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: RHTV
Facility ID: 00903

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245207**

2. STATE VENDOR OR MEDICAID NO. (L2) **722519900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - STILLWATER**
(L4) **1119 OWENS STREET NORTH**
(L5) **STILLWATER, MN** (L6) **55082**

4. TYPE OF ACTION: 7 (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/19/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited | 1 TJC | 2 AOA | 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

11. .LTC PERIOD OF CERTIFICATION

From (a) :

To (b) :

12.Total Facility Beds **94** (L18)

13.Total Certified Beds **94** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:

____1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	94			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS

1861 (e) (1) or 1861 (j) (1): (L15)

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :

Sue Reuss, Unit Supervisor 12/19/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:

Anne Kleppe, Enforcement Specialist 02/28/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY

_X_ 1. Facility is Eligible to Participate

____ 2. Facility is not Eligible

(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **05/01/1976** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS

A. Suspension of Admissions: (L44)

B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**

01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY

05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER

07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **01/16/2014** (L33)

DETERMINATION APPROVAL

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: RHTV

Facility ID: 00903

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24-5207

December 19, 2013 Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective November 30, 2013, the facility is certified for 94 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5207

February 28, 2014

Mr. Nathan Pearson, Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, Minnesota 55082

Dear Mr. Pearson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 30, 2013, the above facility is certified for:

94 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 94 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Mr. Nathan Pearson, Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, MN 55082

RE: Project Number S5207024

Dear Mr. Pearson:

On November 15, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 31, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On December 19, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 31, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 30, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 31, 2013, effective November 30, 2013 and therefore remedies outlined in our letter to you dated November 15, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Susanne Reuss

Susanne Reuss, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 651-201-3793 Fax: 651-201-3790

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245207	A. Building B. Wing	12/19/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - STILLWATER	1119 OWENS STREET NORTH STILLWATER, MN 55082

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	11/30/2013	ID Prefix F0314 Reg. # 483.25(c) LSC	11/30/2013	ID Prefix F0315 Reg. # 483.25(d) LSC	11/30/2013
ID Prefix F0373 Reg. # 483.35(h) LSC	11/30/2013	ID Prefix F0441 Reg. # 483.65 LSC	11/30/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	02/28/2014	16022	12/19/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/31/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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ID: RHTV
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(L1) **245207**

2.STATE VENDOR OR MEDICAID NO.
(L2) **722519900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - STILLWATER**
(L4) **1119 OWENS STREET NORTH**
(L5) **STILLWATER, MN** (L6) **55082**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/31/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **94** (L18)

13.Total Certified Beds **94** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	94			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mary Capes, HFE NE II 12/02/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 01/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1976
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 1/16/14 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24-5207

At the time of the standard survey completed October 31, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7593

November 15, 2013

Mr. Nathan Pearson, Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, Minnesota 55082

RE: Project Number S5207024

Dear Mr. Pearson:

On October 31, 2013, 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>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:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
Fax: (651) 201-3790

