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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SZT6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00967

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245317**

2. STATE VENDOR OR MEDICAID NO. (L2) **692515400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - COMFORCARE**
(L4) **1201 17TH STREET NE**
(L5) **AUSTIN, MN** (L6) **55912**

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 **4/5/2016** (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 **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
X 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
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Christina Smith, HFE NE II 04/18/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/18/2016 (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 **06/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245317

April 18, 2016

Ms. Megan Diamond, Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, MN 55912

Dear Ms. Diamond:

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

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

Effective March 31, 2016 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 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,

Kamala Fiske-Downing

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

Electronically delivered
April 18, 2016

Ms. Megan Diamond, Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, MN 55912

RE: Project Number S5317027

Dear Ms. Diamond:

On February 16, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective March 8, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on January 28, 2016, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on March 24, 2016. The most serious deficiencies at the time of the revisit were found 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 April 5, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on March 24, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 31, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on March 24, 2016, as of March 31, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 31, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of March 30, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 28, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective April 28, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective April 28, 2016, is to

be rescinded.

In our letter of March 30, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 28, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on March 31, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245317		4/5/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 03/31/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 4/18/2016	SIGNATURE OF SURVEYOR 35567	DATE 4/5/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/28/2016	☐ 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

ID: SZT6

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Facility ID: 00967

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2. STATE VENDOR OR MEDICAID NO. (L2) **692515400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - COMFORCARE**
(L4) **1201 17TH STREET NE**
(L5) **AUSTIN, MN** (L6) **55912**

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 **3/25/2016** (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 **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
X 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 __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date : Christina Smith, HFE NE II 03/30/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Enforcement Specialist 04/18/2016 (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 : _____

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23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered

March 30, 2016

Ms. Megan Diamond, Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, MN 55912

RE: Project Number S5317027

Dear Ms. Diamond:

On February 16, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 28, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 24, 2016, the Minnesota Department of Health and on March 21, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 14, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on January 28, 2016. The deficiency not corrected is as follows:

F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being

The most serious deficiencies in your facility 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), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective April 4, 2016. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective April 28, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective April 28, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 28, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Good Samaritan Society - Comforcare is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 28, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

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

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

- 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 July 28, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900

St. Paul, Minnesota 55164-0900

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	R 03/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE AUSTIN, MN 55912**

(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 An onsite post certification revisit (PCR) was completed on March 25, 2016. The certification tags that were corrected can be found on the CMS2567B. Also there was one tag not found corrected at the time of onsite PCR which is located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	{F 000}		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to contact the physician for blood sugar levels greater than 450, as ordered, for 1 of 3 residents (R2) reviewed for blood sugar monitoring. Findings include: R2's Order Summary Report included a diagnosis of diabetes mellitus and order's for blood sugar to be checked three times a day, also it included	{F 309}	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 federal and state law. For the purposes of any allegation that the center is not in substantial compliance	3/31/16

