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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TC2U

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00617

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245598**
2.STATE VENDOR OR MEDICAID NO.
(L2) **641543100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - ARLINGTON**
(L4) **411 SEVENTH AVENUE NORTHWEST**
(L5) **ARLINGTON, MN** (L6) **55307**

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 **03/27/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(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 :
Gayle Lantto, Supervisor 03/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/09/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/10/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5598

Electronically Delivered: April 9, 2015

Ms. Teresa Hildebrandt, Administrator
Good Samaritan Society - Arlington
411 Seventh Avenue Northwest
Arlington, Minnesota 55307

Dear Ms. Hildebrandt:

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 20, 2015 the above facility is certified for:

35 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 35 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 about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 30, 2015

Ms. Teresa Hildebrandt, Administrator
Good Samaritan Society - Arlington
411 Seventh Avenue Northwest
Arlington, Minnesota 55307

RE: Project Number S5598025

Dear Ms. Hildebrandt:

On February 20, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 5, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 27, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 3, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 5, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 20, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 5, 2015, effective March 20, 2015 and therefore remedies outlined in our letter to you dated February 20, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245598	A. Building B. Wing	3/27/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/20/2015**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **03/20/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/20/2015**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **03/02/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **02/25/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/16/2015**
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** GL/kfd	**Date:** 03/30/2015	**Signature of Surveyor:** 15507	**Date:** 03/27/2015
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/5/2015	_____	**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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245598	A. Building B. Wing 01 - MAIN BUILDING 01	3/3/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0062	02/13/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/kfd	Date: 03/30/2015	Signature of Surveyor: 34764	Date: 03/03/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/6/2015		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: TC2U

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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(L2) **641543100**

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(L3) **GOOD SAMARITAN SOCIETY - ARLINGTON**
(L4) **411 SEVENTH AVENUE NORTHWEST**
(L5) **ARLINGTON, MN** (L6) **55307**

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 **02/05/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds 35 (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(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 :
Shawn Soucek, HPR-Social Work Specialist 03/05/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/06/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: February 20, 2015

Ms. Teresa Hildebrandt, Administrator
Good Samaritan Society - Arlington
411 Seventh Avenue Northwest
Arlington, Minnesota 55307

RE: Project Number S5598025

Dear Ms. Hildebrandt:

On February 5, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 17, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 17, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 5, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 5, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		3/20/15

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

Electronically Signed | 03/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	02/05/2015

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GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plans were developed for 1 of 3 residents (R10) reviewed for range of motion services, for 1 of 5 (R2) residents reviewed for unnecessary medications, and for 1 of 1 resident (R28) reviewed for dialysis care. Findings include: R10's care plan (revised 5/5/14) included limited physical mobility related to dementia and arthritis and dependency on staff for transfers and mobility and activities of daily living. The care plan did not address the resident's functional limitations in ROM. R10's registered physical therapist's (RPT) summary dated 5/6/13, indicated the resident would be able to complete a "restorative program designed to maintain functional gain achieved in therapy" with assist from a restorative aide. The plan noted R10 would have "an appropriate restorative program in place at time of discharge from physical therapy...in place with nursing staff for long sitting stretch to maintain or improve knee ROM and also a walking program." The quarterly Minimum Data set (MDS) dated 11/24/14, indicated R10 had long and short term memory problems, severely impaired decision making skills, functional limitations in ROM of bilateral upper and lower extremities and required total assistance from staff for all ADLs. A care plan was not developed and ROM services were not being provided to the resident.	F 279	R10s care plan will be updated to reflect resident's current functional limitations in ROM as resident is now on a Hospice program. R2s care plan will be updated to reflect resident's diabetic care focus, goals, and interventions. R28s care plan will be updated to reflect what is to be monitored on the dialysis site and how often that shall occur. Also included will be guidelines surrounding site/care in case of an emergency. Licensed staff will be educated on monitoring the site and the proper reporting process for any concerns. DON will audit resident care plans weekly X 4 to make sure plans are up to date with the care being provided. Results will be reported through facility QAPI process.	

