff is familia that drills are part Responsibility for passigned only to capualified to exercise conducted between	at unexpected times under, at least quarterly on each shift. r with procedures and is aware of established routine. Dlanning and conducting drills is competent persons who are se leadership. Where drills are in 9 PM and 6 AM a coded by be used instead of audible	a	0		9/2/15
	Based on docume interview, the facili were conducted or staff under varying required by 2000 N. Findings include:  On facility tour bet on 09/01/2015, the documentation for 2014 to Septembe	is not met as evidenced by: entation review and staff ty failed to assure fire drills nce per shift per quarter for all times and conditions as NFPA 101, Section 19.7.1.2.  ween 9:00 AM and 12:00 PM e review of the fire drill the past 12 months (August ar 2015) revealed the drills for did not not sufficiently vary the s were conducted:		The facility Director of Maintena ensure that moving forward, beg with the next quarterly required f that fire drills occur as required a especially at randomized and un times with sufficient lags in the ti that drills occur. The Facility Dir Maintenance will delegate respo for the performance of fire drills case of drills occurring during the shift.	inning ire drills, and expected me of day ector of nsibility n the	
	b. evening - 19 hours	300, 1500, and 1330 hours 900, 1500, 1600, and 1500 2300, 0100, and 2345 hours				
		onfirmed with the chief building he time of discovery.	THE PROPERTY AND ADDRESS OF THE PROPERTY OF TH			

STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2011 ADDITION				(X3) DATE SURVEY COMPLETED	
}		245568	B. WING			09/01/2015		
	PROVIDER OR SUPPLIER	- MARY JANE BROWN		11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH WALNUT AVENUE UVERNE, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 144 SS=E	Generators are ins	FETY CODE STANDARD  pected weekly and exercised  ninutes per month in  FPA 99. 3.4.4.1.	K	144			10/9/15	
	Based observation failed to properly in accordance with the (1999 edition) and fire or other emerg	is not met as evidenced by: n and staff interview, the facility estall Emergency Generators in e requirements at NFPA 99 NFPA 110 (1999 edition). In a ency, this deficient practice ect all 49 residents		man-ver -	The facility has confirmed that the annunciator panel has an audible a on it. The Director of Maintenance coordinate the relocation of the annunciator panel to a location that staffed 24 hours a day with Cummit organization that services the gene	will is ns, the		
	on 09/01/2015, dur emergency genera determined that the located in a manne could not be deterr	veen 9:00 AM and 12:00 PM ing an inspection of the tor announciator panel it was annunciator panel was not 24 hour staff area. It also nined that the panel had an would alert staff in the event of			and/or an electrician as necessary. will be completed in approximately weeks; by 10/9/15.	This		
K 154 SS=D	engineer (DW)at th	onfirmed with the chief building are time of discovery.  FETY CODE STANDARD	K	154			9/2/15	
	out of service for m period, the authorit and the building is	automatic sprinkler system is nore than 4 hours in a 24-hour y having jurisdiction is notified, evacuated or an approved fire ovided for all parties left						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - 2011 ADDITION</b>		(X3) DATE SURVEY COMPLETED	
		245568	B. WING		09/	09/01/2015	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN		STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE LUVERNE, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
K 154	·	shutdown until the sprinkler	K 1	54			
	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			To become compliant with this sethe facility now has a documented procedure located in the Emerge Procedures binder titled ¿Fire Posystems Out of Service. This coutlines the protocol for implementation watch procedure in the even sprinkler system is out of committee.	ed ency rotection document enting a t that the ssion for		
K 155 SS=D	on 09/01/2015, obs reviewed revealed to plan for the out of s sprinkler system.	etween 9:00 AM and 12:00 PM observation and documentation ed that there was not a single of service plan for the fire		a period of 4 hours or more with hour period. This deficiency was immediately corrected after survexited the facility. The current F Protocol is based on resources by the State of MN Fire Marshal event that the Director of Maintenot present to institute a fire wat duty will be that of the Facility	s eyors ire Watch provided In the nance is		
	engineer (DW)at th NFPA 101 LIFE SA Where a required fi service for more that	nfirmed with the chief building e time of discovery. FETY CODE STANDARD re alarm system is out of an 4 hours in a 24-hour period,	K 1	Administrator.		9/2/15	
	building is evacuate provided for all part	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				The second secon	
	Where a required f	s not met as evidenced by: fire alarm system is out of an 4 hours in a 24-hour period,		To become compliant with this the facility now has a documente			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 02 - 2011 ADDITION			COMPLETED		
		245568	B. WING _		09/	09/01/2015	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE BROWN		STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE LUVERNE, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
K 155	building is evacuate provided for all part shutdown until the freturned to service.  On facility tour betwon 09/01/2015, obsreviewed revealed to plan for the out of system.	i jurisdiction is notified, and the ed or an approved fire watch is ies left unprotected by the fire alarm system has been 9.6.1.8  I/een 9:00 AM and 12:00 PM ervation and documentation that there was not a single ervice plan for the fire alarm	K 15	procedure located in the Emerger Procedures binder titled ¿Fire Pro Systems Out of Service. ¿ This do outlines the protocol for implemer fire watch procedure in the event fire alarm system is out of commi a period of 4 hours or more within hour period. This deficiency was immediately corrected after surve exited the facility. The current Fir Protocol is based on resources proposed by the State of MN Fire Marshal. event that the Director of Mainten not present to institute a fire watch duty will be that of the Facility Administrator.	otection ocument ating a that the ssion for a 24 yors e Watch ovided In the ance is		