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

Electronically Signed | 03/31/2016

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
	245317	A. BUILDING _____ B. WING _____	R 03/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 1 staff to contact the doctor if blood sugar readings were less than 70 or greater than 450. On 3/10/16 R2's morning dose of Lantus insulin was increased to eight units daily due to having high blood sugar readings. The American Diabetes Association recommends a fasting plasma glucose level of 70-130 (mg/dL= Milligrams per Deciliter) and after meals less than 180 mg/dL. R2's Medication Administration Record (MAR) revealed on 3/11/16 at 5:30 p.m. R2's blood sugar was 467 and on 3/17/16 at 5:30 p.m. R2's blood sugar was 459. R2's progress notes were reviewed with no documentation of physician contact regarding 3/11/16 or 3/17/16 blood sugar levels found. On 3/25/16 at 10:33 a.m. registered nurse (RN)-A was asked if the R2's blood sugar readings of 467 and 459 had been reported to the doctor and RN-A stated, "If I were to talk to the doctor I would document it in the progress note." Again not documentation was found in regards to notification of the doctor of the blood sugars in the 400s. On 3/25/16 at 11:17 a.m. the director of nursing (DON) stated, "If the documentation isn't in there [progress notes], it isn't in there. The doctor will just tell us to watch them when it's high." Focus Audit's completed by the DON which was part of the plan of correction having been cited on the survey exited 1/28/16 read, "Check the resident [R2] and two other diabetic residents to ensure appropriate notification of abnormal	{F 309}	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 F309 D R2s physician was notified on 3/31/2016 at 10:30 am and reviewed blood glucose levels. The MDS coordinators have reviewed all residents who require blood glucose monitoring to ensure proper physician notifications were made when necessary. The Director of Nursing will provide all nurses with reeducation on 3/31/2016 to ensure facility policy and procedure for physician notification of abnormal glucose levels and change in condition protocols. The Director of Nursing will strengthen the audits for R2 and all other residents who require blood glucose monitoring to ensure appropriate notification of abnormal glucose levels was communicated to the physician. These audits will be increased to be done daily for one month and then weekly times X 4. These audits will be done for all blood glucose checks done in the facility. Results will be taken to quality committee for further recommendations. Completion date will be 3/31/2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	R 03/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE AUSTIN, MN 55912**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 2 glucose levels was communicated to the physician." Audit's were completed 3/11/16, 3/15/16, and 3/22/16 with "yes" box checked for each audit date. On 3/25/16 at 11:30 a.m. the quality assurance (QA) coordinator stated all nursing staff were trained in reporting blood sugar levels out side of parameters to the physician.	{F 309}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245317 Y1	A. Building B. Wing Y2	3/25/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0278	Correction	ID Prefix F0279	Correction	ID Prefix F0280	Correction
Reg. # 483.20(g) - (j)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed
LSC	03/08/2016	LSC	03/08/2016	LSC	03/08/2016
ID Prefix F0282	Correction	ID Prefix F0323	Correction	ID Prefix F0328	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.25(k)	Completed
LSC	03/08/2016	LSC	03/08/2016	LSC	03/08/2016
ID Prefix F0329	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(l)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/08/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	05/05/2016	35567	03/25/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/28/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245317 Y1	A. Building 02 - BUILT IN 2007 B. Wing Y2	3/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0052	03/14/2016	LSC K0104	02/25/2016	LSC K0154	01/27/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0155	01/27/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	03/30/2016	35482	03/21/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/26/2016

☐ 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

ID: SZT6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00967

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245317**

2. STATE VENDOR OR MEDICAID NO. (L2) **692515400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - COMFORCARE**
(L4) **1201 17TH STREET NE**
(L5) **AUSTIN, MN** (L6) **55912**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **01/28/2016** (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 **45** (L18)

13.Total Certified Beds **45** (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
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Christina Smith, HFE NE II 03/02/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/14/2016 (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 **06/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
February 16, 2016

Ms. Megan Diamond, Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, MN 55912

RE: Project Number S5317027

Dear Ms.. Diamond:

On January 28, 2016, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 8, 2016, 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 April 28, 2016 (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 July 28, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278		3/8/16