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F 279	Continued From page 2 During an interview on 2/4/15, at 11:00 a.m. the director of nursing (DON) explained R10 had been receiving ROM services, but they had since been discontinued. The DON was unable to provide a justification as to why they had been stopped, and was unable to provide documentation from therapy staff stating they had been apprised of the decision to discontinue the services. The RPT was unavailable for an interview and the occupational therapist was unaware the resident was no longer receiving ROM services. A 9/12 Range of Motion (ROM) Policy noted the purpose was to "prevent reduction in range of motion whenever possible. The center will ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion as much as possible and to prevent further decrease in range of motion." R2's care plan dated 12/9/14, did not include pertinent information related to the resident's diabetic care. During a review of R2's records were noted a physician's medication orders for insulin (for diabetes). One order, dated 11/1/11 was for a daily bedtime injection of 10 units of Lantus, a long-acting insulin. Another order, dated 8/11/14 directed the use of NovoLog, a short-acting insulin. This was ordered to be given as needed on a "sliding scale" (SS), to be administered based on blood sugar readings. The NovoLog was ordered twice daily. In addition, an order	F 279		

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F 279	Continued From page 3	F 279		

dated 3/14/14 directed laboratory testing for hemoglobin A1c every 6 months, as well as accuchecks by nursing twice daily. The most recent laboratory values were recorded were dated 4/7/14, and were in the normal range. A blood glucose level of 191 was also noted as in the high range of normal.

On 2/5/15, at 11:40 a.m. during an interview with the director of nursing (DON), she looked through R2's record and reported she was unable to locate any information related to diabetes, and stated, "I don't really see one. Yes, I would expect to see a care plan for diabetes."

R28's undated care plan did not include interventions on how often the dialysis access site was to be monitored for the following: bruit or thrill upon return from dialysis, bleeding, signs and symptoms of infection, physical care of the access site, and who was responsible for monitoring or what interventions were in place if case of a medical emergency.

R28's annual MDS dated 11/18/14, indicated the resident was cognitively intact. It was also noted R28 had diagnoses including end stage renal disease (ESRD), with a therapeutic diet and dialysis. The MDS also indicated R28 required extensive assistance of two staff for personal hygiene, bed mobility and transfers with the use of a mechanical lift.

During an interview on 2/3/15, registered nurse (RN)-A stated that she was unaware of any monitoring or documenting being completed regarding to R28 dialysis access site. During an interview on 2/4/15, at 8:03 a.m. a licensed practical nurse (LPN)-A stated that she was

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F 279	Continued From page 4 unsure if R28's dialysis access site was routinely monitored. A trained medication aide (TMA)-A stated in an interview on 2/4/15, at 1:38 p.m. she did not know of any monitoring she need to do for R28 dialysis site. During an interview on 2/4/15,at approximately 1:50 p.m. the director of nursing verified that R28 care plan lacked interventions related to R28's dialysis care. A policy on dialysis access site monitoring was requested, but none was provided.	F 279		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide range of motion (ROM) to minimize the risk for a decline in ROM for 1 of 3 residents (R10)reviewed for ROM services. Findings include: R10's registered physical therapist's (RPT) summary dated 5/6/13, indicated the resident would be able to complete a "restorative program designed to maintain functional gain achieved in therapy" with assist from a restorative aide. The	F 318	R10s care plan will be updated to reflect residents current limitations with ROM as resident has since entered a Hospice program. The MDS Coordinator will identify, through the comprehensive assessment, each resident with ROM deficiets. Those residents will have ROM addressed in their individuatl care plans. Staff will be trained on ROM care planning and expectations of staff for the	3/20/15

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F 318	Continued From page 5 plan noted R10 would have "an appropriate restorative program in place at time of discharge from physical therapy...in place with nursing staff for long sitting stretch to maintain or improve knee ROM and also a walking program." R10 had a diagnoses including dementia and generalized pain. The quarterly Minimum Data set (MDS) dated 11/24/14, indicated R10 had long and short term memory problems and severely impaired decision making skills. The resident was described as having a functional limitation in ROM of bilateral upper and lower extremities and required total assistance from staff for all activities of daily living (ADL's). However, R10's care plan was not developed and ROM was not being provided. R10's care plan (revised 5/5/14) included limited physical mobility related to dementia and arthritis and dependency on staff for transfers and mobility and activities of daily living. The care plan did not address the resident's functional limitations in ROM. During an interview on 2/4/15, at 11:00 a.m. the director of nursing (DON) explained R10 had been receiving ROM services, but they had since been discontinued. The DON was unable to provide a justification as to why they had been stopped, and was unable to provide documentation from therapy staff stating they had been apprised of the decision to discontinue the services. The RPT was unavailable for an interview and the occupational therapist was unaware the resident was no longer receiving ROM services. A 9/12 Range of Motion (ROM) Policy noted the	F 318	completion and documentation of ROM activities. DON will conduct random care plan audits X 4 weeks to insure residents receive appropriate ROM treatment including but not limited to active and passive ROM as well as ROM that occurs naturally as a consequence of being assisted with ADLs. MDS Coordinator to monitor and update all care plans as appropriate when residents have a change occur condition.	

