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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TET0

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 **06/02/2015** (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 **45** (L18)

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

On June 2, 2015, a 2nd PCR was completed. This survey found all deficiencies corrected. Please refer to the CMS 2567.

17. SURVEYOR SIGNATURE — Date :
Marietta Lee, HFE NE II — 06/16/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 07/14/2015 (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
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
04/14/2015
(L33)

Posted 07/15/2015 Co.

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245317

June 19, 2015

Ms. Sara Falk, Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, Minnesota 55912

Dear . Falk:

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 May 29, 2015 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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On June 2, 2015,

I, Sara Falk, Administrator, received
(Name)(Please Print) (Title)(Please Print)
the Notice of Penalty Assessment dated June 2, 2015 and licensing orders issued to:

Good Samaritan Society - Comforcare
1201 17th Street Ne
Austin, MN 55912

The Penalty Assessments and licensing orders attached hereto have been corrected as of June 2, 2015.

Signed: Marietta Lee, Nurse Evaluator II, Date 6-2-15
(Name)(Please Print) (Title)(Please Print)

DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE

On June 2, 2015,

I, _____, _____, of the Division of
(Name)(Please Print) (Title)(Please Print)
Compliance Monitoring, Minnesota Department of Health, delivered the Notice of Penalty Assessment dated June 2, 2015 and issued to:

Good Samaritan Society - Comforcare
1201 17th Street Ne
Austin, MN 55912

The Notice of Penalty Assessment was handed to _____,
(Name)(Please Print)
_____, Date _____
(Title)(Please Print)

Signed: _____, _____, Date _____
(Name)(Please Print) (Title)(Please Print)

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 16, 2015

Ms. Sara Falk, Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, Minnesota 55912

RE: Project Number S5317026

Dear Ms. Falk:

On May 6, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 18, 2015. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on March 12, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on May 6, 2015. 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 June 2, 2015, 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 May 6, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 6, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on May 6, 2015, as of May 29, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 29, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of May 18, 2015. 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 June 12, 2015, 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 June 12, 2015, is to be rescinded. They will also notify the State

Medicaid Agency that the denial of payment for all Medicaid admissions, effective June 12, 2015, is to be rescinded.

In our letter of May 18, 2015, 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 June 12, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 29, 2015, 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
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
245317	A. Building B. Wing	6/2/2015

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0329 Reg. # 483.25(l) LSC	05/29/2015	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	06/16/2015	Marietta Lee HFE Nurse Specialist II	6-2-15
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/12/2015			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

June 16, 2015

Ms. Sara Falk, Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, Minnesota 55912

Re: Reinspection Results - Project Number S5317026

Dear Ms. Falk:

On June 2, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 2, 2015, with orders received by you on June 2, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

AH Form Approved
6/5/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00967	A. Building B. Wing	6/2/2015

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 21535 Reg. # MN Rule4658.1315 Subp.1 LSC	05/29/2015	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 GPN/kfd	Date: 06/16/2015	Signature of Surveyor: Marietta Lee HFE Nurse specialist II	Date: 6-2-15
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/12/2015		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: TET0

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 **05/06/2015** (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 **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

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
	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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 05/18/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/16/2015 (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
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
04/14/2015
(L33)

DETERMINATION APPROVAL

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

CCN 24-5317

On March 12, 2015, a standard survey was completed. This survey found the most serious deficiencie to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F).

On May 6, 2015, the Minnesota Department of Health and on April 24, 2015, the Minnesota Department of Public Safety completed a revisit to verify compliance. This facility has not achieved substantial compliance with the deficiencies issued pursuant to the standard survey, completed on March 12, 2015. The deficiency not corrected is as follows:

F0329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs

The most serious deficiencies in the facility 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). Please refer to the CMS 2567 along with the facility's plan of correction. PCR to follow.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245317

June 19, 2015

Ms. Sara Falk, Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, Minnesota 55912

Dear . Falk:

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 May 29, 2015 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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 18, 2015

Ms. Sara Falk, Administrator
Good Samaritan Society - Comforcare
1201 17th Street Northeast
Austin, Minnesota 55912

RE: Project Number S5317026

Dear Ms. Falk:

On March 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 March 12, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections were required.

On May 6, 2015, the Minnesota Department of Health and on April 24, 2015, 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 March 12, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 21, 2015. 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 March 12, 2015. The deficiency not corrected is as follows:

F0329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs

The most serious deficiencies in your facility 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), 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 May 23, 2015. (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 June 12, 2015. (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 June 12, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 12, 2015. 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 Program or Competency Evaluation Programs for two years effective June 12, 2015. 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
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
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 September 12, 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
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
245317	A. Building B. Wing	5/6/2015

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **05/06/2015**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **05/06/2015**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **05/06/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/06/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **05/06/2015**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **05/06/2015**
ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **05/06/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **05/06/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/06/2015**
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

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GPN/mm	05/18/2015	31221	05/06/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/12/2015			

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 05/06/2015

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 May 5 and 6, 2015. The certification tags that were corrected can be found on the CMS2567B. Also there were tag/s that were not found corrected and/or new tags were issued at the time of onsite PCR which are 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. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
{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	{F 329}		5/29/15

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

Electronically Signed | 05/22/2015

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 05/06/2015

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 329}	Continued From page 1 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 observation, interview and document review, the facility failed to ensure a comprehensive physician justification as to why a gradual dose reduction (GDR) was contraindicated at this time when a psychotropic and antidepressant medication is used for more than one for 1 of 3 residents (R52) reviewed for unnecessary medications; and failed to comprehensively complete a depression/insomnia assessment before starting and antidepressant, then developing temporary care plan interventions to treat depression and insomnia and identify resident specific depression and insomnia symptoms to determine if the Remeron was affective or not for identify resident specific target symptoms for the use of the antidepressant and failed to complete 1 of 3 residents (R134) reviewed for unnecessary medications. Findings include: Lack of GDR or physician's justification as to why the GDR is contraindicated at this time: R52 was observed on 5/6/15 at 4:51 p.m. R52 was lying in bed with head turned away from the	{F 329}	Resident 52 had a GDR dose reduction on 5/15/15 with physician justification. Resident 134 was discharged on 5/7/15 to home. Facility will review and identify other residents on a psychotropic and antidepressant medication to ensure appropriate documentation and behavioral interventions are being used according to state regulations. DON will complete re-education to all nursing staff by 5/29/15. Interdisciplinary team (social services, nurse manager, DON and the nursing staff) will monitor and put appropriate interventions into place for all residents on psychotropic and antidepressant medications. Audits will be conducted on new residents and changes to current resident¿s psychotropic medications and GDR will be completed per state regulation, results will be shared at the Quality Assurance Performance Improvement 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 _____	R 05/06/2015

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 329}	Continued From page 2 door. Licensed practical nurse (LPN)-A stated R52 had been up late last night so was sleeping now. Review of the quarterly Minimum Data Set (MDS) dated 2/3/15 indicated R52 had a BIMS (brief interview of mental status) of 2 or severely cognitively impaired, had a PHQ-9 (depression scale) of 2 or no depression, and had displayed no behaviors during the assessment time period. The quarterly MDS dated 4/28/15 indicated R52 exhibited no behaviors and continued to have a PHQ-9 score of 2 or no depression. Physician notes of 4/11/15 noted a plan to continue Celexa (antidepressant) 10 mg daily and Seroquel (antipsychotic) 50 mg 1 ½ tabs twice a day. On 2/26/15 the consultant pharmacist provided the physician with a note that indicated R52 had received Celexa 10 mg daily since 2/19/13 (over two years) and questioned of a reduction was needed. The physician on 3/11/15 replied to the pharmacist note dated 2/26/15, " No, behavior is stable. It worsened in past with decrease." However, the physician ' s justification lacked a comprehensive analysis of why the gradual dose reduction was not attempted at this time which at a minimum included the dates of the last attempt at reduction and if target behaviors worsened at this attempt and how this the reduction would likely impair the resident ' s function or increase distressed behavior. On 3/27/15 the consultant pharmacist provided the physician with a note that indicated R52 had received Seroquel 75 mg twice a day since 7/16/13 and asked about a gradual dose	{F 329}		

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 05/06/2015

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 329}	Continued From page 3	{F 329}		

reduction. The physician wrote a note on 4/6/15 that said no reduction and stable dementia behavior. Again the physician ' s justification lacked a comprehensive analysis of why the gradual dose reduction was contraindicated at this time which at a minimum needs to include previous attempts at a GDR and what occurred at this time, also how it may impair functional status or increase distressed behavior/s.

The director of nursing was interviewed on 5/6/15 at 4:09 p.m. and stated she thought the facility had contacted the medical director regarding R52 ' s primary physician not providing a detailed rationale for ongoing use of the medications and would pursue this course if not.

Lack of comprehensive depression and sleep assessment and identifying resident specific depression and insomnia symptoms to determine if medication was affective or not:

R134 was admitted on 4/21/15 and had an increase in the Remeron, (antidepressant) on 4/29/15.

R134 was observed on 5/6/15 at 4:18 p.m. R134 was sitting in a recliner with feet elevated watching TV. R134 stated that last night they gave him a pill at 7:00 p.m. so did not sleep so well. R134 said that some nights he slept okay and sometimes he did not. R134 stated that he did use sleeping medication at home.

The admission minimum data set dated 4/27/15 indicated a BIMS (brief interview of mental status) of 13 or no impairment and mood symptoms of feeling down/depressed, no trouble sleeping, and poor appetite.

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 05/06/2015

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 329}	Continued From page 4	{F 329}		

The physician notes dated 4/29/15 indicated an increase in the Remeron to 15 mg and listed the diagnoses as depression/insomnia/poor appetite. The physician documented R134 was more depressed since daughter died this spring and R134 ' s health issues. The physician stated the resident mentioned that he had not slept well and did not have a good appetite.

R134 ' s nursing notes dated 4/24/15 stated he had been resting quietly. On 4/28/15 the notes indicated resident stated feels better. Another note on 4/28/15 noted resident showing more signs of depression (but did not identify the symptoms displayed). On 4/29/15, 5/1/15, and 5/2/15 the nursing notes stated the resident appeared to be sleeping when checked by staff during night. The nursing note of 5/3/15 noted no negative mood or behaviors noted.