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the 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

Good Samaritan Society - Mary Jane Brown September 17, 2015 Page 2

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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 10/05/2015 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00575 09/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE **GOOD SAMARITAN SOCIETY - MARY JANE BF** LUVERNE, MN 56156 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*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

**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/inf obul.htm The State licensing orders are delineated on the attached Minnesota

orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Minnesota Department of Health

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

Electronically Signed 09/29/15

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TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00575 09/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE **GOOD SAMARITAN SOCIETY - MARY JANE BF** LUVERNE, MN 56156 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Continued From page 1 2 000 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

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FOURTH COLUMN WHICH STATES.

"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00575	B. WING		09/0	3/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE RE	H WALNUT E, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 560	MN Rule 4658.0409 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			9/29/15
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The con must include the inc	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, vchosocial needs that are apprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on on obserdocument review the plan of care which is	of 2 residents (R21) reviewed		No POC Needed		
	Findings include:					
	discharged to anoth 6/1/15. R21 had di physician clinic note diverticulosis, gastr	to the facility on 3/17/15, and her skilled nursing facility on agnoses indicated in the less that included: Hypertension, oesophageal reflux, profound lowning, anxiety and				
	On admission, 3/17	7/15, R21 weighed 122 #				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00575	B. WING		09/03/2015		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE		-	
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2 560	Continued From page 3		2 560				
	(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.						
	assessment, dated R21 had adequate	rd included a dietician 3/21/15, which identified that food and fluid for body needs 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.						
	5/1/15 thru 6/1/15, R21 frequently ate 2 occasionally consumplanning documents Swallowing/Nutrition conditions that affect nutrition and hydrat documented in this documentation relations	21's daily meal intake from the documentation indicated 25% or less of her meals and med 26%-50%. The discharge ation dated 6/1/15, indicated: nal Status-(document ct resident's ability to maintain ion). The notation "None" was section. No further ted to the weight loss the resident's stay was					
		es note dated 5/14/15, failed to on concerns for R21.					
	any risk factors, go	ted 4/2/15, failed to identify als or interventions for the ss. The care plan lacked any					

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STATEMENT OF DEFICIENCIES (X1)

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
			B. WING			
NAME OF 5		00575			09/0	3/2015
	PROVIDER OR SUPPLIER	110 SOUT	H WALNUT	STATE, ZIP CODE <b>AVENUE</b>		
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2 560	Continued From pa	ge 4	2 560			
	(DON) on 9/02/15, was unable to ident a plan of care plan was identified with a verified the dieticiar for interventions relinterventions were care. It was also wassessment dated had adequate food a history of insuffici SUGGESTED MET The director of nurs the policy and procas needed, staff tramonitored and eval comprehensive pla lists measurable obmeet each resident	THOD OF CORRECTION: sing or designee could assure edures are reviewed, revised ined and systems assessed, uated to assure the n of care is developed and bjectives and timetables to				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			9/29/15
		omprehensive plan of care I personnel involved in the :.				
	by:	ent is not met as evidenced		No Written POC Needed		
i	Daseu on observati	on, interview, and document		NO WILLETT FOO Needed		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING: COMPLETED