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

Electronically Signed | 02/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 278	Continued From page 1 resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) included diagnosis of diabetes for 1 of 5 residents (R2) reviewed for unnecessary medications. In addition, the facility failed to ensure documentation supported coding dehydration for 1 of 1 resident (R68) reviewed for dehydration. Findings include: R2's quarterly Minimum Data Set (MDS) dated 11/24/15, section I: active diagnoses, lacked the diagnosis of diabetes mellitus. Quarterly MDS's dated 8/25/15 and 5/27/15, section I, included a diagnosis of diabetes mellitus. R2's physician orders signed 11/11/15 included a diagnosis of "Type 2 Diabetes Mellitus" and orders for Novolog Insulin (injectable medication to treat diabetes). On 1/28/15 at 9:42 a.m. registered nurse (RN)-B, designated MDS nurse, stated, "In the RAI (resident assessment instrument) manual for the diagnosis to be coded on the MDS there must be physician documentation of the diagnosis in the last 60 days and the diagnosis must be active. If they don't have it in their dictation notes I can't code it. Her [R2] last quarterly was 11/24 and I can look back to 9/24. [Physician-A] addressed orders in her 11/11 dictation notes, she does not	F 278	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 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 F 278 R2s MDS was reviewed and amended to include the diagnosis of Diabetes. R68s MDS was reviewed and the coding of dehydration was removed. The MDS coordinators have reviewed all residents with the diagnosis of Diabetes and Dehydration to ensure the accuracy of the MDS.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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F 278	Continued From page 2 list diabetes as a diagnosis. The quarterly on 8/25; I listed it on the MDS, the 5/27 quarterly listed diabetes. [Physician-A] will not address anything until the next rounds, we had a lot of issues with her [physician-A]." Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.13 dated October 2015, section I: Active Diagnoses reads; "Intent: The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status." Page I-3 indicates, "Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available..." R68's significant change MDS dated 1/4/16 indicated during the assessment period R2 was dehydrated. The associated care area assessment (CAA) indicated only symptom of dehydration was "newly present constipation, fecal impaction" and decrease in fluid intake. Progress notes reviewed during the MDS assessment period of 12/30/15 through 12/4/15 lacked documentation of signs and symptoms of dehydration. During an interview on 1/27/16, at 7:55 a.m. registered dietician RD indicated she was not aware R68 was assessed to have hydration and was not aware of any decrease fluid intake from baseline. RD explained dehydration is assessed	F 278	MDS coordinators received education from the Director of Nursing on 2/16/2016, regarding correct interpretation of the RAI Manual for the coding of Dehydration and Diabetes. R2 and any resident with a new diagnosis of diabetes or dehydration will be audited weekly x4 to ensure accuracy of the MDS. Results will be taken to quality committee for further recommendations.	

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F 278	Continued From page 3 through labs, fluid intake and output, and appearance of skin. During an interview on 1/27/16, at 8:19 a.m. MDS registered nurse (RN)-B stated dehydration was coded because resident started taking more narcotic pain medication and was eating and drinking less. RN-B stated there was not a physician's evaluation or diagnosis of dehydration. RN-B stated there was not an assessment completed for dehydration. During an interview on 1/27/16, at 9:56 a.m. RN-B indicated after reviewing the direction in the RAI manual there was not documentation to support the coding of dehydration on the MDS. The Resident Assessment Instrument (MDS instruction book) included the direction to code dehydration on the MDS. "check this item [dehydrated] if the resident presents with two or more of the following potential indicators for dehydration: 1. Resident takes in less than the recommended 1500 ml of fluids daily. 2. Resident has one or more potential clinical signs of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset of confusion or increased confusion, fever, or abnormal lab values. 3 Resident's fluid loss exceeds the amount of fluids he or she take in."	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279		3/8/16

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F 279	Continued From page 4 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to update the care plan to include the use of Coumadin for 1 of 5 residents (R48) reviewed for unnecessary medications. Findings include: R48's Admission Record, dated 8/26/15, included diagnoses of hemiplegia (paralysis on one side of the body) and hemiparesis (weakness of the entire left or right side of the body) following cerebral infarction (a type of stroke resulting from a blockage in the blood vessels supplying blood to the brain) and essential hypertension. R48's Order Listing Report, dated 1/22/16, indicated an order by the physician for Coumadin (a blood thinning medication). It stated to give 5 milligrams (mg) by mouth one time a day every Sunday, Monday, Wednesday, Thursday, Friday and Saturday.	F 279	F 279 R48s care plan was reviewed and revised on 2/24/2016 to include the use of anticoagulant medication and monitoring for side effects. All residents on anticoagulant therapy will have had their care plan reviewed and updated as appropriate. All nurses will be reeducated on care planning for anticoagulation therapy by 3/8/2016. Health Information Management Director will audit the care plans of R48 and all new residents receiving anticoagulant therapy weekly x4 to ensure that the residents care plan reflects their treatment and interventions to monitor side effects. Results will be taken to quality committee	