A review of R134 ' s records lacked information on a sleep assessment being completed prior or after the Remeron was started or increased in dose. Also the care plan lacked any non-pharmacological interventions to try for insomnia. On asking the facility for sleep assessment, care planning interventions, and ongoing evaluation of effectiveness of the Remeron for depression and/or sleep none was provided.

RN-B was interviewed on 5/6/13 at 3:18 p.m. RN-B stated the Remeron was for depression and had been increased from 5 mg to 15 mg. RN-B stated she was not able to find any sleep or depression assessments or ongoing evaluation of the effectiveness of the Remeron. RN-B did

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 05/06/2015

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 329}	Continued From page 5 verify the physician listed diagnoses as depression/insomnia/appetite loss. RN-B stated no sleep assessment had been completed and if sleep monitoring done it would have been in the nursing notes. The facility ' s policy entitled Psychopharmacological Medications and Sedative/Hypnotics dated 3/15 was reviewed. The policy directed that before administration of non-emergency psychopharmacological and/or sedative/hypnotics there was to be documentation of observations of mood symptoms or behaviors that cause the resident distress and response to interventions used. If the medication is a hypnotic, a sleep assessment is to be completed. Throughout the administration of the psychopharmacological medications " mood and behavior documentation must continue in order to indicate the effect the medication has on the behavior. " The policy also directed that a gradual dose reduction must be done according to federal regulations. "Tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved and/or non-pharmacological interventions have been effective in reducing the symptoms."	{F 329}		

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245317	A. Building 02 - BUILT IN 2007 B. Wing	4/24/2015

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	04/14/2015	ID Prefix Reg. # NFPA 101 LSC K0141	04/21/2015	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	

Reviewed By State Agency	Reviewed By PS/mm	Date: 05/18/2015	Signature of Surveyor: 12424	Date: 04/24/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/10/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on June 5, 2015.

June 5, 2015

Ms. Sara Falk, Administrator
Good Samaritan Society - Comforcare
1201 17th Street Northeast
Austin, MinnesotaN 55912

Re: Project # S5317026

Dear Ms. Falk:

On May 6, 2015, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 12, 2015 with orders received by you on March 20, 2015.

State licensing orders issued pursuant to the last survey completed on March 12, 2015 and found corrected at the time of this May 6, 2015 revisit, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on March 12, 2015, found not corrected at the time of this May 6, 2015 revisit and subject to penalty assessment are as follows:

21535 - MN Rule4658.1315 Subp.1 ABCD -- Unnecessary Drug Usage; General - $300.00

The details of the violations noted at the time of this revisit completed on May 6, 2015 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $300.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected.

This written notification shall be mailed or delivered to the Department at the address below or to:

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us

Telephone: (507) 206-2731
Fax: (507) 206-2711

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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 related to this letter.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697
Enclosure

cc: Licensing and Certification File
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00967	A. Building B. Wing	5/6/2015

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **20302** Reg. # **MN State Statute 144.6503** LSC	**05/07/2015**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	**05/07/2015**	ID Prefix **20860** Reg. # **MN Rule 4658.0520 Subp. 2 F.** LSC	**05/07/2015**
ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp. 4 A-I** LSC	**05/07/2015**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Subd. 3** LSC	**05/07/2015**	ID Prefix **21545** Reg. # **MN Rule 4658.1320 A.B.C** LSC	**05/07/2015**
ID Prefix **21600** Reg. # **MN Rule 4658.1335 Subp. 2** LSC	**05/07/2015**	ID Prefix **21630** Reg. # **MN Rule 4658.1350 Subp. 2 A.I** LSC	**05/07/2015**	ID Prefix **21695** Reg. # **MN Rule 4658.1415 Subp. 4** LSC	**05/07/2015**
ID Prefix **21830** Reg. # **MN St. Statute 144.651 Subd. 1** LSC	**05/07/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GPN/mm	06/05/2015	31221	05/06/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/12/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: _____ B. WING _____	R 05/06/2015

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) COMPLETE DATE
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: An onsite follow-up visit was completed on May 5 and 6, 2015. During this onsite visit it was determined there are licensing orders that have not been corrected at the time of this licensing survey. These uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for	2 000		

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2 000	Continued From page 1 possible penalty assessment/s.	2 000		
{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 by: Based on observation, interview and document review, the facility failed to ensure a comprehensive physician justification as to why a gradual dose reduction (GDR) was contraindicated at this time when a psychotropic and antidepressant medication is used for more than one for 1 of 3 residents (R52) reviewed for	{21535}		

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{21535}	Continued From page 2	{21535}		

unnecessary medications; and failed to comprehensively complete a depression/insomnia assessment before starting and antidepressant, then developing temporary care plan interventions to treat depression and insomnia and identify resident specific depression and insomnia symptoms to determine if the Remeron was affective or not for identify resident specific target symptoms for the use of the antidepressant and failed to complete 1 of 3 residents (R134) reviewed for unnecessary medications.

Findings include:
Lack of GDR or physician's justification as to why the GDR is contraindicated at this time:

R52 was observed on 5/6/15 at 4:51 p.m. R52 was lying in bed with head turned away from the door. Licensed practical nurse (LPN)-A stated R52 had been up late last night so was sleeping now.

Review of the quarterly Minimum Data Set (MDS) dated 2/3/15 indicated R52 had a BIMS (brief interview of mental status) of 2 or severely cognitively impaired, had a PHQ-9 (depression scale) of 2 or no depression, and had displayed no behaviors during the assessment time period. The quarterly MDS dated 4/28/15 indicated R52 exhibited no behaviors and continued to have a PHQ-9 score of 2 or no depression.

Physician notes of 4/11/15 noted a plan to continue Celexa (antidepressant) 10 mg daily and Seroquel (antipsychotic) 50 mg 1 ½ tabs twice a day.

On 2/26/15 the consultant pharmacist provided the physician with a note that indicated R52 had

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{21535}	Continued From page 3 received Celexa 10 mg daily since 2/19/13 (over two years) and questioned of a reduction was needed. The physician on 3/11/15 replied to the pharmacist note dated 2/26/15, " No, behavior is stable. It worsened in past with decrease." However, the physician ' s justification lacked a comprehensive analysis of why the gradual dose reduction was not attempted at this time which at a minimum included the dates of the last attempt at reduction and if target behaviors worsened at this attempt and how this the reduction would likely impair the resident ' s function or increase distressed behavior. On 3/27/15 the consultant pharmacist provided the physician with a note that indicated R52 had received Seroquel 75 mg twice a day since 7/16/13 and asked about a gradual dose reduction. The physician wrote a note on 4/6/15 that said no reduction and stable dementia behavior. Again the physician ' s justification lacked a comprehensive analysis of why the gradual dose reduction was contraindicated at this time which at a minimum needs to include previous attempts at a GDR and what occurred at this time, also how it may impair functional status or increase distressed behavior/s. The director of nursing was interviewed on 5/6/15 at 4:09 p.m. and stated she thought the facility had contacted the medical director regarding R52 ' s primary physician not providing a detailed rationale for ongoing use of the medications and would pursue this course if not. Lack of comprehensive depression and sleep assessment and identifying resident specific depression and insomnia symptoms to determine if medication was affective or not:	{21535}		

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{21535}	Continued From page 4 R134 was admitted on 4/21/15 and had an increase in the Remeron, (antidepressant) on 4/29/15. R134 was observed on 5/6/15 at 4:18 p.m. R134 was sitting in a recliner with feet elevated watching TV. R134 stated that last night they gave him a pill at 7:00 p.m. so did not sleep so well. R134 said that some nights he slept okay and sometimes he did not. R134 stated that he did use sleeping medication at home. The admission minimum data set dated 4/27/15 indicated a BIMS (brief interview of mental status) of 13 or no impairment and mood symptoms of feeling down/depressed, no trouble sleeping, and poor appetite. The physician notes dated 4/29/15 indicated an increase in the Remeron to 15 mg and listed the diagnoses as depression/insomnia/poor appetite. The physician documented R134 was more depressed since daughter died this spring and R134 ' s health issues. The physician stated the resident mentioned that he had not slept well and did not have a good appetite. R134 ' s nursing notes dated 4/24/15 stated he had been resting quietly. On 4/28/15 the notes indicated resident stated feels better. Another note on 4/28/15 noted resident showing more signs of depression (but did not identify the symptoms displayed). On 4/29/15, 5/1/15, and 5/2/15 the nursing notes stated the resident appeared to be sleeping when checked by staff during night. The nursing note of 5/3/15 noted no negative mood or behaviors noted. A review of R134 ' s records lacked information	{21535}		

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{21535}	Continued From page 5	{21535}		

on a sleep assessment being completed prior or after the Remeron was started or increased in dose. Also the care plan lacked any non-pharmacological interventions to try for insomnia. On asking the facility for sleep assessment, care planning interventions, and ongoing evaluation of effectiveness of the Remeron for depression and/or sleep none was provided.

RN-B was interviewed on 5/6/13 at 3:18 p.m. RN-B stated the Remeron was for depression and had been increased from 5 mg to 15 mg. RN-B stated she was not able to find any sleep or depression assessments or ongoing evaluation of the effectiveness of the Remeron. RN-B did verify the physician listed diagnoses as depression/insomnia/appetite loss. RN-B stated no sleep assessment had been completed and if sleep monitoring done it would have been in the nursing notes.