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 December 10, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 January 31, 2014 (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 May 1, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. BUILDING ____ B. WING ____	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - STILLWATER	1119 OWENS STREET NORTH STILLWATER, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. All deficiencies will be reviewed by the Quality Assurance Committee on 3/28/2012 for appropriate recommendations.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for 2 of 4 residents (R8, R 25) for repositioning and incontinence care. Findings include R8 did not receive assistance with re-positioning and incontinence care according to the plan of care. R8's care plan dated 10/30/13, directed staff: assist of 2 for re-positioning and incontinence care every two hours when awake.	F 282 12/2/13 SER	F 282 Care Plans for R8 & R25 will be reviewed to ensure accuracy related to repositioning, special equipment, off loading and incontinence care. New B&B assessments and tissue tolerance assessments will be completed and care plans will be updated accordingly. We will continue to do our assessments on all residents with every quarterly, annual, or sig change MDS and update care plans accordingly. The Staff Development Coordinator has started training priority staff and will re-educate nursing staff on the importance of following the resident's plan of care related to repositioning and incontinence care. Training will continue and be completed by December 15th. The DNS will develop an audit tool to monitor and ensure compliance. Results of these audits will be reviewed by the QA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 11/26/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 During observation on 10/28/13, at 4:00 p.m. until 7:40 p.m.(three hours and forty minutes), R8 was sitting in a wheel chair without a pressure relieving cushion. The cushion was observed on the floor next to the night stand in R8's room. R8 complained of "Bottom hurting!" During observation on 10/30/13 from 7:00 a.m. until 11:30 a.m. (four hours and thirty minutes), R8 was sitting in a wheel chair with a pressure relieving cushion. Interview with registered nurse RN-B at 9:00 a.m., on 10/31/13, regarding facility expectations for resident's requiring assistance with re-positioning and toileting, RN-B verified it was to be completed every two hours for R8 according to the plan of care. R25 did not receive staff assistance with positioning and incontinence care according to the plan of care. R25's skin integrity care plan, last revised 2/11/13, directed staff ""Bed mobility: Resident requires extensive assist of 1 staff participation to turn and reposition Q2H [every 2 hours] and prn [as needed] in bed. Able to reposition self independently at times with use of grab bars." R25's care plan, last revised 2/7/13, directed staff, "Toilet Use: Resident requires extensive assist of 1 staff participation to use toilet. Toileting Schedule: Check Q2H [every two hours], change prn [as needed] per manufacturers gudielines [sic] Does not make needs known." On 10/30/13, during continuous observation from 7:30 a.m. and 10:40 a.m.,(3 hours and 10 minutes), R25 was not toileted, repositioned or offloaded. At 10:30 a.m. a nursing assistant,	F 282	committee monthly x6 months and then quarterly thereafter. Date Certain RECEIVED DEC 2 - 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	11/30/13

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F 282	Continued From page 2 (NA)-F, moved R25 into his room. NA-F then left the room, reporting that she needed to get the standing lift and another nursing assistant to help. NA-F and NA-B assisted R25 onto the standing lift, moved him into the bathroom and lowered him onto the toilet at 10:40 a.m. NA-B reported R25's brief was a little wet with urine. During interview on 10/30/13 at 10:55 a.m. NA-F reported she last checked R25 for incontinence at 7:30 a.m. When asked when R25 was last repositioned or offloaded, NA-F reported she last had R25 "move his bottom about" at about 9:15 a.m. This was not observed by surveyor continuous observation. NA-F reported R25 was provided morning cares at 6:00 a.m. On 10/30/13 at 12: 13 p.m., the registered nurse manager for the unit, (RN)-B, reported R25 should be checked for incontinence and changed if necessary every 2 hours.On 10/30/13 at 12:13 p.m., the registered nurse manager for the unit, (RN)-B, reported R25 could not reliably offload himself for the full minute required to prevent pressure ulcers due to his lack of arm strength and inability to consistently follow directions. Having R25 offload himself would not be following the care plan.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314	F314 Care plans for R8 & R25 will be reviewed to ensure accuracy related to pressure ulcer prevention and repositioning. A new Braden assess Care plans for R8 & R25 will be reviewed to ensure accuracy related to pressure ulcer prevention and repositioning. A new Braden assessment and tissue tolerance will be completed and care plans updated accordingly.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 3 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 4 residents (R8 and R25) at risk for pressure ulcers, received timely repositioning. Findings include R 8 was not provided services to prevent pressure ulcers. R8 was assessed and care planned to be repositioned every two hours, R8 was not repositioned from 4:00 p.m. to 7:40 p.m. (three hours and forty minutes) on 10/28/13, and R8 was not repositioned from 7:00 a.m. to 11:30 a.m. (four hours and thirty minutes) on 10/30/13. During the initial observation at 4:00 p.m. on 10/28/13, R8 was sitting in the wheel chair and the pressure relieving cushion was on the floor next to the bedside cabinet. R8 complained of "bottom hurting!" and was unable to shift or raise buttocks from the seat of the wheel chair. At 5:00 p.m. R8 was taken to the day room. At 6:00 p.m. a staff member wheeled R8 into the dining room for supper. At 7:00 p.m. R8 was wheeled from the dining room to the day room for an activity. At 7:40 p.m. R8 continued to be at the evening activity sing along. There was no offer to change position for R8. During continuous observation on 10/30/13, at 7:00 a.m. R8 sat up in a wheelchair with a	F 314	We will continue to do Braden and tissue tolerance assessments with every quarterly, annual, and sig change MDS and update care plans accordingly. The DNS will review policies and procedures with the staff development coordinator and nurse managers and update if needed. The staff development coordinator has started training priority staff and will re-educate all nursing staff on correct toileting procedures for continent and incontinent residents. Training will continue and be completed by December 15th. The DNS will develop an audit tool to monitor and ensure compliance. Results of these audits will be reviewed by the QA committee monthly x6 months and then quarterly thereafter Date Certain	11/30/13