00575 B. WING \_\_\_\_\_\_ 09/03/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(VA) ID		, MN 56156	PROVIDER'S DI AN CE CORRECTION	(VE)
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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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		00575	B. WING		00/0	3/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 09/0	3/2013
		110 SOUT	'H WALNUT	•		
GOODS	AMARITAN SOCIETY	- MARY JANE BF LUVERNE	, MN 56156			
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2 565	Continued From pa	age 6	2 565			
	and 5th digits of R1 curled inward towal was no splint devic R17's left hand wer indentation from the centimeter deep; the On 9/1/15, at 7:36 pin w/c in her bedrood digits of left hand coplace. The fingerna	17's left hand were observed rd the palm of her hand, there e in place. The fingernails on re extremely long. The e 3rd digit was approximately 1 ne skin was not broken.  p.m. R17 was observed seated om with the 3rd, 4th, and 5th urled in and no splint device in ails on the left hand continued g into the palm of the residents				
	was observed assist cares. NA-A assist and oral care. Durinot observed to cle nor was NA-A obset the residents left had NA-A also did not chand splint for R17 R17's left hand wer long and soiled, preresident also contir present. During interest the observation NA as much for herself On 9/2/15, at 12:21 seated in w/c in din meal. R17's left had	p.m. R17 was observed ing room eating her lunch and was observed with the 3rd, curled inward toward the palm				
	on back in bed slee observed with the 3	a.m. R17 was observed lying eping. R17's left hand was Brd, 4th, and 5th digits curled balm with no splint device in				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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GOOD S	AMARITAN SOCIETY	- MARY JANE BE	'H WALNUT . E, MN 56156			
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2 565	place.  Review of R17's qu (MDS) assessment interview for mental indicating severe co assessment further required extensive hygiene and bathing.  When interviewed of stated being unawas splint device for her one. NA-C confirm east hallway where.  When interviewed of confirmed R17 had velcro that she work stated they would pfind it but many time from staff. NA-D stated they would pfind it but many time from staff. NA-D stated they would pfind it. NA-D stated	arterly minimum data set dated 6/23/15 included a brief status (BIMS) score of 4, ognitive impairment. The indicated the resident assistance with personal g.  on 9/2/15, at 12:46 p.m. NA-C re if R17 had any kind of a left hand as had never seen ed working primarily on the				