The facility ' s policy entitled Psychopharmacological Medications and Sedative/Hypnotics dated 3/15 was reviewed. The policy directed that before administration of non-emergency psychopharmacological and/or sedative/hypnotics there was to be documentation of observations of mood symptoms or behaviors that cause the resident distress and response to interventions used. If the medication is a hypnotic, a sleep assessment is to be completed. Throughout the administration of the psychopharmacological medications " mood and behavior documentation must continue in order to indicate the effect the medication has on the behavior. " The policy also directed that a gradual dose reduction must be done according to federal regulations. "Tapering may be indicated when the resident's clinical

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{21535}	Continued From page 6 condition has improved or stabilized, the underlying causes of the original target symptoms have resolved and/or non-pharmacological interventions have been effective in reducing the symptoms." This licensing order will be reviewed for possible penalty assessment/s.	{21535}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TET0

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 **03/12/2015** (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 **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

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
	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 :
Marietta Lee, HFE NE II 03/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/09/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 20, 2015

Ms. Sara Falk, Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, Minnesota 55912

RE: Project Number S5317026

Dear Ms. Falk:

On March 12, 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:

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
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 April 21, 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 April 21, 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 June 12, 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 September 12, 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
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

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 _____	03/12/2015

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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to promote dignity by promptly removing soiled incontinence products after personal cares for 1 of 3 residents (R106) reviewed for activities of daily living. Findings include: R106's admission Minimum Data Set (MDS), dated 2/3/15, identified R106 had moderate cognitive impairment, and required extensive assistance with toileting and personal hygiene.	F 241	Resident 106 was corrected immediately; the soiled bag was removed from the room. Small black garbage bags have been ordered for soiled incontinent products so it will not affect any other residents. Re-education was provided to all staff on 3/19/15, CNA□s on 3/24/15 and more education will be sent to nursing staff on 4/3/15 to ensure resident dignity is being followed. Audits will be conducted weekly X4 weeks then presented at the QAPI meeting for further recommendations. Social services	4/21/15

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

Electronically Signed | 03/30/2015

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 _____	03/12/2015

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F 241	Continued From page 1 During general observation on 3/11/15, at 9:22 a.m. R106 was seated in his room watching television. A clear bag was visible from the hallway on R106's vanity, which contained a yellow incontinence brief, and several wipes containing a brown substance (stool). In addition, several used wet washcloths were sitting on the vanity next to the clear bag containing soiled incontinence products. When interviewed on 3/11/15, at 9:26 a.m. nursing assistant (NA)-A stated R106 had been incontinent of stool during morning cares earlier that day, and added the bag should not have been left on the vanity, visible to the public as they pass by the room, "I know better." During interview on 3/11/14, at 2:26 p.m., family member (FM)-C stated she had never observed staff to leave soiled incontinence products in R106's room before, but that it should never occur, "No, that shouldn't be." When interviewed on 3/12/15, at 12:19 p.m. the director of nursing (DON) stated the soiled incontinence products should have been removed from R106's room immediately after care, and failing to do so was a concern for R106's dignity. Further, the DON added, "I wouldn't like it if it were me." A facility Resident Dignity policy, dated 2/2013, identified a purpose of, "To maintain the dignity of all residents." Further, the policy directed, "The center will promote care for residents in a manner and in an environment that maintains of enhances each resident's dignity and respect..."	F 241	Director will be responsible for ensuring this standard is met.	
F 242	483.15(b) SELF-DETERMINATION - RIGHT TO	F 242		4/21/15

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F 242 SS=D	Continued From page 2 MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure each resident's preference for waking up in the morning was respected and the facility failed to ensure that bathing frequency preference was provided for 1 of 3 residents (R104) who was reviewed for choices. Findings Include: R104's admission Minimum Data Set (MDS) dated 1/30/15, identified but not limited to diagnoses of cancer, thyroid disorder and depression, and required physical help in part of bathing of one person physical assist. R104's brief interview for mental status (BIMS) score of fifteen indicated intact cognition. R104 was interviewed on 3/10/15 at 1:53 p.m. in her room. When asked, "Do you choose when to get up in the morning?" R104 responded, "No, they [staff] come and wake me up and get me dressed. I would like to sleep in to about 9 a.m. " R104 stated she has not told them she would like to sleep in or that they were getting her up to early. When asked, "Do you choose how many	F 242	Resident 104 discharged on 3/19/15. All residents Medical records will be reviewed or interviews conducted to determine if staff is honoring their preference for time to get up in the morning and frequency of bathing. Facility will provided re-education to nursing staff on 4/3/15 regarding resident choices and following GSS policy for honoring those choices. Audits will be conducted weekly for 4 weeks; they will be presented at the QAPI meeting for further recommendations. Social services Director will be responsible for ensuring this standard is met.	

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F 242	Continued From page 3	F 242		

times a week you take a bath or shower?" R104 responded, "No, I was told one time a week on Friday." When asked if she would like more than one shower or bath a week, R104 stated she would like at least five. When asked if she had told staff she would like more than one shower or a bath each week R104 stated she had and was told no.

R104's Nursing Admit Re-admit Data Collection dated 2/18/14 indicated residents usual waking time was 8:00 a.m. However, the staff was getting R104 up as early as 6:45 a.m.

R104 was observed on 3/12/15 at 7:13 a.m. to be dressed ready for the day and sitting in her wheelchair in her room. R104 stated staff came in and woke her up that morning at approximately 6:45 a.m. R104 stated she was just sitting in her room thinking and did not understand why she needed to be woken up at that "ungodly hour" and gotten ready for the day and then you have to wait an hour before breakfast.

On 3/12/15 at 8:42 a.m. nursing assistant (NA)-E stated she helped R104 get up this morning and helped her with morning cares at approximately 7:00 a.m. NA-E stated R104 liked to get up in the morning between 6:30 and 7:00 a.m. and stated R104 was easy going and if we go in her room and ask her if she would like to get up, she will. NA-E verified she was unaware resident would prefer to sleep in till 8:00 a.m. NA-E stated nursing assistants were responsible for resident bathing. NA-E stated residents' bathing scheduled was determined by the room the resident was assigned upon admission. NA-E stated the facility did accommodate additional baths or showers if the resident or family made a

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F 242	Continued From page 4	F 242		

request. NA-E was unaware R104 preferred more than one bath or shower a week.
On 3/12/15 at 10:56 a.m. registered nurse (RN)-F stated upon admission the residents are asked what time they would like to get up in the morning and this was documented on the Nursing Admit Re-Admit Data Collection assessment. RN-F verified R104's Nursing Admit Re-admit Data Collection dated 2/18/15 indicated residents usual waking time was 8:00 a.m. When asked about how wake times preferences were communicated to staff, RN-F stated there was not a specific way. RN-F stated staff is pretty good about knocking on the residents' door and asking them if they would like to get up. RN-F stated we really try to promote resident choices, but stated sometimes we are on a time crunch from therapy and stated therapy will get upset if residents are not up and stated nurse management stated residents needed to be up before breakfast or 9:00 a.m. RN-F stated there was a scheduled bath day for residents based on their room assignment in the facility. RN-F stated residents are told upon admission what day their bath/shower was scheduled for and stated the resident was asked if that was ok. RN-F verified staff did not ask residents how many times a week they would like a bath or shower.
On 3/12/15 at 11:36 a.m. the director of nursing (DON) stated her expectations was the residents are asked what their preference for bathing frequency and asked what time they would like to get up in the morning upon admission. The DON stated she would expect staff to get the resident up as close as they could to their preference and stated if a resident's preference was to get up at 8:00 a.m., she would expect staff to get the resident up between 7:30 a.m. and 8:30 a.m. The DON verified waking a resident up at 6:45

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F 242	Continued From page 5 a.m. to get them ready for the day would be too early for a resident that had a preference of waking up for the day at 8:00 a.m.	F 242		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure wheelchairs were clean and sanitary for 2 of 2 residents (R33 and R47). Findings included: R33 was observed on 3/10/15, at 9:38 a.m., on 3/11/15, at 1:03 p.m., and on 3/12/15, at 8:04 a.m. revealed R33's wheel chair had white crumbly debris on the seat cushion of the wheel chair and the left side had dried shiny film with a dried yellow crusted debris near the arm of the chair. R33 was to have wheel chair cleaned on Monday 3/9/15 according to the wheelchair washing schedule. An observation done on 3/10/15, at 2:30 p.m. revealed R47 had large particle flakes of white food debris on the seat cushion of their wheel chair. A family (F)-A member was present during this time and pointed the dirty wheelchair out to this surveyor. F-A stated, R47's is routinely dirty and has asked staff clean it frequently. According to the facility's wheelchair washing schedule, R33's wheelchair was scheduled to be cleaned on Mondays and R47's wheelchair was scheduled to be cleaned on Fridays.	F 253	Resident 33 and 47 were cleaned immediately. All chairs have been washed. A new cleaning schedule will be posted and implemented for the nursing staff. Re-education will be done with all nursing staff on 4/3/15. Audits will be conducted daily for 2 weeks; which will ensure all wheelchairs are being cleaned two times during those two weeks. Audits will be conducted randomly for 1 month. The audits will be reported to QAPI for further recommendation. Nurse Managers in each area will be responsible for ensuring this standard is met.	4/21/15

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F 253	Continued From page 6 During an interview on 3/12/15, at 8:02 a.m. nursing assistant (NA)-B stated wheel chair are cleaned once a week by the overnight shift. NA-B stated, "During the day when we see if something is bad we wipe it off." During an interview on 3/12/15, at 2:30 p.m. director of environmental services (DES)-H explained the overnight nursing assistance clean the wheelchairs on weekly schedule. DES-H stated, if the wheel chairs were heavily soiled they would notify him and chairs would then be power washed. A policy on maintenance of resident care equipment was requested and not provided by the facility.	F 253		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care planned interventions for skin protection and nail care were followed by staff for 2 of 3 residents (R106, R33) reviewed for activities of daily living. Findings include: LACK of SKIN PROTECTION: R106's admission Minimum Data Set (MDS), dated 2/3/15, identified R106 had moderate	F 282	Resident 106 and 33 had nails trimmed immediately. Protective skin care was provided to resident 106 immediately by putting heels up off the bed as directed from the care plan. All resident□s nails were checked to ensure nails were trimmed and clean. All residents needing protective skin care were checked to ensure the care plan was being followed. Nail care policy and protective skin care education will be provided to all nursing staff on 4/3/15. Audits will be conducted	4/21/15

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F 282	Continued From page 7 cognitive impairment, and required extensive assistance with personal hygiene. R106's Therapy Documentation Notes, dated 1/28/15, identified, "Elevate feet + (and) protect heel when in bed with cushion." R106's care plan, dated 1/29/15, identified R106 had a current skin impairment on his coccyx, and identified an intervention of, "elevate heels off bed", to reduce his risk of further pressure ulcer development. During observation of morning cares, on 3/12/15, at 7:30 a.m. nursing assistant (NA)-D entered R106's darkened room to provide care with the surveyor. NA-D removed the white linen covering his feet to apply a new pair of cotton socks. R106's heels were lying directly on the bed, not elevated as directed by the care plan. A blue "HEELZUP" device (used to help elevate heels from a surface) was lying on the floor, propped up against the wall, by the foot of R106's bed. When interviewed on 3/12/15, at 8:20 a.m. nursing assistant (NA)-D verified R106's heels were not elevated when she entered the room to complete morning care. Further, R106's care plan should have been followed, and his heels should have been elevated as directed. During interview on 3/12/15, at 8:48 a.m. licensed practical nurse (LPN)-B stated R106 was at risk for skin breakdown on his heels, and the care plan interventions should have been followed by the staff. When interviewed on 3/12/15, at 12:19 p.m. the director of nursing (DON) stated a resident ' s care plan is written to guide a resident's care, and that they should be followed.	F 282	weekly for 1 month. The audits will be reported to QAPI. Director of Nursing will be responsible to ensure this standard is met.	