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F 279	Continued From page 5 R48's care plan, dated 8/26/15, did not indicate the resident was taking Coumadin nor any interventions for possible medication induced bleeding, bruising, etc. R48's Treatment Record, dated 1/1/16 through 1/28/16 did not indicate that she had been receiving Coumadin medication. When interviewed on 1/27/16 at 12:44 p.m. Registered Nurse (RN)-B stated that the fact R48 had been receiving Coumadin medication it should have been care planned. She stated that her care plan should have contained information on the risk for bleeding with the use of this medication. Review of the policy titled Care Plan (issued February 2013), it stated that residents would receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. It stated that each resident would have an individualized comprehensive plan of care that would achieve and maintain the resident's needs.	F 279	for further recommendations.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280		3/8/16

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F 280	Continued From page 6 comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure blood sugar monitoring parameters were care planned as ordered by the physician for 1 of 5 residents (R2) reviewed for unnecessary medications. Findings Include: R2's current physician orders signed 1/13/16 included an order that read, "notify physician if blood sugar less than 60 or greater than 450." Per physician orders R2's blood sugar was to be checked three times daily and as needed for hypoglycemia (low blood sugar) symptoms. R2's Admission Record revealed a diagnosis of Type 2 Diabetes Mellitus (metabolic disorder with insulin resistance). R2's medication administration record (MAR), treatment administration record (TAR), and care plan lacked the physician ordered blood sugar parameters. R2's MAR revealed blood sugar levels were checked three times a day at 7:30	F 280	F 280 R2s care plan was reviewed and revised on 2/24/2016 to reflect the physician□s parameters for notifying of high and low blood sugars. The MDS coordinators have reviewed all residents who receive insulin and to ensure parameters were included in the care plan/MAR/TAR. The DNS will provide all nurses with reeducation by 3/8/2016 on the facility process for obtaining, care planning and documenting parameters for blood glucose results. The Director of Nursing will audit the care plans for R2 and all residents who are diabetic to ensure parameters are included in the care plan/MAR/TAR weekly x4. Results will be taken to quality	

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F 280	Continued From page 7 a.m., 11:00 a.m., and 5:30 p.m. On 1/27/16 at 7:18 a.m. registered nurse (RN)-A stated, "She [R2] gets a regular dose of six units Lantus [insulin] every am, she also gets Novolog eight units every morning plus sliding scale 0-299 zero, over 300 four units. Blood sugars for every meal. I don't think there is parameters, she goes up and down, it doesn't say to call the doctor for over X amount." Facility policy, Physician/Practitioner Orders dated September 2012 reads: "Maintaining Physician/Practitioner Orders 2. Transcribing/Processing orders. Orders are processed and transcribed into PCC (point click care, [electronic medical record]) immediately upon receipt of an order...5. eMAR/eTAR (electronic medical administration record/electronic treatment record) administration. Once the order is entered into PCC, depending on order category, the order will populate the appropriate electronic document location within the application."	F 280	committee for further 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 interview, and document review, the facility failed to ensure weights were obtained as ordered by the physician for 1 of 5 residents (R2)	F 282	F 282 R2s weight was checked on 1/27/2016	3/8/16

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F 282	Continued From page 8 reviewed for unnecessary medications. Findings Include: R2's Admission Record included diagnoses of type 2 diabetes, hypothyroidism, anxiety, depression, and bullous pemphigoid (rare skin condition that causes large fluid filled blisters.) R2's current physician orders included weekly weights per doctor request, Lantus and Novolog insulin, Zyprexa (anti-psychotic medication), prednisone (corticosteroid medication), and zoloft (antidepressant medication). R2's medication administration record (MAR) revealed, "weekly weights one time a day every Wednesday for doctor request" signed off "administered" for Wednesdays from 12/2/15 through 1/20/15. R2's electronic medical record revealed only two weights, December (no date shown) 142.2 pounds, 1/13/16 143.3 pounds had been documented. On 1/27/16 at 7:18 a.m. registered nurse (RN)-A stated, "In POC (point of care) the aides chart weights and it should be in PCC (point click care [electronic medical record]). She has a weight today." On 1/27/16 at 10:57 a.m. RN-B, a nurse manager, reviewed R2's weights and stated, "I guess they are not done weekly." On 1/27/16 at 10:09 a.m. the dietary manger stated, "She [R2] is a monthly weight. Everyone here is a monthly weight."	F 282	and has been stable with no significant changes in the past year. The Dietary Manager will review all residents to ensure weight has been completed and documented as ordered. All certified nursing assistants and nurses will be reeducated on facility protocols by 3/8/2016 to ensuring weights are done weekly or more frequently per physicians order. The Dietary Manager will audit R2 and all other residents weekly x4 and monthly x3 to ensure weights are completed and documented. Results will be taken to quality committee for further recommendations.	