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2 565	left hand and confir fingernails were too the residents skin. staff should be offer to prevent skin break cleansing the left had when interviewed of director of nursing (expect nail care to be bath day and as neunaware (as docum that R17 had not has stated if the resident would expect the Nowas unsure why R1 8/28/15 per charting DON observed R17 and confirmed they acknowledged the cand 5th digit nails hoon confirmed experimed and assista R17's left hand as whand splint per the R24's care plan dat required turning and as needed to poweakness and fatig mobility.  R24's positioning as dated 5/28/15, indicated 5/28/15, indicated to prevent skin and lethargy.	med the 3rd, 4th, and 5th digit long causing indentations into LPN-A further confirmed that ring the left hand splint to R17 akdown and assist with and per the plan of care.  on 9/3/15, at 9:40 a.m. the DON) stated she would be provided to residents on eded. DON stated being mented in the medical record at a bath since 8/10/15. DON at is refusing to bathe she A's to notify nursing. DON 7's bath "did not occur" on and would check into it. "Is fingernails on the left hand were too long and deep impressions the 3rd, 4th, and left in the residents palm. Dectations that nails should be ance given with cleansing of well as offering use of the left				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
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2 565	Continued From pa	ge 9	2 565			
		developing a pressure ulcer guide included frequent rs.				
	3:02 p.m. to 5:22 p.	observations on 9/1/15, from m. (2 hours and 20 minutes), 24 remained lying in bed on				
	9:08 a.m. to 12:02	observation on 9/2/15, from o.m. (2 hours and 54 minutes) hat R24 remained lying in bed g.				
	nursing assistant (Nurned and reposition	on 9/2/15, at 1:51 p.m. IA)-B stated R24 was to be oned every 2 hours and n't repositioned within the 2 at morning.				
	dated 9/2/15, at 9:2	ng note and treatment record 0 p.m. indicated Calmoseptine ed to R24's coccyx area due	е			
	and NA-C changed there were 2 small	9/3/15, at 9:11 a.m. that NA-E R24's incontinent pad and reddened areas on the inside NA-C confirmed the reddened parrier cream.				
	manager (CM)-A st NAs to turn and rep	on 9/3/15, at 9:15 a.m. clinica ated she would expect the position R24 every 2 hours as re plan and document if R24	al			
	director of nursing (	on 9/3/15, at 9:24 a.m. the DON) stated R24 should be 2 hours as indicated on the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '			SURVEY PLETED	
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2 565	care plan and confirwasn't done.  Along with the surve the DON and licens observed the redde The DON confirmed areas which could le R24 should be reported by the facilit dated September 2 receive appropriate maintain skin integrous SUGGESTED MET The director of nurs develop, review, an procedures to ensurplans according to the needs. The director could educate all approcedures. The designee could devensure ongoing contast directed by the contact of the survey of of the surv	rmed it was a concern if this eyor on 9/3/15, at 9:50 a.m. led practical nurse (LPN)-A ned areas on R24's buttocks. It R24 had 2 small reddened ead to skin breakdown and esitioned every 2 hours.  By's Pressure Ulcer Policy 012, indicated residents will services to promote and ity.  CHOD OF CORRECTION:  Sing (DON) or designee could d/or revise policies and re the facility develops care the residents individualized of nursing (DON) or designee opropriate staff on the policies are director of nursing (DON) or elop monitoring systems to inpliance with providing cares				
2 840	Proper Nursing Car Subp. 2. Criteria fo	r determining adequate and criteria for determining	2 840			9/29/15

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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.

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2 840	Continued From page 12	2 840				
	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).		No Written POC Needed			
	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					

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STREET ADDRESS, CITY, STATE, ZIP CODE

GOOD S	AMARIJAN SOCIETY - MARY JANE RE	H WALNUT A E, 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) COMPLET DATE
2 840	Continued From page 13	2 840		
	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			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00575	B. WING		09/0	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BE	H WALNUT E, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 840	Continued From pa	ge 14	2 840			
		N was unsure why R17's bath 3/28/15 per charting and would				
	director of nursing a policies and proced assure residents ar bathing plan could resident's plan of ca	THOD OF CORRECTION: The and/or designee could review lures and revise as needed, to be free from offensive odors. A be developed as part of each are. The DON could conduct ch resident is being bathed as				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 860	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 2 F. Adequate and re; Hands-Feet	2 860			9/29/15
	proper care. The c adequate and prop E. per care and att	or determining adequate and riteria for determining er care include: ention to hands and feet. nails must be kept clean and				
	by: Based on observati review the facility fa	ent is not met as evidenced ion, interview and document alled to provide nail care for 1 ) reviewed for activities of daily		No Written POC Needed		
	Findings include:					
	in her wheelchair (v	o.m. R17 was observed seated v/c) in bedroom. The 3rd, 4th, 7's left hand were observed				

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PRINTED: 10/05/2015 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ B. WING 00575 09/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE **GOOD SAMARITAN SOCIETY - MARY JANE BF** LUVERNE, MN 56156 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2860 Continued From page 15 2 8 6 0 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.

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hygiene.

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

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

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PRINTED: 10/05/2015 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00575 09/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE **GOOD SAMARITAN SOCIETY - MARY JANE BF** LUVERNE, MN 56156 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2860 Continued From page 16 2 860 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

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expectations that nails should be trimmed.

audits to monitor for compliance.