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F 282	Continued From page 8	F 282		

A facility Care Plan policy, dated 2/2013, identified, "The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services."
LACK of NAIL CARE:

R33 was observed on 3/10/15, at 9:28 a.m., 3/11/15, at 8:52 a.m., and on 3/12/15, at 7:55 a.m. revealed R33 had long finger nails on both hands and dried brown debris was underneath the nails.
The facility admission record indicated R33 was admitted to the facility on 11/25/2013 and included diagnoses of but not limited to dementia, anxiety, and Parkinson's disease.
R33's quarterly Minimum Data Set (MDS) dated 12/16/15 indicated severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 3 and required extensive assist from two staff members to provide personal hygiene and grooming tasks.
R33's most recent care plan provided by the facility on 3/12/15 instructed staff to provide nail care weekly on bath day and as needed.
During an interview on 3/12/15, at 7:56 a.m. nursing assistant (NA)-B stated the restorative nursing assistant is the primary person that provided nail care for residents. NA-B stated, "Sometimes me and the other aide will do to help out, or we will do it if we notice the nails are dirty." NA-B explained nails are checked on shower day, and in the case of resident refusal NA's would report to the nurse.
During an interview on 3/12/15, at 8:03 a.m. NA-C (worked as the restorative nursing assistant) stated, "I provide nail care the majority of the time, once a week on bath days, but it's not

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F 282	Continued From page 9 just up to me. The nurses and the aides also do it." During an interview on 3/12/15, at 8:07 a.m. registered nurse (RN)-A verified R33 nails were long and dirty and should be cleaned. RN-A also explained R33 used his hands quite a bit to eat. RN-A then stated she would make sure the nails got trimmed and cleaned. A facility procedure nail care last reviewed on November 2013 did not give direction on how often nail care should be provided.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide nail care for a dependent resident according to the care plan for 1 of 3 residents (R33) reviewed for activities of daily living. Findings included: R33 was observed on 3/10/15, at 9:28 a.m., 3/11/15, at 8:52 a.m., and on 3/12/15, at 7:55 a.m. revealed R33 had long finger nails on both hands and dried brown debris was underneath the nails. The facility admission record indicated R33 was admitted to the facility on 11/25/2013 and included diagnoses of but not limited to dementia,	F 312	Resident 33 had nails trimmed immediately. All resident□s nails were checked to ensure nails were trimmed and clean. Nail care policy and education will be provided to all nursing staff on 4/3/15. Audits will be conducted weekly for 1 month. The audits will be reported to QAPI for further recommendation. Director of Nursing will be responsible to ensure this standard is met.	4/21/15

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F 312	Continued From page 10 anxiety, and Parkinson ' s disease. R33's quarterly Minimum Data Set (MDS) dated 12/16/15 indicated severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 3 and required extensive assist from two staff members to provide personal hygiene and grooming tasks. R33's most recent care plan provided by the facility on 3/12/15 instructed staff to provide nail care weekly on bath day and as needed. The care plan did not indicate when R33's bath was. During an interview on 3/12/15, at 7:56 a.m. nursing assistant (NA)-B stated the restorative nursing assistant is the primary person that provided nail care for residents. NA-B stated, "Sometimes me and the other aide will do to help out, or we will do it if we notice the nails are dirty." NA-B explained nails are checked on shower day, and in the case of resident refusal NAs would report to the nurse. During an interview on 3/12/15, at 8:03 a.m. NA-C (worked as the restorative nursing assistant) stated, "I provide nail care the majority of the time, once a week on bath days, but it ' s not just up to me. The nurses and the aides also do it." During an interview on 3/12/15, at 8:07 a.m. registered nurse (RN)-A verified R33 nails were long and dirty and should be cleaned. RN-A also explained R33 used his hands quite a bit to eat. RN-A then stated she would make sure the nails got trimmed and cleaned. A facility procedure nail care last reviewed on November 2013 did not give direction on how often nail care should be provided.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		4/21/15

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F 329	Continued From page 11 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 identify indications for use of and antipsychotic medication (Risperidone) or identify clinical symptoms to determine if the medication was effective; and did not complete a comprehensive sleep study to determine the need for the use of Mirtazapine, Melatonin ordered for insomnia for 1 of 5 residents (R108) reviewed for unnecessary medications; and failed to justify the ongoing use and did not attempt a mandatory gradual dose reduction of	F 329	Resident 108 was discharged on 3/19/15. Resident 52 had a dose reduction of Seroquel and Celexa in June of 2013, at the consultant pharmacist□s request. The consultant pharmacy will continue to make GDR recommendations, even though the physician has declined further GDR for resident. Nurse Manager and DON will consult with the facility□s medical director to work with the resident□s physician. The Nurse Manager	

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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 329	Continued From page 12 antipsychotic medications for 1 of 5 residents reviewed for unnecessary medications (R52). Findings Include: R108's admission record revealed R108 was admitted on 2/11/15 with diagnoses that included but were not limited to anxiety state and hypothyroidism. The admission Minimum Data Assessment (MDS) dated 2/18/15, indicated R108 did not display behavior problems or difficulty sleeping according, feeling tired or having little energy. R108 currently received Risperidone (antipsychotic) 0.5 milligrams (mg) one time a day for generalized anxiety. The current physician's orders reflected a start date for Risperidone as 2/19/15 and the resident had received the medication daily since then. R108's medical record review revealed targeted behaviors had not been determined and behavior monitoring for the effectiveness and continued use of the Risperidone had not been initiated for R108 since admission which was over thirty days. R108 ' s physician certification progress note dated 3/11/15 read, " ...Depression, insomnia, anxiety with previous paranoia. Resolved with low-dose Risperidone and extensive psychiatry review in the past. Continue low-dose and has felt that this has been weaned to the lowest effective dose in the outpatient setting. She also continues on melatonin (hormone to regulate sleep) and Remeron (antidepressant)... " R108 currently received Mirtazapine (antidepressant) 15 mg one time a day for sleep	F 329	will set up target behavior monitoring for resident 52 on antipsychotic medication. All residents taking antiemetics, antianxiety agents, antidepressants, antipsychotic/antimanic agents and hypnotics will be reviewed for appropriate monitoring and GDR reductions per GSS policy and procedures. Re- education will be provided to nursing staff regarding GSS policy and procedure on 4/3/15. Monthly medication reviews will be conducted by consultant pharmacist and reviewed at QAPI meeting. All residents with above mentioned medications will be audited weekly for 1 month to ensure appropriate monitoring and use of these medications. Results will be taken to QAPI meeting for further recommendations. Director of Nursing will be responsible to ensure this standard is met.	

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and Melatonin 3 mg at bedtime for sleep. The current physician's orders reflected a start date for Mirtazapine as 2/12/15 and a start date for Melatonin as 2/11/15.

R108's medical record review revealed a lack of documentation of sleep pattern and comprehensive sleep assessment.

On 3/12/15 at 11:21 a.m. registered nurse (RN)-F stated R108 did not display any mood or behavioral concerns. RN-F stated R108 received the Risperidone for sleep and verified a comprehensive sleep assessment had not been completed since admission. RN-F verified the facility did not identify targeted behaviors for the use of Risperidone and behavior and monitoring for the effectiveness and continued use of the antipsychotic medication had not been implemented.

On 3/12/15 at 11:52 a.m. the director of nursing (DON) stated her expectation was the facility would have determined the justification for use and have had developed targeted behavior monitoring for the Risperidone to determine the effectiveness of the medication and need for the ongoing use of the antipsychotic. In addition, the DON stated residents should have a comprehensive sleep assessment completed to establish a baseline of sleep when admitted to the facility on medication to help with sleep.

The Psychopharmacological Medications and Sedative/Hypnotics policy revised 3/15 read, " Non-Emergency Administration ...c. If the resident is experiencing sleep disturbance, complete the Sleep Assessment ...5. If the physician prescribes an antipsychotic for the resident, a registered

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F 329	Continued From page 14 nurse must complete the initial Antipsychotic Medication Assessment and The Abnormal Involuntary Movement Scale ...9. Throughout the administration of the psychopharmacological medications and sedative/hypnotic drugs the following must be completed ...a. Mood and behavior documentation must continue in order to indicate the effect the medication has on the behavior ..." R52 received an antipsychotic (Seroquel) for greater than a year and no gradual dose reduction (GDR) was not attempted nor was there a physician ' s justification why the GDR was contraindicated at this time documented. R52 according to the facility admission record was admitted on 11/9/12 and had diagnoses that included but were not limited to: Alzheimer ' s disease, major depressive disorder, and dementia with behavioral disturbances. R52's quarterly Minimum Data Set (MDS) dated 2/13/15 indicated severe cognitive impairment with a Brief Interview for Mental Status score of 2, had minimal depression according to the PHQ-9 (depression screener) with a score of 1, and had no behaviors. R52's annual MDS dated 8/26/14 indicated severe cognitive impairment with a BIMS score of 3, had minimal depression according to the PHQ-9 with a score of 1, and had no behaviors. R52's most recent care plan provided by the facility on 3/12/15 indicated R52 had a mood problem and behavioral symptoms such as repetitive verbalizations "of where do I go and I love you" related to Alzheimer's disease and depression. The care plan directed staff to observe for signs and symptoms of increased irritability and depressive symptoms. The care plan instructed staff to minimize behaviors by develop more appropriate methods of interacting,	F 329		