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F 318	Continued From page 6 purpose was to "prevent reduction in range of motion whenever possible. The center will ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion as much as possible and to prevent further decrease in range of motion."	F 318		
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:	F 329		3/20/15

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F 329	Continued From page 7 Based on observation, interview and document review, the facility failed to identify the clinical indications for the continued use of an antipsychotic and antianxiety medication for 2 of 5 residents (R30, R14) reviewed for unnecessary medication. Findings include: R30 was observed on 2/3/15, at 4:10 p.m. sitting calmly in her wheelchair trying to place a blanket on top for her bed and mumbling inaudibly. R30 self-propelled herself around the room looking at items on the nightstand. R30's quarterly Minimum Data Set (MDS) dated 12/30/14, indicated R30 had severe cognitive impairment and required extensive assistance of two staff for personal hygiene, bed mobility and transfers. The MDS identified R30 had a diagnoses including anxiety, Alzheimer's disease and depression. She also had mood problems including trouble falling asleep or staying asleep, or sleeping too much, and feeling tired or having little energy nearly every day. R30's Medication Administration Record (MAR) from 9/14 to 2/15 indicated R30 was receiving one tablet scheduled Ativan (medication used to treat anxiety disorders) 0.5 milligrams (mg) daily and every Tuesday. R30 also was receiving Ativan 0.5 mg as needed (PRN) up to three times daily. R30 had been administered the PRN Ativan three times in the last six months. A Psychoactive Medication Monitoring for R30 dated 12/24/14 and 1/21/15, was reviewed. The pharmacist indicated a recommendation as followed: re-evaluate use of Ativan and consider attempting dose reduction or stopping if providing	F 329	Pharmacy recommendations for R30 and R14 will be relayed to resident's respective physician for follow up. R14 Tardive Dyskensia assessment will be completed and thereafter every 6 months as recommended. MDS Coordinator to monitor. DON will receive Pharmacy consultant recommendations on monthly basis. DON will review and address any urgent concerns/issues with the Charge Nurse who will be instructed to follow up with appropriate physician. Pharmacy consultant's monthly recommendations will be forwarded by the MDS coordinator to the resident's physicians for comment and/or follow up during monthly rounds. DON to audit the process X 3 months to assure recommendations are being brought forward and addressed by appropriate physican.	

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F 329	Continued From page 8	F 329		

no benefit. R30's Psychoactive Medication Monitoring forms lacked a physician signature acknowledging this request. Nursing notes were reviewed and noted no documentation that a physician was notified of the request for gradual dose reduction (GDR) of Ativan nor was there evidence that a GDR was attempted.

During an interview on 2/4/15, at 10:37 a.m. director of nursing and the MDS coordinator both reported R30 had been sleepier than usual.

On 2/5/15 at 12:36 p.m. the pharmacy recommendations were requested from the DON, however, only one recommendation dated 7/28/14 was provided. The DON explained she had the rest of the reviews on her desk, and explained that she was "late" getting out the pharmacist GDR recommendations to the physicians. Regarding whether R30's physician was aware of the recommendations for Ativan she replied "no, not that I am aware of."

R14 was observed on 2/3/15, at 8:26 a.m. wheeling himself up and down the hallway. He was neatly dressed and groomed, was alert and exhibited no notable behavioral issues.

R14's MDS assessment dated 1/15/15, noted diagnoses including dementia with no behavioral disturbance. Medications included the use of an antipsychotic. The resident was moderately cognitively impaired, and no behaviors were noted in the assessment period.

The care plan for R14 indicated mood symptoms related to diagnoses including personality disorder evidenced by irritability, repetitive verbalizations, and agitation. Interventions

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F 329	Continued From page 9	F 329		

included giving adequate rest periods, discussing with resident/family "any concerns...or other subjects as needed," reporting to the health care provider when R14 was refusing specified cares, sleep pattern changes, increased irritability, and individualized non-pharmacological interventions.