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

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00575	B. WING		09/0	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BE	H WALNUT , MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPOSED TO THE APPROPOSED TO THE APPROPOSED CORRECTION (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
2 860	Continued From page 17		2 860			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 895	MN Rule 4658.0529 Motion	5 Subp. 2.B Rehab - Range of	2 895			9/29/15
	that is directed towe through positioning implemented and m comprehensive res of nursing services development of a n provides that:	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which				
	receives appropriat	e treatment and services to notion and to prevent further				
	by: Based on observati review the facility fa maintain and/or pre	ent is not met as evidenced on, interview and document tiled to apply a hand splint to event further decrease in range or 1 of 1 resident (R17) and range of motion.		No Written POC Needed		
	Findings include:					
	observed in the din residents during a s and 5th digits of R1	roximately 3:00 p.m. R17 was ing room with staff and other social activity. The 3rd, 4th 7's left hand were observed to wards the palm with no splint				
	On 9/1/15, at 1:25 p	o.m. R17 was observed seated				

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STATEMENT OF DEFICIENCIES (X1) F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/SUP			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
				7.1. 20122.110.1			
		00575		B. WING		09/0	3/2015
NAME OF PR	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD SA	GOOD SAMARITAN SOCIETY - MARY JANE BE			H WALNUT E, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY I SC IDENTIFYING INFORMA'	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
	4th, and 5th digits of observed curled invivand. When questic could straighten the able to and if forced break". R17 was old and 5th fingertips of them slightly off the remaining curled intermed them any moved them and gifts of left hand cuplace.  On 9/2/15, at 7:44 awas observed assist cares. NA-A comploral care but did no hand splint for R17'  On 9/2/15, at 12:21 seated in w/c in dinimeal. R17's left had th, and 5th digits owith no evidence of On 9/3/15, at 8:47 as supine in bed asleed observed with the 3 inward toward the place.  The occupational the and discharge sumincluded: "Pt. (patie	w/c) in her bedroom.  If R17's left hand wer  If R17's left hand wer  If and toward the palm  If to they would "probate  If to they would "probate  If the left hand enough  If palm of her hand who  If ward. R17 stated if sore, it would hurt.  If was observed  If your left hand.  If was observed  If was observed  If your left hand.  If was observed  If was obser	of her of her of if R17 not being ably 3rd, 4th, of to raise nile still the ed seated and 5th device in t (NA)-A g (AM) e and btain a ved unch of the 3rd, the palm ed lying as a curled vice in progress 1/14 ar	2 895			

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STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00575	B. WING		09/0	3/2015
NAME OF PROVIDER OR SUP	PLIER STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD SAMARITAN SOO	HETY - MARY JANE RE	TH WALNUT A E, MN 56156	VENUE		
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
"Caregivers tr with instruction skin checks, a palmar skin be review of R11 (MDS) assess Brief Interview 4, indicating so R17's plan of following: "PE requires 1 state hygiene. Reshand; "trigger to keep clean palm protecto."  When interview stated being use of a splint deviseen one. Not the east hallw. When interview stated being use her left hand to the palm. When interview stated being use her left hand to the palm. When interview stated they we locate the spling would "hide it" cooperative wow was able to respect to the spling would "hide it" cooperative wow was able to respect to the spling would "hide it" cooperative wow was able to respect to the spling would "hide it" cooperative wow was able to respect to the spling would "hide it" cooperative work was able to respect to the spling would "hide it" cooperative wow was able to respect to the spling would "hide it" cooperative work was able to respect to the spling would "hide it" cooperative work was able to respect to the spling would "hide it" cooperative work was able to respect to the spling would "hide it" cooperative work was able to respect to the spling would "hide it" cooperative work was able to respect to the spling would "hide it" cooperative work was able to respect to the spling would "hide it" cooperative work was able to respect to the spling would "hide it" cooperative work was able to respect to the spling would "hide it" cooperative work was able to respect to the spling work was able to respect to th	The note further indicated: ained on daily wearing schedule ns to remove for dressing changes and bathing, to prevent left (L)				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00575	B. WING		09/0	3/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  110 SOUTH WALNUT AVENUE						
GOOD S	AMARITAN SOCIETY	- MARY JANE RE	, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 20	2 895			
	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.					
	director of nursing of	on 9/3/15, at 9:40 a.m. the confirmed she would expect e of the left hand splint to R17 e.				
	physical therapist (I R17's splint was mi therapy had not bee to be replaced. PT	on 9/3/15, at 10:26 a.m. the PT) stated being unaware that issing and to his knowledge en notified if the splint needed stated that he manages the t and would have notified if a ed to be ordered.				
	director of nursing of residents at risk for assure they are rec treatment/services range of motion. The designee, could could delivery of care; to	THOD OF CORRECTION: The or designee, could review all limited range of motion to reiving the necessary to prevent further limitation in the director of nursing or induct random audits of the ensure appropriate care and mented; to reduce the risk of a motion.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 905	MN Rule 4658.0525	5 Subp. 4 Rehab - Positioning	2 905			9/29/15
	Subp. 4. Positionin	g. Residents must be				