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redirect resident she make repetitive verbalizations (take for a walk, offer coffee or snack, or visit).
R52's monthly nursing documentation assessment dated 2/13/15 indicated R52 did not have a current behavioral symptom/mood problem.
R52's monthly nursing documentation assessment dated 11/9/15 indicated R52 had behavioral symptom/mood problems and indicated behavioral symptoms were not directed toward others and indicated R52 made repetitive verbalization and interventions were not effective most of the time. The assessment did not address revision of the interventions. The assessment indicated R52 can be combative with showers and routine cares, however after review of nursing notes, one instance was documented on 9/18/14, no further documentation was found pertaining to being combative during this assessment period.
R52's physician's orders reviewed on 3/11/15 included Celexa 10 milligrams (mg) daily for major depressive disorder and Seroquel 75 mg every a.m. and p.m. for major depressive disorder.
A pharmacy recommendation dated 1/13/14 read, ".has been taking Seroquel 75 mg twice daily since 7/16/13 and Celexa 10 mg daily since 2/19/13, for dementia with behavioral disturbances and major depressive disorder."
The recommendation also advised the PHQ-9 was 0 on 12/23/13 and no mood or behaviors during the assessment period. R52's doctor declined the attempt at gradual dose reduction of either medication and wrote ".Previous decrease led to increase in behavior symptoms. The recommendation was signed by the MD on 2/11/14. The note lacked what the increase in

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behavior symptoms were or how the facility was managing the increase in behaviors.
The consulting pharmacist made a recommendation for a gradual dose reduction (GDR) of Seroquel in September 2014 however, the physician declined to attempt the GDR for either medication.
The consulting pharmacist made a recommendation for a GDR of Seroquel in February 2015. The MD declined to attempt GDR and indicated the reason was disruptive behaviors. The note lacked assessment and evaluation of behaviors.
Physician visit notes were reviewed since January 2014.
A physician visit note dated 4/7/14 that included mention of behavioral disturbances or depression read " Behavior is stable ....Can be somewhat snappy to family at times."
A physician note dated 6/27/14 that included mention of behavioral disturbance or depression read, " Discussed options of slowly discontinuing medications for now ....Seroquel 50 mg 1-1/2 [75 mg] tablets twice a day to control behavior ...slowly and steadily losing weight." The note lacked description of what the behavior the medication was controlling or use/plan for non-pharmacological interventions.
A physician note dated 8/8/14 that included mention of behavioral disturbance or depression read, " Alzheimer ' s disease with slowly worsening dementia ...calm and alert ....has become less active ...affect is appropriate ...cooperative, but clearly demented."
A physician note dated 8/29/14 that included mention of behavioral disturbance or depression read, " No anxiety, depression, or memory changes/concerns ...Patient is more agitated today but still was pleasant and cooperative " .

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F 329	Continued From page 17 A physician note dated 11/18/14 that included mention of behavior disturbance or depression read, " Worsening Alzheimer disease with worsened dementia and decreased activity ....can be angry and irritable at times, but most times is quiet and tolerates her cares. There are times she will refuse her shower or cleaning. Appetite is decreased but activity level was decreased, so weight is stable. " A physician note dated 11/28/14 that included mention of behavioral disturbance or depression read, " Alzheimer ' s disease is stable to slightly worse [does not elaborate on how disease is worse] ... and " dementia is stable, moods are stable, behaviors are stable ...no evidence of movement disorder [side effect from psychotropic medication]." A physician note dated 2/6/15 that included mention of behavioral disturbance or depression read, " she has become less active ....at times is louder with yelling at other people; her main yell is " I love you." Physician notes failed to address clinical assessment and evaluation of depression and associated behavioral disturbances related to dementia that would require on-going use Seroquel and Celexa at the same regimen. A nursing note dated 2/11/15 included mention of R52 had behavioral disturbances however did not indicate what the behavioral disturbances were, frequency, and evaluation of non-pharmacological interventions. During an interview on 3/12/15, at 1:25 p.m. in the presence of facility administrator, pharmacy consultant explained, the last time R52 had a GDR of Seroquel and Celexa was June 2013 and the facility considered it a failed dose reduction related to increased behaviors. The pharmacy consultant stated she would continue to make	F 329		

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F 329	Continued From page 18 GDR ' s recommendations even though the physician declined. Pharmacy consultant verified there was not enough documented clinical rational to continue same doses of medication without attempting GDR. The pharmacy consultant also stated R52 ' s family had not wanted a dose reduction of either medication. A facility policy entitled psychopharmacological medications and sedative/hypnotics last revised March 2015 read, "Gradual dose reductions must be done according to federal regulations ....Tapering may be indicated when the resident ' s clinical condition has improved or stabilized ...nonpharmacological interventions have been effective in reducing the symptoms ....the center must attempt GDR in two separate quarters with at least one month between attempts, unless clinically contraindicated." The policy gave direction to physicians to consider GDR's contraindicated for resident's who received antipsychotic medications to treat psychiatric disorders (major depressive disorder) and read, consider contraindication if, "....the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder, or the resident's target symptoms returned or worsened after the most recent attempt at a gradual dose reduction within the center and the physician has documented the clinical rational for why any additional attempted dose reduction would likely impair the resident's function or cause psychiatric instability ...."	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		4/21/15

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F 332	Continued From page 19 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 10 residents (R31, R33) was given medication in accordance with physician orders and manufacturer's guidelines, resulting in a facility medication error rate of 12 percent (%). Findings include: R31's signed Order Summary Report; dated 3/4/15 had identified the following orders: "Fish Oil Capsule 500 mg [milligrams] (Omega-3 Fatty Acids) Give 1 capsule by mouth two times a day related to UNSPECIFIED DISORDER OF LIPOID METABOLISM...Take with meals" and; "Citrucel/Vitamin D Tablet 250-200 mg... Give 1 tablet by mouth two times a day related to AFTERCARE HEALING TRAUMATIC FRACTURE OTHER BONE...with meals." During observation of medication administration, on 3/10/15 at 4:03 p.m., licensed practical nurse (LPN)-A prepared R31's medications in her room. LPN-A removed a calcium with vitamin D tablet, along with a Sea-Omega capsule (a fish oil supplement) for administration. The medication labels read, " w/ (with) meals." LPN-B then explained each medication to R31 and administered the medications. When interviewed immediately after the medication administration, on 3/10/15 at 4:07	F 332	Medication times for Resident 31 have been changed to give her calcium with vitamin D and C-Omega capsules to be given with meals; all residents with similar medications were reviewed to ensure medication administration time was appropriate. A note was added to the MAR instructing nurses to give medications with food. For Resident 33, a note was added to the MAR to instruct nurses not to crush extended release medications. All residents taking extended release medications were reviewed and notes added to their MAR are to not crush medication. A current list of medications that are not to be crushed will be placed at the nurse□s station in each area by 4/3/15. Facility will conduct 1 medication pass audit on each shift weekly (3 audits per week) for 4 weeks and results will be reported to QAPI on results for further recommendations. Director of Nursing will be responsible to ensure this standard is met.	

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p.m., LPN-A stated R31 normally is eating a snack when she takes the medications, but verified she had not been during the observation, "This is an un-normal day today." LPN-B stated she thought R31 had a cookie earlier that day, around 2:30 p.m., but verified the next meal R31 would eat was not until after 5:00 p.m. Further, LPN-A added, the medications should have been given with meals as directed by the physician orders and medication labels.

R33's signed Order Summary Report, dated 1/30/15, identified the following order: "Tylenol Arthritis Pain Tablet Extended Release 650 mg (Acetaminophen ER [extended release]) Give 1 tablet by mouth in the morning for Pain related to AFTERCARE FOLLOW SURGERY..." R33's signed orders did not identify any guidance to crush R33's extended release medications.

During a different observation of medication administration, on 3/11/15 at 8:37 a.m., registered nurse (RN)-A removed a bottle of Tylenol from a cabinet in R33's room, and prepared his medications for administration at a mobile cart in the hallway. RN-A crushed R33's medications, including the Tylenol ER, mixed them with applesauce, and administered them to R33. RN-A stated she was aware she had crushed the Tylenol ER medication, but always does so because of R33's swallowing trouble.

When interviewed on 3/11/14 at 11:30 a.m. LPN-C stated that extended release (ER) medications that are being crushed should have a physician order directing them to be, or the medication should be changed to a non-ER type. Further, LPN-C said that the facility staff receives formal training on oral medication administration

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F 332	Continued From page 21 that she was aware of. During interview on 3/11/15, at 2:35 p.m. R31 and R33's medical doctor (MD) stated medications should be given as ordered as they are written, "ordered that way for a reason." Further, the MD was unaware R33's ER medication was being crushed, and stated an order to crush ER medication should have been obtained before doing so. When interviewed on 3/11/15, at 3:48 p.m., the consulting pharmacist (CP) stated she was unaware the nursing staff was crushing R33's ER medication. The Tylenol should not have been crushed, as it removes the extended release properties and changes the way it is absorbed by the body. Further, the CP stated all MD orders should be followed, and R31's medications should have been given with meals as directed. During interview on 3/11/15, at 4:11 p.m. the director of nursing (DON) stated all MD orders should be followed as written. A facility Administration of Medication policy, dated 9/2012, identified purposes that include, "promote therapeutic effects of prescribed medication", and, "To administer medications correctly using the center medication system." Further, the policy directed staff to administer medications after verifying the right time for administration by comparing the medication label to the Medication Administration Record (MAR), "at least three times..." The policy did not provide any guidance for staff regarding crushing ER medications.	F 332		
F 425	483.60(a),(b) PHARMACEUTICAL SVC -	F 425		4/21/15

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F 425 SS=D	Continued From page 22 ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have non-expired emergency medication readily available for use in 1 of 1 facility emergency kits. This had potential to affect all 44 residents in the facility that could have needed the medication in an emergent situation. In addition, the facility failed to ensure correct medication labeling for 1 of 10 residents (R33) observed to receive medication pass. Findings include: EXPIRED MEDICATIONS IN EMERGENCY KIT:	F 425	Emergency medication kit was picked up by pharmacy and a new one was provided to the facility on 3/10/15; no expired medications were given to residents. For Resident 33, the physician clarified the medication pass time and the medication was relabeled and put in the MAR correctly for the physician order. According to the pharmacy consultant, this medication can be given any time of the day. All medications were checked to ensure correct labeling. Re-Education will be provided to all nurses on correct order	

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F 425	Continued From page 23 During a tour of medication storage in the facility with registered nurse (RN)-D, on 3/9/15 at 6:49 p.m., the only facility emergency kit (a small supply of medications kept on hand in-case of an emergency situation) was checked for outdated medications. RN-D stated it had just recently been delivered by the pharmacy the previous week. The kit was opened, and the medications were checked for outdated medications and the following three medications were found to be expired: Two vials of 1 ml (milliliter) morphine (medication used for severe pain), expired on 2/2015. Four tablets of 0.5 mg (milligram) f haloperidol (an anti-psychotic medication), expired on 1/31/15. Two tablets of 0.1 mg clonidine (a medication for high blood pressure), expired on 1/7/15. When interviewed on 3/9/15, at 7:13 p.m., RN-D checked and verified the three medications in the emergency kit were expired, and available for resident use. On asking RN-D if a system for monitoring medications for outdates was in place for the medications used in the emergency kit RN-D replied, " Not that I am aware of at least." During interview on 3/9/15, at 7:21 p.m. RN-C stated the medications in the emergency kit should not be expired, and verified the facility had no process to monitor for expired medications in the emergency kit, but rather relied on the dispensing pharmacy to check for outdated medications. When interviewed on 3/10/15, at 2:23 p.m. the consulting pharmacist (CP) stated the emergency	F 425	entry by 4/3/15. Facility will conduct 1 medication pass audits on each shift weekly (3 audits per week) for 4 weeks and results will be reported to QAPI on results. Director of Nursing will be responsible to ensure this standard is met.	