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F 282	Continued From page 9 R2's physician/facility medical director was unavailable to interview in regards to his order for weekly weights. A policy was requested and not provided.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to contact the physician for blood sugar levels greater than 450, as ordered, for 1 of 5 residents (R2) reviewed for unnecessary medications. Findings Include: R2's current physician orders signed 1/13/16 included an order that read, "notify physician if blood sugar less than 60 or greater than 450." Per physician orders R2's blood sugar was to be checked three times daily and as needed for hypoglycemia symptoms. R2's Admission Record revealed a diagnosis of Type 2 Diabetes Mellitus (metabolic disorder with insulin resistance). R2's medication administration record (MAR)	F 309	F 309 R2s physician was notified and reviewed blood glucose levels. The MDS coordinators have reviewed all residents who require blood glucose monitoring to ensure proper physician notifications were made when necessary. The Director of Nursing will provide all nurses with reeducated by 3/8/2016 to ensure facility policy and procedure for physician notification of abnormal glucose levels and change in condition protocols. The Director of Nursing will conduct of audits for R2 and random other diabetic	3/8/16

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F 309	Continued From page 10 revealed blood sugar levels were checked three times a day at 7:30 a.m., 11:00 a.m., and 5:30 p.m. R2's December 2015 MAR revealed five blood sugar readings greater than 450. January 2016 MAR revealed five blood sugar readings greater than 450. However, these high readings had not been communicated with the physician even though a doctors order was in place at these times. On 1/27/16 at 7:18 a.m. registered nurse (RN)-A stated, "She [R2] gets a regular dose of six units Lantus [insulin] every am, she also gets Novolog eight units every morning plus sliding scale 0-299 zero, over 300 four units. Blood sugars for every meal. I don't think there is parameters, she goes up and down, it doesn't say to call the doctor for over X amount. She usually is ok when she runs high. Functions best at around 250. She may have some high readings but she is ok. We don't recheck the blood sugar." On 1/27/16 at 10:57 a.m. RN-B, a nurse manager, reviewed R2's progress notes and verified the physician was not contacted for the 10 blood sugars over 450 for the months of December and January. On 1/28/16 at 11:32 a.m. the director of nursing stated, "Generally I would expect them [nursing staff] to notify the doctor. For anything that read high on the meter which is way too high. Some of our people [residents] run into the 300's, anything higher than that. I would let the physician know about 450, 500 range. For [R2] I would expect them to contact the physician." Facility policy, Blood Glucose Monitoring, Disinfecting and Cleaning dated September 2012	F 309	resident□s to ensure appropriate notification of abnormal glucose levels was communicated to the physician. These audits will be done weekly X 4 and then monthly X 3. Results will be taken to quality committee for further recommendations.	

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F 309	Continued From page 11 reads: "General Procedures 1. Verify that the physician's orders include blood glucose high and low parameters and when to notify the resident's physician...12. Notify physician if necessary per parameters.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to secure sharps and chemicals from cognitively impaired residents from access in 3 of 3 soiled utility rooms in the facility. Findings include: During initial tour of the Lodge unit on 1/25/16 at 12:00 p.m. observations were made of the soiled utility room. The room was unlocked and stored a large red hazardous waste bucket in the room on the floor near the door that contained a container of sharps (needles, syringes, etc). There was also a large container of bleach wipes on top of the counter that was within reach. Observations were made on 1/26/16 at 7:30 a.m. and again at 11:30 a.m. on the Lodge unit, the utility room was unlocked and there was a large	F 323	F 323 The red hazardous waste bins have been put in the locked garage until key pad locks can be installed on the soiled utility rooms. New keypad locks will be installed on all dirty utility rooms to keep hazardous waste and cleaning chemicals secured from residents by 3/8/2016 and bins will be moved into the soiled utility rooms. All residents were identified as having the potential to be affected. DNS will provide education for all staff regarding facility procedure for storage and disposal of hazard waste by 3/8/2016. Environmental Services Director will	3/8/16