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F 314	Continued From page 4 pressure relieving cushion. R8 propelled self into the dining room for coffee and breakfast. At 8:45 a.m. registered nurse (RN)B took R8 from the dining room to the medication cart by the nursing office to administer medications. At 9:00 a.m. R8 was wheeled into the Garden Room for an activity and remained in the Garden Room until 10:35 a.m. when R8 propelled self while in the wheel chair to R8's bedroom where R8 remained in the wheel chair and was looking out of the window. At 10:50 a.m. an activity staff member asked R8 if they would like to go to music and R8 stated, "No, I don't feel very well." At 11:15 a.m. R8's call light was turned on for assistance with positioning. At 11:30 a.m. NA-A and NA-B using the mechanical lift, raised R8 off buttocks after removing R8's feet from the wheel chair pedals and R8 stated, "Oh that feels good." R8 was turned from side to side in the bed to remove Capri pants where observation revealed the outside of pants legs in the back had softball size wet areas bilaterally. After the pants were removed it was discovered the brief was saturated with urine and R8 was observed to be incontinent of a small soft bowel movement. R8's skin was observed to have red creases and crevices from the brief and deep indentations on the bilateral buttocks. There was a small, open, new abrasion approximate size 1.5 X .25 centimeter in the left lower abdominal area of R8's body that RN-C thought could have been caused by the incontinence brief tab. During an interview at 11:00 a.m. on 10/30/13, with nursing assistant (NA)-A, verified the night shift had gotten R8 up for the day and that NA-A had provided no cares and stated," [R8] usually turns on the call light if [R8] has to go to the bathroom." RN-B was interviewed at 11:30 a.m. on 10/30/13 and verified R8 was to be on an	F 314		

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F 314	Continued From page 5	F 314		

every two hour position change due to [R8] being at risk for developing pressure ulcers. RN-C was interviewed at 11:45 a.m. and verified R8 had multiple deep crevices and creases throughout the areas of where the brief had been and that the new abrasion was probably from the incontinence and plastic of the brief.

Document review of R8's plan of care dated 10/30/13, directed staff to reposition every two hours. R8's plan of care indicated a diagnosis of multiple sclerosis with Dementia requiring the use of a sit-stand lift for positioning and extensive assist of 2 staff due to no longer bearing body weight.

The facility failed to provide the services necessary to prevent pressure ulcers for R25, assessed as at risk of pressure ulcers.

R25's care area assessment for pressure ulcers, dated 1/22/13, revealed, "Resident is at risk for developing pressure ulcers" with an assessed goal as minimizing risk and avoiding complications. R25's quarterly Minimum Data Set, dated 9/26/13, indicated R25 required extensive physical assistance of two staff members for bed mobility and extensive physical assist of one staff member for transferring between surfaces.

R25's skin integrity care plan, last revised 2/11/13, directed staff "Resident has actual impairment to skin integrity R/T [related to] fecal incontinence E/B [evidenced by] shearing on sacrum." with goals of "Resident will be free of further skin injury through the review date." R25's ADL [activities of daily living] care plan directed staff "Resident has an ADL self care performance

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F 314	Continued From page 6	F 314		

deficit R/T Parkinson's, dementia, osteoarthritis E/B need for extensive assist with dressing, bathing, grooming and oral care." Interventions included "Bed mobility: Resident requires extensive assist of 1 staff participation to turn and reposition Q2H [every 2 hours] and prn [as needed] in bed. Able to reposition self independently at times with use of grab bars."