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kit was supplied by Sterling Pharmacy, and that an investigation would be completed regarding the expired medications as this kit was sent to the facility in the past week. Further, CP said that there should not be expired medications in the emergency kit.

During interview on 3/10/15, at 2:35 p.m., Sterling Pharmacy the dispensing pharmacy (DP) was contacted regarding the expired medications found in the emergency kit they supplied to the facility in the past week. The DP stated the facility emergency kit had been replaced that day (3/10/15), but were unaware how some of the medications had expired and not replaced before sending to the facility. DP-A then added, "Probably pharmacy error." The DP-A stated they would ensure expired medications would be replaced before sending the emergency kit to the facility.

When interviewed on 3/10/15, at 2:46 p.m. the director of nursing (DON) stated the pharmacy should be tracking the medications inside the emergency kit for expiration, "I expect them just to do it." Further, the DON stated the medications in the kit should not have been allowed to expire because they were available for resident use.

MISLABELED MEDICATION:

During an observation of medication administration on 3/11/15, at 8:37 a.m. RN-A prepared R33's medications at a mobile cart in the hallway. A medication package was provided to the surveyor for review and read, "TAMSULOSIN [a medication used to treat an

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enlarged prostate] CAP [capsule] 0.4 MG [milligrams] ... TAKE 1 CAPSULE BY MOUTH EVERY NIGHT AT BEDTIME." RN-D prepared the medications and administered them to R33.

When interviewed on 3/11/15, at 8:45 a.m. RN-A stated R33 had always been given the medication in the morning, despite the label identifying to give it at bedtime. Staff had written, "AM [a.m.]" next to the label, but RN-A was not sure who, nor when that had been written on the package. Further, the facility had just switched to a new packaging system for their medications and had other medications recently come from the pharmacy that was mislabeled.

R33's signed Order Summary Report, dated 1/30/15, identified the following order, "Flomax Capsule 0.4 mg [Tamsulosin HCL) Give 1 capsule by mouth in the morning related to UNSPECIFIED RETENTION OF URINE..."

During interview on 3/11/15, at 3:48 p.m. the consulting pharmacist stated tamsulosin could be given at any time of the day, however if medications have a change in order it should be noted on the label with a sticker directing staff to refer to the current orders. A mislabeled medication could lead to an error, and the facility should have contacted the pharmacy to have the medication re-packaged.

When interviewed on 3/11/15, at 4:11 p.m. the director of nursing (DON) stated mislabeled medications from the pharmacy " has been a problem for a few years." Further, the DON added the labels on medications should be accurate, or have a sticker placed on them to direct the staff to refer to the current orders to

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F 425	Continued From page 26 prevent an error. An undated facility Medication Labels policy read, "Medications are labeled in accordance with facility requirements and state and federal laws. Only the dispensing pharmacy can modify or change prescription labels." Further, the policy directed staff, "If the physician's directions for use change or the label is inaccurate, the nurse may place a "change of order-check chart" or "see MAR [medication administration record]" label on the container indicating there is a change in directions for use..."	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		4/21/15

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F 431	Continued From page 27 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement policies and procedures to ensure the appropriate destruction of Fentanyl (a narcotic pain medication) duragesic patches to reduce the risk of diversion. This had potential to affect 4 of 44 residents (R18, R6, R104, and R102) who had current orders for Fentanyl duragesic patches in the facility. Findings include: During review of The Healing Grace medication room, on 3/9/15 at 6:49 p.m., registered nurse (RN)-D opened a locked cabinet containing resident narcotic medications, and Fentanyl patch boxes were observed. RN-D was asked what the facility protocol for destruction of Fentanyl patches was and RN-D stated, "I'm not sure what protocol is." RN-D went on to say that her personal practice was to remove the patch, apply it to a piece of paper and leave it in the medication room until another nurse could help her destroy it, adding, "Not everybody does it that way, but that is how I do it."	F 431	The updated facility procedure for Fentanyl patch destruction was provided for licensed nursing staff. Nurses will be re-educated on how to find updated nursing policies and what the new policy is for destruction of Fentanyl patches on 4/3/15. Nurses will be audited weekly for 1 month on correct destruction of Fentanyl patches and results will be given to the QAPI committee for further recommendations. Director of Nursing will be responsible to ensure this standard is met.	

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During review of The Garden medication room, on 3/9/15 at 7:51 p.m., RN-A opened a locked cabinet containing resident narcotic medications, and Fentanyl patch boxes were observed. RN-A stated Fentanyl patches were to be folded and placed in a sharps container (a container with a removable lid that is used to dispose of sharp objects) and that had been the practice of the facility "since I started here." Further, RN-A stated she had never received any education on how to dispose of used Fentanyl patches by stating, "I can't recall anything on it."

During review of The Lodge medication room, on 3/9/15 at 8:06 p.m., licensed practical nurse (LPN)-G opened a locked cabinet containing resident narcotic medications, and Fentanyl patch boxes were observed. LPN-G stated she started working at the facility about a month prior, and she removes used Fentanyl patches for residents and discards them in the sharps container adding, "As far as I know, that is the policy." Further, LPN-G stated she was not provided any education from the facility on how to dispose of used Fentanyl patches then said, "I have to get on that" in regards to inquiring what the facility policy was for destruction of Fentanyl patches.

A facility Order Listing Report, dated 3/10/15, identified R18, R6, R104, and R102 resided in the facility, and had active orders for Fentanyl duragesic patches.

When interviewed on 3/10/15, at 2:23 p.m. the consulting pharmacist (CP) stated current Food and Drug Administration (FDA) guidance was to fold used Fentanyl patches in half, and flush them down a drain to reduce the risk of diversion. The

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F 431	Continued From page 29 CP was unaware what policy or procedure the facility used to dispose of their patches. When interviewed on 3/10/15, at 2:46 p.m. the director of nursing (DON) stated she was new to the facility, but was aware staff was disposing of used Fentanyl patches in the facility sharps containers by stating, "That is the practice here." Further, the DON stated policies and procedures should be followed, "If I write a policy, I expect them to follow it." The facility Transdermal Patch Application policy, dated 9/2012, identified a procedure including, "When removing a previously used patch, use caution to protect skin. Fold the patch in two with the medicated sides together. Place old patch in a plastic bag for transport to medication room for disposal. It is not acceptable to put used patches in a sharps container." Further, "If the patch contains a controlled substance it must be disposed of and wasted as any controlled substance. The FDA recommends flushing duragesic patches...A best practice is that two nurses always sign for destruction of narcotic patches."	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		4/21/15

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F 441	Continued From page 30 (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: Based on observation, interview and document review, the facility failed to operationalize their infection control program that included consistent surveillance of monitoring and tracking of infection organisms, monitoring symptoms, and putting timely interventions to prevent spread of infection/s. This included residents (R36, R106 and R108 with current significant infections and had the potential to affect all residents living in the	F 441	Resident 36 and 106 is healed from infection; resident 108 was discharged on 3/19/15. All nursing staff will be re-educated on appropriate use of gloves (PPE) when testing blood glucose monitoring per GSS Infection Control procedure on 4/3/15. Facility will follow GSS policy and procedure on infection control tracking and trending for	

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F 441	Continued From page 31 facility also the facility failed to ensure staff wore adequate personal protective equipment (PPE) (gloves) when possible contact with blood during glucose testing for 1 of 2 residents (R1) observed to have their blood glucose checked. Findings included: LACK OF OPERATIONALIZING INFECTION CONTROL PROGRAM: The facility ' s monthly summary of infections" record were obtained from January 2015 and February 2015. The record was reviewed and noted to lack date of onset of infection, specific resident room location that would enable tracking and trending of spread of infection, infection control precautions used to prevent the spread of infection, whether culture of organism was obtained (or rational if not performed), differentiation of which antibiotic was used to treat which resident and which organisms, symptom analysis, and if cultures had been obtained to identify organisms to prevent the spread of infection and appropriate antibiotic use. The logs did identified number of infection(s), site or body system of infection(s), and number of residents per unit that had an infection, and type of antibiotics used during the month to treat infections. During the month of January 2015 the log indicated the facility had a total of six infections; five of those were on the Healing Grace unit and one was on the Garden unit. Four of the six infections were identified as urinary tract infections (UTI) s. The log indicated the UTIs were treated with Ceftin and Amoxicillin (both antibiotics). The monthly infection summary also indicated there had been one upper respiratory	F 441	infections. Audits will be conducted randomly for using proper PPE when blood contamination is possible for 1 month. Results will be shared at the QAPI committee for further recommendations. Nurse Managers will be responsible to ensure this standard is met.	

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infection and one lower respiratory infection that was treated with these three antibiotics Azithromycin, Doxycycline, and Teflaro. However, the summary lacked date of onset of infections, location of resident, associated symptoms of the infection and symptom analysis, which resident was treated with which antibiotic, and precautions used to prevent the spread of infection. The summary record also failed to identify culture and sensitivity of the infection causing organism, and resolution date of infection. Also the facility monthly summary lacked evaluation and analysis of infections, antibiotic usage trend, and prevalent organisms.