This care plan additionally indicated behavior symptoms related to diagnoses such as refusal of cares, derogatory comments, history of false accusations and name calling. Interventions included protecting rights and safety of others, and individualized non-pharmacological interventions.

A review of R14's medical record revealed a current physician order for Risperdal, dated 12/16/13, with an 0.5 milligrams daily at 4:00 p.m. for "agitation, delusions, and sundowning [a phenomenon common with dementia evidenced by increased confusion and agitation in the evening hours] related to anxiety state, unspecified." In addition, the current orders indicated, "Requires a private room because of behavior issues."

R14's monthly pharmacy reviews were requested of the DON, as they could not be found in the resident's medical record. The DON returned with two Arlington Good Samaritan Drug Regimen Review Report documents from the pharmacy consultant's reviews, and said she was unable to locate any other reviews for R14. One of the two reports did not concern the use of antipsychotic medication. The second was dated 9/26/14 reiterated the resident had been due for a tardive dyskensia (abnormal movement disorder associated with antipsychotic use) assessment as it had last been completed in 2/14 and not since

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F 329	Continued From page 10 (recommended every six months). The document indicated, Completed" with an entry date of 10/14/14. In addition to the missing pharmacy consultant reports, the record lacked sufficient evidence a gradual dose reduction (GDR) had been attempted for the use of the antipsychotic medication.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 334		3/2/15

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F 334	Continued From page 11 The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by:	F 334		

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F 334	Continued From page 12 Based on interview and document review, the facility failed to determine pneumococcal vaccination status and provide risk/benefit education for 1 of 5 residents or their legal representatives (R30) reviewed for pneumococcal vaccination. Findings include: R30's was admitted to the facility on 7/2/14, and remained in the facility. R30's quarterly Brief Interview for Mental Status dated 12/30/14, indicated R30's had severe cognitive impairment. R30's immunization report provided by the health information manager indicated no data could be located regarding whether R30 was offered and/or received pneumococcal vaccination. During an interview on 2/4/15, at 10:32 a.m. the director of nursing stated she could not find any documentation that R30 received the pneumococcal vaccination nor whether the resident's representative was provide education regarding the benefits and potential side effects of the pneumococcal vaccination. The facility's Pneumococcal Vaccination Immunizations for Residents Procedure revised date 11/14, directed staff as follows: "Pneumococcal vaccination is recommended to be administered in a series to all adults aged 65 and older for the prevention of pneumococcal disease, assess the resident's current immunization status. If eligible obtain a physician's order for vaccinations unless contraindicated or the resident chooses not to be vaccinated. Document administration under the resident's immunization tab and if the resident and/or legal representative chooses not to be	F 334	It was determined through investigation that R30 had not been offered the pneumococcal vaccination at her prior facility or through her primary clinic. Therefore, her family was notified to explain the risks and benefits of the vaccination. Verbal approval given by family representative to give the vaccine. Upon admission a resident's pneumococcal vaccination status will be verified using the States on-line immunization website (MICC). The resident and/or resident's representative will recieve information on the risk and benefits of the vaccines and this will be documented in resident's medical record. The MDS Coordinator will monitor to insure compliance.	

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F 334	Continued From page 13 vaccinated document the resident or name of family in the notes section for pneumococcal vaccination under the resident's immunization tab."	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		2/25/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 356	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure current nursing staff hours were posted for viewing. This had the potential to affect all residents and visitors to the facility. Findings include: During the initial tour of the facility on 2/2/15, at 2:47 p.m. a Daily Nursing Staffing was observed in a hard plastic holder in an angled mesh wall shelf in the hallway near the entry to the dining room. The only visible document in a stack of similar documents was dated 1/30/15. Additional documents were below the visible document and were dated 1/31 through 2/7/15. A registered nurse (RN)-B verified at 2:55 p.m. that the posting was not current. A 12/14 facility policy Nursing Staff Daily Posting Requirements directed staff to post the daily staffing information as required. "...post daily the staffing and resident census at the beginning of each shift and update as appropriate (for each shift)" and was to include the current date. On 2/2/15, at 3:01 p.m. the administrator stated, "Yes, the wrong day is showing. Usually the charge nurse on the weekend will pull these [outdated sheets] and give them to the medical records person [for filing]." The three outdated sheets were then removed and the current information was then visible.	F 356	The Staffing Coordinator and Charge nurses have been instructed to update the Daily Nursing Staffing on a daily basis. Charge nurses have been instructed to make sure the current day is visible during the weekends. Staffing Coordinator to monitor.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		3/16/15