On 10/30/13, R25 was not repositioned or offloaded for 3 hours and 10 minutes during continuous morning observation between 7:30 a.m. and 10:40 a.m. R25 was observed sitting in the wheelchair at 7:30 a.m. At 7:45 a.m. R25 was taken to the dining room for breakfast. R25 remained in the dining room until 9:35 a.m. At 9:35 a.m. R25 was moved to the commons area. Between 9:40 a.m. and 10:15 a.m., R25 remained in the commons area with no staff interaction, nodding his head, opening and closing his eyes and leaning to the left. At 10:15 a.m. the floor nurse, (LPN)-A, moved R25's left arm from hanging off the seat to R25's lap. No offer to offload or reposition R25 was made at this time. At 10:30 a.m. a nursing assistant, (NA)-F, moved R25 into his room. NA-F then left the room, reporting that she needed to get the standing lift and another nursing assistant to help. At 10:35 a.m. NA-F entered the room with NA-B and the standing lift. NA-F and NA-B assisted R25 onto the standing lift, moved him into the bathroom and lowered him onto the toilet at 10:40 a.m. After toileting, R25 was assisted back onto the standing lift and placed in bed to rest at 10:50 a.m.

During interview on 10/30/13 at 10:55 a.m., when asked when R25 was last repositioned or

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F 314	Continued From page 7 offloaded, NA-F reported she last had R25 "move his bottom about" at about 9:15 a.m. This was not observed during continuous observation. NA-F reported R25 was provided morning cares at 6:00 a.m. NA-F explained three aides were on the unit from approximately 6:00 a.m. until 10:00 a.m. instead of the usual four, resulting in her being responsible for the care of 14 residents during that time. NA-F reported "it was crazy" and she did not feel she could adequately care for that many residents. On 10/30/13 at 12:13 p.m., the registered nurse manager for the unit, (RN)-B, reported R25 could not reliably offload himself for the full minute required to prevent pressure ulcers due to his lack of arm strength and inability to consistently follow directions. Having R25 offload himself would not be following the care plan.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 4 residents	F 315	F315 Care plans for R8 and R25 will be reviewed to ensure accuracy related to toileting and pressure ulcer prevention. A new B&B assessment, Braden, and tissue tolerance assessment will be completed and care plans updated accordingly. We will continue to do Braden, tissue tolerance, and B&B assessments with every quarterly, annual, and sig change MDS and care plans updated accordingly. The staff development coordinator has started training priority staff and will re-educate all nursing staff on the importance of following toileting programs and pressure ulcer prevention. Training will continue and be completed by December 15th. The DNS will develop an audit tool to monitor and ensure compliance. The QA	

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F 315	Continued From page 8 (R8, R25), who were identified as incontinent of urine, received the necessary care and services to manage urinary incontinence.	F 315	committee will review these audits monthly x6 months and then quarterly thereafter. Date Certain	11/30/13

Findings include

R 8 did not recieve care and services to manage urinary incontinence.

R8 was assessed and care planned to be toileted every two hours, R8 was not toileted from 4:00 p.m. to 7:40 p.m. (three hours and forty minutes) on 10/28/13, and R8 was not toileted from 7:00 a.m. to 11:30 a.m. (four hours and thirty minutes) on 10/30/13.

During the initial observation at 4:00 p.m. on 10/28/13, R8 was sitting in the wheel chair and the pressure relieving cushion was on the floor next to the bedside cabinet. R8 complained of "bottom hurting!" and was unable to shift or raise buttocks from the seat of the wheel chair. At 5:00 p.m. R8 was taken by husband to the day room. At 6:00 p.m. a staff member wheeled R8 into the dining room for supper. At 7:00 p.m. R8 was wheeled from the dining room to the day room for an activity. At 7:40 p.m. R8 continued to be at the evening activity sing along. There was no offer from staff to toilet R8.

During continuous observation on 10/30/13, at 7:00 a.m. R8 was observed to be sitting in a wheelchair. R8 propelled self into the dining room for coffee and breakfast. At 8:45 a.m. registered nurse (RN)B took R8 from the dining room to the medication cart by the nursing office to administer medications. At 9:00 a.m. R8 was wheeled into the Garden Room for an activity and remained in the Garden Room until 10:35 a.m. when R8