During the month of February 2015 the monthly summary of infections record indicated the total number of infections were six; three infections on the Healing Grace unit, two on the Lodge unit, and one on the Garden unit. The record revealed four of the infections were UTIs; Amoxicillin and Ciprofloxacin were the antibiotics used to treat the infections. One lower respiratory tract infection case was treated with Azithromycin, one skin infection (shingles) treated with Acyclovir, and one gastroenteritis (Clostridium Difficile (CDIFF)) case was treated with Ciprofloxacin. Again the summary record failed to identify location of resident, onset of infection, associated symptoms of infection and symptom analysis, which resident was treated with which antibiotic, and culture and sensitivity of the infection causing organism, and resolution date of infection. The monthly summary report also lacked interventions to reduce or preventing spread of infection, ongoing evaluation and analysis of infections and rate, antibiotic usage trend, and prevalent organisms.

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R36 was admitted on 10/27/14 according to the facility admission record with diagnoses that included diverticulitis of the colon, dementia, Parkinson's disease, and congestive heart failure.

A nursing note dated 2/21/15 indicated R36's daughter requested a urinalysis related R36 ' s urinary urgency and an order were obtained based off the daughter ' s request.

A nursing note dated 2/22/15 indicated a physician ordered Cipro 250 milligrams (mg) two times per day for 10 days. The note read, " The analysis showed white blood cells and bacteria, the sample will be cultured, if the culture shows anything different a new med [medication] can be started."

Nursing notes were read from 2/22/15 to 3/11/15 and it was noted that no further mention of symptoms of UTI experienced by the resident since the nursing note dated 2/22/15. Nursing notes also did not address clarification of during of antibiotic or clarification on the bacterium culture report as there was a discrepancy between the two physicians.

R106 was admitted to the facility on 1/27/15 according to the admission record with diagnoses that included but not limited to, diabetes and generalized muscle weakness.

R106's physician orders included the use of an indwelling Foley catheter.

A nursing note dated 2/26/15 indicated R106 had brown tea/amber colored urine, small blood clots, with some cloudiness and no odor was present. Nursing note dated 2/27/15 indicated urine

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continued to be cloudy and blood tinged and a urine specimen was obtained for analysis in the absence of another symptom other than urine integrity. Nursing note dated 2/28/15 indicated a physician ordered Cipro 250 mg twice per day for ten days and R106's urine continued to be dark amber and cloudy. This note lacked mention of what the urinalysis revealed. Nursing notes dated 3/1/15 and 3/2/15 indicated R106's urine was clear.

The next nursing note dated 3/5/15 acknowledged monitoring of UTI or antibiotic use was on 3/5/15; the note indicated the color of urine was yellow, red and clear. Nursing note dated 3/7/15 explained R106 was experiencing back pain, the urine had foul odor, medium size blood clots were present, and urine was blood tinged. The author of the note indicated a call placed to a clinic nurse who reported the urine culture and sensitivity report indicated the bacteria causing infection was Methicillin Resistant Staphylococcus Aureus (MRSA) and the Cipro was resistant. A follow up nursing note indicated new orders from the physician that included Doxycycline 100 mg twice per day for ten days and Amoxicillin 500 mg three times a day for 10 days.

However, the MRSA was not an organism that was identified or included on the facility's infection control log nor interventions to prevent spread developed.

R108 was admitted to the facility on 2/11/15 according to the admission record with diagnoses that included but was not limited to diverticulitis, C-Diff.

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R108's admission physician orders included Flagyl 500 mg four times a day for 14 days related to C-Diff (last dose 2/25/15) and Cipro 500 mg twice per day for 10 days related to diverticulitis (last dose 2/21/15).

Nursing notes from 2/11/15 through 2/16/15 indicated R108 was on isolation precautions and continued to have episodes of loose stools. Nursing notes from 2/17/15 through 2/24/15 did not reflect consistent monitoring of effectiveness of antibiotic treatment or R108's symptoms or lack thereof.

A nursing note dated 2/26/15 indicated R108 continued to have loose stools twice per day. No mention of follow-up or monitoring was done. Nursing note dated 2/28/15 indicated R108 was having more loose stools with abdominal cramping. The note read, "Will need to monitor and notify primary care physician if this persist or worsens." Nursing notes dated from 3/1/15 through 3/6/15 indicated R108 continued to episodes of loose stools. Documentation reflected R108 disclosing she had been lactose intolerant and facility accommodating diet type. Nursing noted dated on 3/10/15 indicated R108 continued to have episodes of loose stools and a physician order had been obtained to repeat the C-Diff culture. A nursing note on 3/11/15 indicated stool sample was obtained and delivered for testing. Nursing note dated on 3/12/15 indicated a physician order was given for Flagyl 500 mg three times per day for 14 days to treat C-Diff even though culture results were still pending.

During an interview on 3/12/15, at 12:35 p.m. with registered nurse (RN)-I designated infection control officer explained she had started with the

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facility about two months ago and she had to catch-up the infection control logs because they had been behind. RN-I and the director of nursing (DON) both explained physicians do not always take urine cultures even in the absence of three symptoms despite encouragement of facility staff.

A facility policy infection control policies/procedures Surveillance last revised November 2014 read, " Outcome surveillance is designed to identify and report evidence of infection collecting, documenting and analyzing data will be done by the infection preventionist or designated staff."

A facility policy infection control policies/procedure surveillance/report forms last revised November 2014 explained components of surveillance and indicated forms to use, however this policy did not give direction on how to track or record infections so trending and infection control rate could be analyzed for outcome or intervention.

LACK OF GLOVES FOR BLOOD GLUCOSE CHECKS:

During observation of medication administration, on 3/11/15 at 11:38 a.m., registered nurse (RN)-A prepared to check R1 blood glucose using an Accucheck device (machine that reads blood glucose when a sample of blood is applied). RN-A wiped R1's finger with an alcohol preparation pad, and pierced R1 ' s skin using a lancet exposing blood. However, RN-A did not have gloves on while checking R1's blood glucose. RN-A then placed the Accucheck machine in R1's cabinet, then applied gloves, and administered R1 her scheduled insulin.

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F 441	Continued From page 37 When interviewed on 3/11/15, at 11:46 a.m. RN-A stated she normally wears gloves when checking a residents blood glucose because of the risk of infection when exposed to blood, "I normally have them on." During interview on 3/11/15, at 1:48 p.m. RN-E stated the facility had policies and procedures that were to be followed for checking a residents blood glucose, and RN-A should have had gloves on when checking R1's blood glucose "for everybody's protection." When interviewed on 3/11/15, at 4:11 p.m. the director of nursing (DON) stated gloves should be worn if handling any blood or bodily fluids, "You should put your gloves on to protect yourself." A facility Blood Glucose Monitoring policy, dated 9/2012, read, "Perform hand hygiene and put on gloves", before piercing the skin and exposing blood.	F 441		

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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
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	K 000	EPOC	

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

Electronically Signed | 03/29/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING **02 - BUILT IN 2007** B. WING _____	**03/10/2015**

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 alarm 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. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 050	Continued From page 2	K 050		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports and records and interview, it was determined that the facility failed to conduct the required number of fire drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Findings include: During the facility tour between 09:00 AM and 1:00 PM on 03/10/2015, based on review of available documentation it was reveled that fire drills have not been conducted on a one per shift per quarter basis. No Evening Shift fire drills were conducted during the 4th quarter of 2014. This deficient practice was confirmed by the facility Environmental Service Director (PC) at the time of discovery.	K 050	A new schedule was created to ensure Fire Drills are completed on a monthly basis for each shift. The Evening shift fire drill was conducted during the first quarter of 2015. The completion date for this will be schedule will be April 14, 2015. The person to monitor and ensure this is being completed is the Environmental Services Director. The results of these fire drills will be reported to the Safety Committee and the QAPI committee each month.	4/14/15
K 141	NFPA 101 LIFE SAFETY CODE STANDARD	K 141		4/21/15

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K 141 SS=C	Continued From page 3 Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 18.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Observations revealed that the two oxygen storage rooms do not have proper safe-guard signage on the doors. Failure to properly sign oxygen storage could poses a hazard to the patients, guests and staff. Findings include: During the facility tour between 09:00 AM and 1:00 PM on 03/10/2015, observation reveled that oxygen was being stored in Oxygen Storage Room across from the IT room & Oxygen Storage Room South wing, without proper signage on the door stating "CAUTION - OXIDIZING GASES STORED WITHIN - NO SMOKING" as required by NFPA 99 (1999 edition) 8-3.1.11.3: This deficient practice was confirmed by the facility Environmental Service Director (PC) at the time of discovery.	K 141	New signs will be placed at each oxygen storage room by April 21st, 2015. The Environmental Services Director will be responsible for ensuring the signs are posted. The results will be shared at the QAPI Committee meeting.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 20, 2015

Ms. Sara Falk, Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, Minnesota 55912

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5317026

Dear Ms. Falk:

The above facility was surveyed on March 9, 2015 through March 12, 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.

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

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

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

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

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

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

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: _____ B. WING _____	03/12/2015

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On March 9, 10, 11, and 12, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		4/21/15

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2 302	Continued From page 3 Based on interview and document review, the facility failed to provide required staff training for Alzheimer's disease and related dementia education. Findings include: Document review of the facility information provided on the Centers for Medicare and Medicaid Services (CMS) form 672, revealed the facility had 14 residents diagnosed with Alzheimer's disease/dementia. Document review of facility Alzheimer's disease/dementia training revealed training titled Communicating with Older Adults with Dementia. Attendance included staff names, titles and training dates in 2014. Document review of training titled Aggressive Residents, included staff names, titles and training dates in 2014. Document review of facility Alzheimer's disease/dementia training revealed the education lacked evidence of staff training in explanation of Alzheimer's disease and related disorders, training on assistance with activities of daily living, and lacked documented evidence of frequency of training. During interview on 3/11/15, at 2:30 p.m., human resources (HR)-G verified the facility lacked training and documented staff attendance in all the required areas. HR-G stated the facility expected to conduct Alzheimer's training two times a year. Although a policy was requested, none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all direct care staff and their supervisors on how to work with persons with dementia type behavior. This	2 302	Director of Nursing will be responsible for ensuring direct care staff have the correct training for dementia type behavior according to state regulations.	