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F 441	Continued From page 15 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441		

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F 441	Continued From page 16 Based on interview and document review, the facility failed to develop a written infection control plan that included procedures for handling persons with active tuberculosis (TB) disease. This had the potential to affect all 27 residents in the facility. Findings include: On 2/4/15, at approximately 10:00 a.m. while reviewing the facility's infections control policies related to tuberculosis, the facility's written infection control plan procedure for handling residents with active TB could not be located. During an interview on 2/4/15, at 3:50 p.m. a licensed practical nurse (LPN)-A stated if she suspected a resident to had active TB she would isolate the resident to their room and update the physician. LPN-A attempted to find an online corporate TB, but could not locate one. LPN-A then asked two other staff employees for help, but none of the staff were able to find the corporate policy. The director of nursing (DON) was present at the time. During an interview on 2/4/15, at 3:00 p.m. the DON said she was unable to provide the facility's written infection control plan. The DON did produce a cooperate procedure titled Residents with Suspected or Confirmed Tuberculosis (TB) and added a revised date on the form of "2/4/15."	F 441	Upone admission all residents are given a two-step mantoux to determine TB status. In addition, in keeping with our infection control policies, residents are offered influenza and pneumo vaccinations. Charge nurses are trained to identify and report to the appropriate physician the signs and symptoms of potential infections including TB. Charge nurses will be instructed where to locate facility infection control policies. DON has been instructed on State TB guidelines. DON has updated the written TB plan per State regulations. Going forward the DON will monitor the policy and update it bi-annually according to state regulations. DON currently tracks all infections on a on-going basis and monthly reports findings to the Quality committee.	

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	245598	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/06/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on February 06, 2015. At the time of this survey, Good Samaritan Society Arlington was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/02/2015

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

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K 000	Continued From page 1 By eMail to: Marian.Whitney@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 Arlington was constructed as follows: The original building was built in 1958, is one story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st addition was built in 1963, is one story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction; The 2nd addition was built in 1977, is one story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 3rd addition was built in 1988, is one story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 4th addition was built in 1993, is one story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. A two-hour fire wall with a labeled, self-closing, 90-minute fire rated door	K 000		

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K 000	Continued From page 2 assembly separates the nursing home from an assisted living facility. The facility has a capacity of 35 beds and had a census of 28 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 28 residents, staff and visitors. Findings include: On facility tour between 09:30 AM and 12:30 PM on 02/06/2015, a review of documentation and interview with the Facility Maintenance Director (DF), revealed the facility failed to provide	K 062	An Annual Fire Sprinkler test was completed by Viking Automatic Sprinkler Company on 02/12/15. Our maintenance director will schedule annual inspections going forward and will monitor for timely completion. Maintenance Director to monitor.	2/13/15

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K 062	Continued From page 3 documentation for the annual fire sprinkler test as required by NFPA 13(99) and NFPA 25(98). The last fire sprinkler annual test/inspection was conducted on 10/02/2013. This deficient practice was verified by the Facility Maintenance Director (DF).	K 062		

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: February 20, 2015

Ms. Teresa Hildebrandt, Administrator
Good Samaritan Society - Arlington
411 Seventh Avenue Northwest
Arlington, Minnesota 55307

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5598025

Dear Ms. Hildebrandt:

The above facility was surveyed on February 2, 2015 through February 5, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 2, 3, 4, and 5, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Certification Program, P.O. Box 64900 St. Paul, MN 55164-0900.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the	2 555		3/13/15

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2 555	Continued From page 2 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, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plans were developed for 1 of 3 residents (R10) reviewed for range of motion services, for 1 of 5 (R2) residents reviewed for unnecessary medications, and for 1 of 1 resident (R28) reviewed for dialysis care. Findings include: R10's registered physical therapist's (RPT) summary dated 5/6/13, indicated the resident would be able to complete a "restorative program designed to maintain functional gain achieved in therapy" with assist from a restorative aide. The plan noted R10 would have "an appropriate restorative program in place at time of discharge from physical therapy...in place with nursing staff for long sitting stretch to maintain or improve knee ROM and also a walking program." R10 had a diagnoses including dementia and generalized pain. The quarterly Minimum Data set (MDS) dated 11/24/14, indicated R10 had long and short term memory problems and severely impaired decision making skills. The resident was described as having a functional limitation in ROM of bilateral upper and lower extremities and required total assistance from staff for all activities of daily living (ADL's).	2 555	The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are developed to ensure appropriate care of residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance.	