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F 315	Continued From page 9 propelled self while in the wheel chair to R8's bedroom where R8 remained in the wheel chair and was looking out of the window. At 10:50 a.m. an activity staff member asked R8 if they would like to go to music and R8 stated, "No, I don't feel very well." At 11:15 a.m. R8's call light was turned on for assistance with toileting. At 11:30 a.m. NA-A and NA-B using the mechanical lift, raised R8 off buttocks after removing R8's feet from the wheel chair pedals and R8 stated, "Oh that feels good." R8 was turned from side to side in the bed to remove Capri pants where observation revealed the outside of pants legs in the back had softball size wet areas bilaterally. After the pants were removed it was discovered the brief was saturated with urine and R8 was observed to be incontinent of a small soft bowel movement. During an interview at 11:00 a.m. on 10/30/13, with nursing assistant (NA)-A, verified the night shift had gotten R8 up for the day and that NA-A had provided no cares and stated," [R8] usually turns on the call light if [R8] has to go to the bathroom." RN-B was interviewed at 11:30 a.m. on 10/30/13 and verified R8 was to be on an every two hour check and change for incontinence. Document review of R8 plan of care dated 10/30/13, directed staff to be checked and changed every two hours for incontinence. R8's plan of care indicated a diagnosis of multiple sclerosis with Dementia requiring the use of a sit-stand lift for positioning and extensive assist of 2 staff due to no longer able to bear body weight. The facility failed to provide the services necessary to manage incontinence for R25.	F 315		

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R25's bladder assessment, dated 9/20/13, revealed R25 had functional incontinence (incontinence secondary to other factors) and required check and change services every two hours. R25's minimum data set [MDS], dated 9/06/2013, revealed R25 was frequently incontinent of urine and required extensive assistance of two staff for toileting.

R25's care plan, last 2/7/13, directed staff " Resident has bladder incontinence R/T [related to] Parkinson's, dementia, E/B [evidenced by] need for extensive assist with toileting. Functional incontinence." Interventions included "Brief use: T-pad." Directions also included "Resident has an ADL [activities of daily living] self care performance deficit R/T Parkinson's, dementia, osteoarthrosis E/B need for extensive assist with dressing, bathing, and oral care." Interventions included "Toilet Use: Resident requires extensive assist of 1 staff participation to use toilet. Toileting Schedule: Check Q2H [every two hours], change prn [as needed] per manufacturers gudielines [sic] Does not make needs known."

On 10/29/13 an odor of urine was observed when standing near R25 in his room. The urine odor was not noticeable elsewhere in the room.

On 10/30/13, R25 was not toileted for 3 hours and 10 minutes during continuous morning observation between 7:30 a.m. and 10:40 a.m. R25 was observed sitting in his wheelchair at 7:30 a.m. At 7:45 a.m. R25 was taken to the dining room for breakfast. R25 remained in the dining room until 9:35 a.m. At 9:35 a.m. R25 was moved to the commons area. Between 9:40 a.m. and 10:15 a.m., R25 remained in the commons area with no staff interaction, nodding his head,

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F 315	Continued From page 11 opening and closing his eyes and leaning to the left. At 10:15 a.m. the floor nurse, (LPN)-A, moved R25's left arm from hanging off the seat to R25's lap. No offer to toilet R25 was made at this time. At 10:30 a.m. a nursing assistant, (NA)-F, moved R25 into his room. NA-F then left the room, reporting that she needed to get the standing lift and another nursing assistant to help. At 10:35 a.m. NA-F entered the room with NA-B and the standing lift. NA-F and NA-B assisted R25 onto the standing lift, moved him into the bathroom and lowered him onto the toilet at 10:40 a.m. At 10:46 a.m. NA-B reported R25's brief was a little wet with urine. NA-B, reported being familiar with R25's habits, explained R25 typically stored his urine and released a lot of it at once. At 10:50 a.m., NA-F cleaned R25's perineal area, assisted putting R25's clothes back on, stood him up with the lift and moved him to his bed. R25 was placed in bed to rest at 10:50 a.m. During interview on 10/30/13 at 10:55 a.m. NA-F reported she last checked R25 for incontinence at 7:30 a.m. NA-F reported R25 was provided morning cares at 6:00 a.m. On 10/30/13 at 12:13 p.m., the registered nurse manager for the unit, (RN)-B, reported R25 should be checked for incontinence and changed if necessary every 2 hours.	F 315		
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding	F 373	F373 A review of staff who are assisting with feeding residents will be completed to ensure that they have completed the required eight hour feeding assistant program. Staff who do not meet the criteria will not be allowed to feed residents until they have successfully completed the paid feeding assistance class.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. BUILDING ______ B. WING ______	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - STILLWATER	1119 OWENS STREET NORTH STILLWATER, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 373	Continued From page 12 residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control.	F 373	A resident dining assessment will be completed on all residents that are currently receiving assistance with eating to determine if they would be appropriate to receive feeding assistance from a paid feeding assistant. All residents will have a resident dining assessment completed on admission and with quarterly, annual, and sig change MDSs. The staff development coordinator will maintain a record of all persons who have successfully completed the paid feeding assistant program. A list of all residents that are appropriate to receive dining assistance from a paid feeding assistant will be maintained in the resident dining areas. It will be the responsibility of the RN completing the assessment to maintain an accurate list. The DNS will develop an audit tool to monitor and ensure compliance. The QA committee will review the audits monthly x6 months and quarterly thereafter. Date Certain	11/30/13