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PRINTED: 10/05/2015 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00575 09/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE **GOOD SAMARITAN SOCIETY - MARY JANE BF** LUVERNE, MN 56156 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 9 0 5 Continued From page 21 2 9 0 5 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 No Written POC Needed 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.

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and lethargy.

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

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00575	B. WING		09/	03/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BE	TH WALNUT E, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 905	was at mild risk for and the intervention turning every 2 hou R24's care plan dat required turning and and as needed to p weakness and fatig mobility.  During continuous 3:02 p.m. to 5:22 p. it was noted that R2 her back sleeping.  During continuous 69:08 a.m. to 12:02 p. it was again noted to n her back sleepin.  During an interview nursing assistant (N turned and reposition)	developing a pressure ulcer a guide included frequent rs.  led 6/9/15, indicated R24 drepositioning every 2 hours revent skin-breakdown due to ue from limited physical  lobservations on 9/1/15, from m. (2 hours and 20 minutes), 24 remained lying in bed on lobservation on 9/2/15, from lo.m. (2 hours and 54 minutes) that R24 remained lying in bed leg.  on 9/2/15, at 1:51 p.m. lay. B stated R24 was to be oned every 2 hours and n't repositioned within the 2				
	dated 9/2/15, at 9:2	ng note and treatment record 0 p.m. indicated Calmoseptine ed to R24's coccyx area due	9			
	and NA-C changed there were 2 small	9/3/15, at 9:11 a.m. that NA-B R24's incontinent pad and reddened areas on the inside NA-C confirmed the reddened parrier cream.				
	manager (CM)-A st	on 9/3/15, at 9:15 a.m. clinica ated she would expect the position R24 every 2 hours as	1			

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PRINTED: 10/05/2015 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ B. WING 00575 09/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE **GOOD SAMARITAN SOCIETY - MARY JANE BF** LUVERNE, MN 56156 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 9 0 5 Continued From page 23 2 9 0 5 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

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compliance.

(21) days.

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

TIME PERIOD FOR CORRECTION: Twenty One

PRINTED: 10/05/2015 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00575 09/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE **GOOD SAMARITAN SOCIETY - MARY JANE BF** LUVERNE, MN 56156 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 965 Continued From page 24 2 965 2 965 MN Rule 4658.0600 Subp. 2 Dietary Service 2 965 9/29/15 -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 No Written POC Needed 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

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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

R21's medical record included a dietician

months post admission.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00575	B. WING	·····	09/	03/2015
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- MARY JANE RE 110 SOU	DDRESS, CITY, S TH WALNUT A E, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 965	assessment, dated R21 had adequate but with a history of Documentation in the nutritional progress 11:43 a.m. that R21 weight loss in the laidentified R21 was recommendation in receive calorie dens strength (DS) choos and between meal substantial	3/21/15, which identified that food and fluid for body needs insufficient food and fluid.  The medical record identified a note dated 5/7/15, timed weighed 113.5 #, a 5% ast month. The note further receiving a regular diet. A the note indicated R21 should be foods with 8 ounces double colate milk BID (twice daily) snacks.  21's daily meal intake from the documentation indicated 25% or less of her meals and med 26%-50%. The discharge ation dated 6/1/15, indicated: nal Status-(document ct resident's ability to maintain ion). The notation "None" was		DEL ROLLINOT)		
	(DON) on 9/02/15, a was unable to ident a plan of care deve	th the director of nursing at 1:49 p.m. she stated she ify in the record that R21 had loped after the resident was weight loss. The DNS verified				

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FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00575 09/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE **GOOD SAMARITAN SOCIETY - MARY JANE BF** LUVERNE, MN 56156 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 9 6 5 Continued From page 26 2 965 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.

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