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F 323	Continued From page 12 container of bleach wipes sitting on top of the counter near the door as well as a large hazardous waste container that contained a container of sharps. Observations on 1/26/16 at 8:15 am on the Healing grace unit, the soiled utility room was observed to be unlocked and stored a hazardous waste container near the door that contained a container of sharps. Observation on the Garden unit on 1/26/16 at 10:32 a.m., were made of the soiled utility room that stored a large hazardous waste container on the floor that contained a sharps container. There was also a large container of bleach wipes that were placed on the counter top. There were several cognitively impaired residents who resided on these units and potentially had access to the sharps and bleach wipes which both could cause harm to the resident. During a tour with employee-A responsible for laundry/housekeeping on 1/27/16 at 9:00 a.m., the Healing Grace soiled utility room was found to be unlocked. There was a large red bin that contained sharps containers in the bin. A tour of the Lodge soiled utility room was found to be unlocked. It had a large container of bleach wipes that were placed on a shelf. There was a large red hazardous waste container on the floor that contained sharps containers. A tour of the Garden unit soiled utility room was found to be unlocked. It contained a large red hazardous waste bin in the room. It revealed opened sharps containers in the bin which were scattered all over the bottom of the bin. When asked if there was the potential of anyone getting in to this bin, employee-A	F 323	conduct audits to ensure proper storage and disposal of hazard waste weekly X 4. Results will be submitted to Quality Committee for further recommendations.	

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F 323	Continued From page 13 stated, "...if someone really wanted to get to the needles." When interviewed on 1/27/16 at 1:30 p.m., the Director of Nursing (DON) stated that when sharps were to be disposed they were placed in a sealed sharps container and then placed in a biological waste bin. They were to be picked up once a month. The DON stated that until they were to be picked up, the sharps were stored in the utility rooms. When interviewed on 1/28/16 at 11:07 a.m., the Director of Nursing stated maybe the reason the sharps container was open was that it had not been shut properly. She stated that they did take the biological waste bin that contained all the loose needles and placed it in the locked garage. They did contact Stericycle to have the bin picked up. The DON also stated that the bleach wipes found in the soiled utility room should have been locked away. She stated that the doors to the soiled utility rooms should have been locked. She stated that they could certainly find a locked place for the sharps containers to be stored in. Review of the facility policy titled, Needle or Sharps Disposal (revised 6/2014), it stated that sharps devices such as needles would not be discharged in the regular trash. It stated that proper needle disposal containers would be used for disposal. A policy on hazardous chemicals was requested but none provided.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		3/8/16