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F 373	Continued From page 13 Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 4 residents, R82, R101 and R153, reviewed for assistance with feeding, were comprehensively assessed to be fed by a paid feeding assistant [non-nursing trained staff used to assist residents with feeding] and fed by a feeding assistant with the proper training. Findings include: R101 was fed by an untrained paid feeding assistant and was not appropriately assessed to be fed by a paid feeding assistant. R101's Minimum Data Set, 10/3/13, indicated R101 had no signs of current swallowing disorders and was fed a mechanically altered diet. R101's care plan for nutrition, last revised 4/16/13 directed staff to serve a "regular diet. Pureed level 1 texture, nectar thickened fluids." and "Staff to provide assisted feeding at mealtimes." A	F 373		

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F 373	Continued From page 14	F 373		

palliative care care plan, last revised 10/22/13, directed staff "The resident has a terminal prognosis R/T [related to] End Stage Dementia E/B [evidenced by] difficulty swallowing and weight loss"

During breakfast observation on 10/30/13 from 8:30 a.m. until a.m., R101 was observed being fed spoonfuls of pureed french toast and pureed sausage into her mouth by a social worker, (LSW)-A. R101 was observed to expel emesis with mucus and brown food particles into a napkin. The director of social services (LSW)-B then sat down and was observed to put a glass of thickened juice up to R101's mouth to assist her to drink.

On 10/31/13 at 8:00 a.m., the nurse manager for the unit, (RN)-B, reported there was no further assessment of R101's suitability to be fed by a paid feeding assistant.

On 10/31/13 at 1:18 p.m., the education coordinator, (LPN)-B, reported R101 should not have been fed by a paid feeding assistant due to requiring a thickened liquid.

R82 was fed by an untrained feeding assistant and was not appropriately assessed to be fed by a paid feeding assistants.

During breakfast observation on 10/30/13 between 8:30 a.m. and 9 a.m LSW-A was observed feeding spoonfuls of cereal to R82's mouth and putting a cup of orange juice to his mouth to drink. LSW-B then sat next to R82 and assisted R82 with drinking juice by putting the cup up to his mouth. R82 shook his head "no". R82

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F 373	Continued From page 15	F 373		

then accepted spoonfuls of mechanically altered sausage and regular raisin bran with milk from a spoon put near his mouth by LSW-B.

A "Resident Dining Assessment" completed by a dietary staff member dated 8/30/13, indicated R82 did not have signs of a current swallowing disorder. The assessment did not indicate if it would be appropriate for R82 to be fed by a paid feeding assistant. R82's Admission Record, last revised 8/30/13, indicated diagnoses of dysphagia (difficulty swallowing), dementia with lewy bodies and paralysis agitans. The nutritional care plan, last revised on 10/25/13, directed staff to serve a "Regular diet, level 2 mechanical soft texture."

On 10/31/13 at 8:00 a.m. RN-B reported there was no other formal assessment to determine suitability for R82 to be fed by a paid feeding assistant.

On 10/31/13 at 1:18 p.m. LPN-B reported paid feeding assistants should check with a nurse prior to feeding R82.

R153 was fed by an untrained feeding assistant and was not appropriately assessed to be fed by a paid feeding assistants.