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2 555	Continued From page 3 However, R10's care plan was not developed and ROM was not being provided. R10's care plan (revised 5/5/14) included limited physical mobility related to dementia and arthritis and dependency on staff for transfers and mobility and activities of daily living. The care plan did not address the resident's functional limitations in ROM. During an interview on 2/4/15, at 11:00 a.m. the director of nursing (DON) explained R10 had been receiving ROM services, but they had since been discontinued. The DON was unable to provide a justification as to why they had been stopped, and was unable to provide documentation from therapy staff stating they had been apprised of the decision to discontinue the services. The RPT was unavailable for an interview and the occupational therapist was unaware the resident was no longer receiving ROM services. A 9/12 Range of Motion (ROM) Policy noted the purpose was to "prevent reduction in range of motion whenever possible. The center will ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion as much as possible and to prevent further decrease in range of motion." R2's care plan dated 12/9/14, did not include pertinent information related to the resident's diabetic care. During a review of R2's records were noted a physician's medication orders for insulin (for diabetes). One order, dated 11/1/11 was for a	2 555		

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2 555	Continued From page 4	2 555		

daily bedtime injection of 10 units of Lantus, a long-acting insulin. Another order, dated 8/11/14 directed the use of NovoLog, a short-acting insulin. This was ordered to be given as needed on a "sliding scale" (SS), to be administered based on blood sugar readings. The NovoLog was ordered twice daily. In addition, an order dated 3/14/14 directed laboratory testing for hemoglobin A1c every 6 months, as well as accuchecks by nursing twice daily. The most recent laboratory values were recorded were dated 4/7/14, and were in the normal range. A blood glucose level of 191 was also noted as in the high range of normal.

On 2/5/15, at 11:40 a.m. during an interview with the director of nursing (DON), she looked through R2's record and reported she was unable to locate any information related to diabetes, and stated, "I don't really see one. Yes, I would expect to see a care plan for diabetes."

R2's care plan dated 12/9/14, did not include pertinent information related to the resident's diabetic care.

During a review of R2's records were noted a physician's medication orders for insulin (for diabetes). One order, dated 11/1/11 was for a daily bedtime injection of 10 units of Lantus, a long-acting insulin. Another order, dated 8/11/14 directed the use of NovoLog, a short-acting insulin. This was ordered to be given as needed on a "sliding scale" (SS), to be administered based on blood sugar readings. The NovoLog was ordered twice daily. In addition, an order dated 3/14/14 directed laboratory testing for hemoglobin A1c every 6 months, as well as accuchecks by nursing twice daily. The most recent laboratory values were recorded were

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2 555	Continued From page 5 dated 4/7/14, and were in the normal range. A blood glucose level of 191 was also noted as in the high range of normal. On 2/5/15, at 11:40 a.m. during an interview with the director of nursing (DON), she looked through R2's record and reported she was unable to locate any information related to diabetes, and stated, "I don't really see one. Yes, I would expect to see a care plan for diabetes." R28's undated care plan did not include interventions on how often the dialysis access site was to be monitored for the following: bruit or thrill upon return from dialysis, bleeding, signs and symptoms of infection, physical care of the access site, and who was responsible for monitoring or what interventions were in place if case of a medical emergency. R28's annual MDS dated 11/18/14, indicated the resident was cognitively intact. It was also noted R28 had diagnoses including end stage renal disease (ESRD), with a therapeutic diet and dialysis. The MDS also indicated R28 required extensive assistance of two staff for personal hygiene, bed mobility and transfers with the use of a mechanical lift. During an interview on 2/3/15, registered nurse (RN)-A stated that she was unaware of any monitoring or documenting being completed regarding to R28 dialysis access site. During an interview on 2/4/15, at 8:03 a.m. a licensed practical nurse (LPN)-A stated that she was unsure if R28's dialysis access site was routinely monitored. A trained medication aide (TMA)-A stated in an interview on 2/4/15, at 1:38 p.m. she did not know of any monitoring she need to do for R28 dialysis site. During an interview on 2/4/15,at	2 555		