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F 328	Continued From page 14 The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper administration of an insulin pen for 1 of 1 resident (R48) reviewed for insulin administration. Findings include: R48 had been observed on 1/27/16 at 7:45 a.m., Licensed Practical Nurse (LPN)-B entered their room to give insulin injection. LPN-B introduced herself, washed her hands and prepared the supplies needed in order to get a blood sugar reading and then administer insulin using a Novolog FlexPen (pre-filled syringe with insulin). LPN-B then proceeded to take R48's blood sugar reading. LPN-B got a reading of 179. She stated based on that reading that R48 was to be given an extra two units of Novolog (a fast-acting insulin that works very quickly) insulin due to an order for a sliding scale dosing schedule (used in order to calculate how much insulin to give based on a particular blood sugar reading). LPN-B took the cap off of the insulin pen and wiped with an alcohol pad. She then affixed a needle to the pen. LPN-B then proceeded to draw up fourteen units of insulin in the pen. LPN-B wiped an area on	F 328	F 328 R3 immediate re-education was provided for the nurse identified (LPNB) by the staff development nurse on the correct use of an insulin pen on 2/29/2016 date. All residents using an insulin pen were identified as being at risk. Staff education for all nurses will be completed by 3/8/2016 on procedure for using insulin pens. Staff Development nurse will conduct observation audits of insulin administration using insulin pens for R3 and random other residents. These audits will be done twice a week for four weeks. Results will be taken to quality committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 328	Continued From page 15 R28's left arm and administered the insulin. When asked on 1/27/16 at 7:50 a.m., why she did not prime the insulin pen, LPN-B stated that she was not sure if she needed to prime the FlexPen (a procedure that is performed that releases a small amount of insulin into the pen to help get rid of air bubbles that may be in the pen and needle. Air bubbles can affect the flow of insulin and accurate dose injected) before each administration or not. LPN-B stated that she knew that the nursing staff would prime the insulin pens when there was a new insulin pen but not after an insulin pen had already been used the first time. When interviewed on 1/28/16 at 11:07 a.m., the Director of Nursing (DON) stated that the nursing staff was supposed to prime the pens (FlexPen)according to the manufacturer's instructions. She stated that the insulin pens (FlexPen) were recently introduced in to the facility and have been present for the past five to six months. The DON stated when the pens first arrived she went over the instructions with the nursing staff that was present that day of the education. She stated that the nurses that were present for that education would then pass on the instructions to the rest of the nursing staff who were not present. When asked for a policy on insulin pens, the DON provided a copy of the instructions that were used in order to education the nursing staff when the insulin pens first arrived at the facility. How to Use Insulin Pens (no date) stated to look at the dose window and turn the dosage know to 2 (two) units. It stated to hold the pen with the needle pointed upwards, press the button until at least a drop of insulin appeared. This was called the 'air shot' or safety shot. Repeat this step if needed until a drop appeared.	F 328		

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F 329	Continued From page 16	F 329		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure ongoing monitoring of therapeutic blood levels of long term use of thyroid medicaiton for 1 of 5 residents (R3) reviewed for unnecessary medications. Findings include: R3 had a diagnosis of hypothyroidism that	F 329	F 329 The physician for R3 was notified and ordered yearly TSH level every February and care plan was updated. MDS nurses will review labs of residents taking thyroid stimulating hormones and	3/8/16

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F 329	Continued From page 17 required long-term medication treatment of levothyroid that required routine lab monitoring for therapeutic levels of the thyroid stimulating hormone (TSH). Also a TSH level was not obtained to determine effectiveness of the thyroid medication prior to adding an antidepressant medication to R3's medication regimen. R3 was admitted to the facility on 3/4/15 with diagnoses that included hypothyroidism (low thyroid function) according to the facility Admission Record. R3's record indicated last TSH blood level was within normal range at 3.1 mIU/L (milli-international units per liter) obtained on 7/21/14. R3's hospital discharge summary dated 3/4/15 included, "Hypothyroidism. Clinically euthyroid. Levothyroxine (replacement for hormone normally produced by the thyroid) 75 micrograms (mcg) once daily will be considered." R3's current signed physician orders included levothroid 75 micrograms (mcg) one time daily for hypothyroidism. Physician orders also included antidepressant Zoloft. R3's physician visit dated 5/1/15 included, "hypothyroidism. Continue levothyroxine. Labs are followed." The visit note further read, "She [R3] is more weepy today and emotional. Daughters report that they have noted more anxiety." The physician indicated diagnosis of depression/anxiety and initiated Zoloft 25 mg. It was not evident in the record, a TSH level was obtained to determine effectiveness of the thyroid medication prior to the initiation of the antidepressant as low thyroid hormone can cause symptoms of depression. R3's physician visit dated 7/1/15 reported, "Hypothyroidism. Continue levothyroxine. Annual labs will be ordered at next certification visit." R3's physician visit dated 9/2/15 reported,	F 329	contact their primary physicians for lab parameters for their residents as appropriate. Director of Nursing will provide reeducation for all nurses by 3/8/2016 regarding reviewing, monitoring and reporting labs to physicians. The nurse managers will review labs for all residents taking thyroid stimulating hormones and make sure that they have current labs. Audits will be done weekly x4. Results will be taken to quality committee for further recommendations.	