R153's admission record, dated 10/29/13, revealed R153 was receiving care following surgery of the teeth, oral cavity and digestive system. R153's care plan, dated 10/30/13, directed staff "[R153] is recently post operative and receives a Regular diet, Dental soft texture."

During breakfast observation on 10/30/13

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F 373	Continued From page 16 between 8:30 a.m. and 9 a.m., LSW-A was observed feeding R153 spoonfuls of hot rice cereal. On 10/30/13 at approximately 11:00 a.m. LSW-B reported she was not aware of which residents she was allowed to feed as a paid feeding assistant and who she was not allowed to feed. LSW-A reported she assumed a nurse would tell her if she should not feed someone and would determine who to feed by walking around the dining room and feeding residents who appeared to need assistance. On 10/30/13 at approximately 2:00 p.m. the human resource manager confirmed LSW-A was not current on the nursing assistant registry. On 10/31/13 at 8:00 a.m., RN-B, reported R153 had not yet been assessed for nutritional and dining related concerns due to still being new to the facility. On 10/31/13 at 1:00 p.m. LPN-B confirmed LSW-A did not have documentation confirming completion of a paid feeding course. On 10/31/13 at 1:18 p.m. LPN-B reported staff should check with a licensed nurse prior to assisting R153 with feeding. The Dining Assistant Policy and Procedure, last revised 08/2012, directed staff " An RN completes an assessment of the resident before the services of a dining assistant are used for the first time. The center must ensure that a dining assistant feeds only residents who have no	F 373		

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F 373	Continued From page 17 complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The resident selection must be based on the latest assessment and plan of care." " The assessment must be reviewed and updated whenever there is a change in dining ability, and at a minimum, reviewed quarterly." "The center will maintain a record of all individuals used by the center as paid dining assistants and must maintain documentation of successful completion of a state-approved training course by these individuals."	F 373		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	F441 The facility staff will continue to follow appropriate infection control policies and procedures. Nurse RNA has received 1:1 education regarding following correct infection control techniques with emphasis on changing gloves. The staff development coordinator has started training priority staff and will re-educate all nursing staff on correct infection control techniques and practices. Training will continue and completed by December 15th The DNS will develop an audit tool to monitor and ensure compliance. Results of these audits will be reviewed by the QA committee monthly x6 months and quarterly thereafter. Date Certain	11/30/13

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F 441	Continued From page 18 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper handwashing and glove changes were completed on 1 of 1 residents (R27) receiving tracheostomy (tube placed in the trachea) cares. Findings include: Observation of tracheostomy tube change on 10/28/13 at 7:00 p.m., the registered nurse (RN) A, did not change gloves and wash hands per facility policy. RN A completed the tracheostomy tube change, R27's eyedrops, and then administered R27's nebulizer medications. RN A then removed gloves and washed hands. Upon interview,at 7:35 p.m., RN A indicated should have changed gloves and washed hands after the tracheostomy change and again after the eye drops were administered. Review of the undated "change of Tracheostomy	F 441		

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F 441	Continued From page 19 tube" policy, indicated upon the completion of the tube change, the staff was to wash hands thoroughly. Review of the eye medication procedure dated November 2002 and revised January 2009, directed staff to wash hands before and after the administration of eye medication.	F 441		

F5207023

Printed: 11/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. BUILDING **01 - STILLWATER GOOD SAMARITAN** B. WING ______	10/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - STILLWATER	**1119 OWENS STREET NORTH STILLWATER, MN 55082**

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K 000	INITIAL COMMENTS Surveyor: 12424 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society Stillwater was found 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Good Samaritan Society Stillwater is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1966 and was determined to be of Type II(111) construction. In 1968, an addition was constructed to the South side of the building that was determined to be of Type II(111) construction. In 1995, an addition was constructed to the East side of the building that was determined to be of Type II(111) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 99 beds and had a census of 92 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 000	Continued From page 1 *TEAM COMPOSITION* Tom Linhoff, Life Safety Code Spc.	K 000		

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7593

November 15, 2013

Mr. Nathan Pearson, Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, Minnesota 55082

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5207024

Dear Mr. Pearson:

The above facility was surveyed on October 28, 2013 through October 31, 2013 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, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
Fax: (651) 201-3790

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 me.

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,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File