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2 555	Continued From page 6 approximately 1:50 p.m. the director of nursing verified that R28 care plan lacked interventions related to R28's dialysis care. A policy on dialysis access site monitoring was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are developed to ensure appropriate care of residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced	2 895		3/13/15

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2 895	Continued From page 7 by: Based on observation, interview and document review the facility failed to provide range of motion (ROM) to minimize the risk for a decline in ROM for 1 of 3 residents (R10)reviewed for ROM services. Findings include: R10's registered physical therapist's (RPT) summary dated 5/6/13, indicated the resident would be able to complete a "restorative program designed to maintain functional gain achieved in therapy" with assist from a restorative aide. The plan noted R10 would have "an appropriate restorative program in place at time of discharge from physical therapy...in place with nursing staff for long sitting stretch to maintain or improve knee ROM and also a walking program." R10 had a diagnoses including dementia and generalized pain. The quarterly Minimum Data set (MDS) dated 11/24/14, indicated R10 had long and short term memory problems and severely impaired decision making skills. The resident was described as having a functional limitation in ROM of bilateral upper and lower extremities and required total assistance from staff for all activities of daily living (ADL's). However, R10's care plan was not developed and ROM was not being provided. R10's care plan (revised 5/5/14) included limited physical mobility related to dementia and arthritis and dependency on staff for transfers and mobility and activities of daily living. The care plan did not address the resident's functional limitations in ROM. During an interview on 2/4/15, at 11:00 a.m. the	2 895	The director of nursing and therapy staff will review and revise policies and procedures related to range of motion services. Plans will be developed and staff will be educated. An audit tool will be developed and audit results sent to the quality committee for review.	

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2 895	Continued From page 8 director of nursing (DON) explained R10 had been receiving ROM services, but they had since been discontinued. The DON was unable to provide a justification as to why they had been stopped, and was unable to provide documentation from therapy staff stating they had been apprised of the decision to discontinue the services. The RPT was unavailable for an interview and the occupational therapist was unaware the resident was no longer receiving ROM services. A 9/12 Range of Motion (ROM) Policy noted the purpose was to "prevent reduction in range of motion whenever possible. The center will ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion as much as possible and to prevent further decrease in range of motion." SUGGESTED METHOD OF CORRECTION: The director of nursing and therapy staff could review and revise policies and procedures related to range of motion services. Plans could be developed and staff could be educated. An audit tool could be developed and audit results sent to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		3/13/15

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21375	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a written infection control plan that included procedures for handling persons with active tuberculosis (TB) disease. This had the potential to affect all 27 residents in the facility. Findings include: On 2/4/15, at approximately 10:00 a.m. while reviewing the facility's infections control policies related to tuberculosis, the facility's written infection control plan procedure for handling residents with active TB could not be located. During an interview on 2/4/15, at 3:50 p.m. a licensed practical nurse (LPN)-A stated if she suspected a resident to had active TB she would isolate the resident to their room and update the physician. LPN-A attempted to find an online corporate TB, but could not locate one. LPN-A then asked two other staff employees for help, but none of the staff were able to find the corporate policy. The director of nursing (DON) was present at the time. During an interview on 2/4/15, at 3:00 p.m. the DON said she was unable to provide the facility's written infection control plan. The DON did produce a cooperate procedure titled Residents with Suspected or Confirmed Tuberculosis (TB) and added a revised date on the form of "2/4/15." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or infection control nurse could ensure policies are developed that	21375	Charge nurses will be instructed where to locate facility infection control policies. DON has been instructed on State TB guidelines. DON has updated the written TB plan per State regulations. Going forward the DON will monitor the policy and update it bi-annually according to state regulations.	

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21375	Continued From page 10 are consistent with current TB standards of practice. Systems could be implented to ensure the policy is followed and staff education related to TB could be provided for pertinent staff. The director of nursing or designee could develop an audit tool to ensure TB practices are followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced	21535		3/13/15