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F 329	Continued From page 18 "Hypothyroidism. Her last TSH was at goal." The visit note reported R3 becomes weepy when talking about husband. It was not evident the annual TSH labs were ordered or obtained as per the 7/1/15 visit note. R3's physician visit dated 11/4/15 reported, "Hypothyroidism. Her last TSH was at goal within the year." The visit note also indicated R3 had a weight loss of four pounds in six months. The record did not reflect a TSH level had been obtained since 7/21/14. R3's Zoloft increased to 50 mg daily on 11/13/15 for increased signs and symptoms of depression. It was not evident in the record; a TSH level was obtained to determine effectiveness of the thyroid mediation prior to the increase of the antidepressant medication. R3's physician visit dated 1/6/16 reported, "History of hypothyroidism. She has an annual TSH that has been at goal." According to the record, the last TSH obtained was 7/21/14. During an interview on 1/28/16, at 9:50 a.m. the director of nursing (DON) indicated the facility does not have standing orders for laboratory monitoring and stated the physician handles all of the labs as needed. The DON explained nursing suggests labs when needed. During an interview on 1/28/16, at 11:43 a.m. the consulting pharmacist (CP) stated, TSH levels are typically done annually, but really depends on the person. CP stated, generally if someone has a diagnoses of hypothyroidism a TSH level should be checked prior to starting someone on an antidepressant. The physician was not available for an interview to determine the lack of TSH level for past 18 months to determine if thyroid level subtherapeutic which could cause depression symptoms.	F 329		

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F 329	Continued From page 19 Facility policy Laboratory Services dated September 2012 included, "Clinical laboratory services will be provided or obtained to meet resident needs. The center assumes the responsibility for the quality, standards and timelines of these services."	F 329		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Good Samaritan Society Comforcare was found not 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 18 New Health Care. 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, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/26/2016

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

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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us>

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Good Samaritan Society Comforcare, is a 1-story building with no basement. The building was constructed in 2007 and was determined to be of Type II(111) construction.

The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridors that is monitored for automatic fire department notification. There is smoke alarms in all resident rooms that are monitored by the nurse call system and light outside each resident room.

The facility has a capacity of 45 beds and had a census of 44 at the time of the survey.

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4.1 and 9.6, as well as 1999 NFPA 72, Section 1-5.6. This deficient condition could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting all patients, staff, and visitors of the facility. Findings include: On facility tour between 10:00 AM to 2:00 PM on 01/26/2016, observation revealed, that the front entrance door where the facility's fire alarm control unit (fire alarm aunnicator panel) is located, is an area that is not continuously occupied. These deficient practices were confirmed by the Maintenance Manager.	K 052	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 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 K 052 Contacted Custom Alarm System, quote was given and date of March 14, 2016 has been set for installation of annunciator panel to be installed in nurse	3/14/16

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K 052	Continued From page 3	K 052	office in Healing Grace, where there is 24/7 staff. Maribeth Walton, Environmental Services Director will follow until completion.	
K 104 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. Findings include: On facility tour between 10:00 AM to 2:00 PM on 01/26/2016, observation revealed, that the last smoke/fire damper test was conducted on 11/01/2011.	K 104	K104 Smoke/Fire Dampers were tested on 02/25/2016 by MJ O□Connor Inc. Calendar reminder for year 2019 is set in alarms for scheduling of testing.	2/25/16
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour	K 154	K154	1/27/16

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K 154	Continued From page 4 period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 10:00 AM to 2:00 PM on 01/26/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 154	New policy specifically for fire sprinkler system out of service was written on 01/27/2016 and placed in fire book. Maribeth Walton, Environmental Services Director completed.	
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 10:00 AM to 2:00 PM on 01/26/2016, observation and documentation reviewed revealed that there was not a single	K 155	K155 New policy specifically for fire alarm system out of service was written on 01/27/2016 and placed in fire book. Maribeth Walton, Environmental Services Director completed.	1/27/16

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K 155	Continued From page 5 plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 155		