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21535	Continued From page 11 by: Based on observation, interview and document review, the facility failed to identify the clinical indications for the continued use of an antipsychotic and antianxiety medication for 2 of 5 residents (R30, R14) reviewed for unnecessary medication. Findings include: R30 was observed on 2/3/15, at 4:10 p.m. sitting calmly in her wheelchair trying to place a blanket on top for her bed and mumbling inaudibly. R30 self-propelled herself around the room looking at items on the nightstand. R30's quarterly Minimum Data Set (MDS) dated 12/30/14, indicated R30 had severe cognitive impairment and required extensive assistance of two staff for personal hygiene, bed mobility and transfers. The MDS identified R30 had a diagnoses including anxiety, Alzheimer's disease and depression. She also had mood problems including trouble falling asleep or staying asleep, or sleeping too much, and feeling tired or having little energy nearly every day. R30's Medication Administration Record (MAR) from 9/14 to 2/15 indicated R30 was receiving one tablet scheduled Ativan (medication used to treat anxiety disorders) 0.5 milligrams (mg) daily and every Tuesday. R30 also was receiving Ativan 0.5 mg as needed (PRN) up to three times daily. R30 had been administered the PRN Ativan three times in the last six months. A Psychoactive Medication Monitoring for R30 dated 12/24/14 and 1/21/15, was reviewed. The pharmacist indicated a recommendation as followed: re-evaluate use of Ativan and consider attempting dose reduction or stopping if providing	21535	The Director of Nursing (DON) will work with the medical director and consultant pharmacist to ensure medications are reviewed for appropriate interventions and monitoring. The DON will ensure the staff are educated on the importance of monitoring for unnecessary medications.The DONwillrandomly audit resident records to ensure adequate monitoring and documentation was in place.	

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21535	Continued From page 12	21535		

no benefit. R30's Psychoactive Medication Monitoring forms lacked a physician signature acknowledging this request. Nursing notes were reviewed and noted no documentation that a physician was notified of the request for gradual dose reduction (GDR) of Ativan nor was there evidence that a GDR was attempted.

During an interview on 2/4/15, at 10:37 a.m. director of nursing and the MDS coordinator both reported R30 had been sleepier than usual.

On 2/5/15 at 12:36 p.m. the pharmacy recommendations were requested from the DON, however, only one recommendation dated 7/28/14 was provided. The DON explained she had the rest of the reviews on her desk, and explained that she was "late" getting out the pharmacist GDR recommendations to the physicians. Regarding whether R30's physician was aware of the recommendations for Ativan she replied "no, not that I am aware of."
R14 was observed on 2/3/15, at 8:26 a.m. wheeling himself up and down the hallway. He was neatly dressed and groomed, was alert and exhibited no notable behavioral issues.

R14's MDS assessment dated 1/15/15, noted diagnoses including dementia with no behavioral disturbance. Medications included the use of an antipsychotic. The resident was moderately cognitively impaired, and no behaviors were noted in the assessment period.

The care plan for R14 indicated mood symptoms related to diagnoses including personality disorder evidenced by irritability, repetitive verbalizations, and agitation. Interventions included giving adequate rest periods, discussing with resident/family "any concerns...or other

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21535	Continued From page 13 subjects as needed," reporting to the health care provider when R14 was refusing specified cares, sleep pattern changes, increased irritability, and individualized non-pharmacological interventions. This care plan additionally indicated behavior symptoms related to diagnoses such as refusal of cares, derogatory comments, history of false accusations and name calling. Interventions included protecting rights and safety of others, and individualized non-pharmacological interventions. A review of R14's medical record revealed a current physician order for Risperdal, dated 12/16/13, with an 0.5 milligrams daily at 4:00 p.m. for "agitation, delusions, and sundowning [a phenomenon common with dementia evidenced by increased confusion and agitation in the evening hours] related to anxiety state, unspecified." In addition, the current orders indicated, "Requires a private room because of behavior issues." R14's monthly pharmacy reviews were requested of the DON, as they could not be found in the resident's medical record. The DON returned with two Arlington Good Samaritan Drug Regimen Review Report documents from the pharmacy consultant's reviews, and said she was unable to locate any other reviews for R14. One of the two reports did not concern the use of antipsychotic medication. The second was dated 9/26/14 reiterated the resident had been due for a tardive dyskensia (abnormal movement disorder associated with antipsychotic use) assessment as it had last been completed in 2/14 and not since (recommended every six months). The document indicated, Completed" with an entry date of 10/14/14.	21535		

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21535	Continued From page 14 In addition to the missing pharmacy consultant reports, the record lacked sufficient evidence a gradual dose reduction (GDR) had been attempted for the use of the antipsychotic medication. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or desigee could work with the medical director and consultant pharmacist to ensure medications were reviewed for appropriate interventions and monitoring. The DON could ensure the staff were educated on the importance of monitoring for unnecessary medications.The DON or designee could randomly audit resident records to ensure adequate monitoring and documentation was in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		