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2 302	Continued From page 4 should at a minimum include explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, and communication skills. The director of nursing could maintain a list of staff attendance and frequency of training. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care planned interventions for skin protection and nail care were followed by staff for 2 of 3 residents (R106, R33) reviewed for activities of daily living. Findings include: LACK of SKIN PROTECTION: R106's admission Minimum Data Set (MDS), dated 2/3/15, identified R106 had moderate cognitive impairment, and required extensive assistance with personal hygiene.	2 565	Resident 106 and 33 had nails trimmed immediately. Protective skin care was provided to resident 106 immediately by putting heels up off the bed as directed from the care plan. All resident□s nails were checked to ensure nails were trimmed and clean. All residents needing protective skin care were checked to ensure the care plan was being followed. Nail care policy and protective skin care education will be provided to all nursing staff on 4/3/15. Audits will be conducted weekly for 1 month. The audits will be reported to QAPI. Director of Nursing will be responsible to ensure this standard is	4/21/15

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2 565	Continued From page 5 R106's Therapy Documentation Notes, dated 1/28/15, identified, "Elevate feet + (and) protect heel when in bed with cushion." R106's care plan, dated 1/29/15, identified R106 had a current skin impairment on his coccyx, and identified an intervention of, "elevate heels off bed", to reduce his risk of further pressure ulcer development. During observation of morning cares, on 3/12/15, at 7:30 a.m. nursing assistant (NA)-D entered R106's darkened room to provide care with the surveyor. NA-D removed the white linen covering his feet to apply a new pair of cotton socks. R106's heels were lying directly on the bed, not elevated as directed by the care plan. A blue "HEELZUP" device (used to help elevate heels from a surface) was lying on the floor, propped up against the wall, by the foot of R106's bed. When interviewed on 3/12/15, at 8:20 a.m. nursing assistant (NA)-D verified R106's heels were not elevated when she entered the room to complete morning care. Further, R106's care plan should have been followed, and his heels should have been elevated as directed. During interview on 3/12/15, at 8:48 a.m. licensed practical nurse (LPN)-B stated R106 was at risk for skin breakdown on his heels, and the care plan interventions should have been followed by the staff. When interviewed on 3/12/15, at 12:19 p.m. the director of nursing (DON) stated a resident ' s care plan is written to guide a resident's care, and that they should be followed. A facility Care Plan policy, dated 2/2013, identified, "The care plan will emphasize the care and development of the whole person ensuring	2 565	met.	

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2 565	Continued From page 6	2 565		

that the resident will receive appropriate care and services."
LACK of NAIL CARE:

R33 was observed on 3/10/15, at 9:28 a.m., 3/11/15, at 8:52 a.m., and on 3/12/15, at 7:55 a.m. revealed R33 had long finger nails on both hands and dried brown debris was underneath the nails.
The facility admission record indicated R33 was admitted to the facility on 11/25/2013 and included diagnoses of but not limited to dementia, anxiety, and Parkinson's disease.
R33's quarterly Minimum Data Set (MDS) dated 12/16/15 indicated severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 3 and required extensive assist from two staff members to provide personal hygiene and grooming tasks.
R33's most recent care plan provided by the facility on 3/12/15 instructed staff to provide nail care weekly on bath day and as needed.
During an interview on 3/12/15, at 7:56 a.m. nursing assistant (NA)-B stated the restorative nursing assistant is the primary person that provided nail care for residents. NA-B stated, "Sometimes me and the other aide will do to help out, or we will do it if we notice the nails are dirty." NA-B explained nails are checked on shower day, and in the case of resident refusal NA's would report to the nurse.
During an interview on 3/12/15, at 8:03 a.m. NA-C (worked as the restorative nursing assistant) stated, "I provide nail care the majority of the time, once a week on bath days, but it's not just up to me. The nurses and the aides also do it."
During an interview on 3/12/15, at 8:07 a.m. registered nurse (RN)-A verified R33 nails were long and dirty and should be cleaned. RN-A also

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2 565	Continued From page 7 explained R33 used his hands quite a bit to eat. RN-A then stated she would make sure the nails got trimmed and cleaned. A facility procedure nail care last reviewed on November 2013 did not give direction on how often nail care should be provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies to ensure staff provided care according to policies. Director of nursing could inservice all staff to provide care according to the care plan. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide nail care for a dependent resident according to the care plan for 1 of 3 residents (R33) reviewed for activities of daily living. Findings included: R33 was observed on 3/10/15, at 9:28 a.m., 3/11/15, at 8:52 a.m., and on 3/12/15, at 7:55	2 860	Resident 33 had nails trimmed immediately. All resident□s nails were checked to ensure nails were trimmed and clean. Nail care policy and education will be provided to all nursing staff on 4/3/15. Audits will be conducted weekly for 1 month. The audits will be reported to QAPI for further recommendation. Director of Nursing will be responsible to ensure	4/21/15

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2 860	Continued From page 8 a.m. revealed R33 had long finger nails on both hands and dried brown debris was underneath the nails. The facility admission record indicated R33 was admitted to the facility on 11/25/2013 and included diagnoses of but not limited to dementia, anxiety, and Parkinson ' s disease. R33's quarterly Minimum Data Set (MDS) dated 12/16/15 indicated severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 3 and required extensive assist from two staff members to provide personal hygiene and grooming tasks. R33's most recent care plan provided by the facility on 3/12/15 instructed staff to provide nail care weekly on bath day and as needed. The care plan did not indicate when R33's bath was. During an interview on 3/12/15, at 7:56 a.m. nursing assistant (NA)-B stated the restorative nursing assistant is the primary person that provided nail care for residents. NA-B stated, "Sometimes me and the other aide will do to help out, or we will do it if we notice the nails are dirty." NA-B explained nails are checked on shower day, and in the case of resident refusal NAs would report to the nurse. During an interview on 3/12/15, at 8:03 a.m. NA-C (worked as the restorative nursing assistant) stated, "I provide nail care the majority of the time, once a week on bath days, but it ' s not just up to me. The nurses and the aides also do it." During an interview on 3/12/15, at 8:07 a.m. registered nurse (RN)-A verified R33 nails were long and dirty and should be cleaned. RN-A also explained R33 used his hands quite a bit to eat. RN-A then stated she would make sure the nails got trimmed and cleaned. A facility procedure nail care last reviewed on November 2013 did not give direction on how	2 860	this standard is met.	

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2 860	Continued From page 9 often nail care should be provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies to ensure nail care was provided to all residents. The director of nursing could inservice staff to provide nail care according to policy. The director of nursing could monitor compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and	21390		4/21/15

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21390	Continued From page 10 I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to operationalize their infection control program that included consistent surveillance of monitoring and tracking of infection organisms, monitoring symptoms, and putting timely interventions to prevent spread of infection/s. This included residents (R36, R106 and R108 with current significant infections and had the potential to affect all residents living in the facility also the facility failed to ensure staff wore adequate personal protective equipment (PPE) (gloves) when possible contact with blood during glucose testing for 1 of 2 residents (R1) observed to have their blood glucose checked. Findings included: LACK OF OPERATIONALIZING INFECTION CONTROL PROGRAM: The facility ' s monthly summary of infections" record were obtained from January 2015 and February 2015. The record was reviewed and noted to lack date of onset of infection, specific resident room location that would enable tracking and trending of spread of infection, infection control precautions used to prevent the spread of infection, whether culture of organism was obtained (or rational if not performed), differentiation of which antibiotic was used to treat which resident and which organisms, symptom analysis, and if cultures had been obtained to identify organisms to prevent the spread of infection and appropriate antibiotic use. The logs did identified number of infection(s), site or body	21390	Resident 36 and 106 is healed from infection; resident 108 was discharged on 3/19/15. All nursing staff will be re-educated on appropriate use of gloves (PPE) when testing blood glucose monitoring per GSS Infection Control procedure on 4/3/15. Facility will follow GSS policy and procedure on infection control tracking and trending infections. Audits will be conducted randomly for using proper PPE when blood contamination is possible for 1 month. Results will be shared at the QAPI committee for further recommendations. Nurse Managers will be responsible to ensure this standard is met.	

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21390	Continued From page 11	21390		

system of infection(s), and number of residents per unit that had an infection, and type of antibiotics used during the month to treat infections.

During the month of January 2015 the log indicated the facility had a total of six infections; five of those were on the Healing Grace unit and one was on the Garden unit. Four of the six infections were identified as urinary tract infections (UTI) s. The log indicated the UTIs were treated with Ceftin and Amoxicillin (both antibiotics). The monthly infection summary also indicated there had been one upper respiratory infection and one lower respiratory infection that was treated with these three antibiotics Azithromycin, Doxycycline, and Teflaro. However, the summary lacked date of onset of infections, location of resident, associated symptoms of the infection and symptom analysis, which resident was treated with which antibiotic, and precautions used to prevent the spread of infection. The summary record also failed to identify culture and sensitivity of the infection causing organism, and resolution date of infection. Also the facility monthly summary lacked evaluation and analysis of infections, antibiotic usage trend, and prevalent organisms.

During the month of February 2015 the monthly summary of infections record indicated the total number of infections were six; three infections on the Healing Grace unit, two on the Lodge unit, and one on the Garden unit. The record revealed four of the infections were UTIs; Amoxicillin and Ciprofloxacin were the antibiotics used to treat the infections. One lower respiratory tract infection case was treated with Azithromycin, one skin infection (shingles) treated with Acyclovir, and one gastroenteritis (Clostridium Difficile

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21390	Continued From page 12 (CDIFF)) case was treated with Ciprofloxacin. Again the summary record failed to identify location of resident, onset of infection, associated symptoms of infection and symptom analysis, which resident was treated with which antibiotic, and culture and sensitivity of the infection causing organism, and resolution date of infection. The monthly summary report also lacked interventions to reduce or preventing spread of infection, ongoing evaluation and analysis of infections and rate, antibiotic usage trend, and prevalent organisms. R36 was admitted on 10/27/14 according to the facility admission record with diagnoses that included diverticulitis of the colon, dementia, Parkinson's disease, and congestive heart failure. A nursing note dated 2/21/15 indicated R36's daughter requested a urinalysis related R36 ' s urinary urgency and an order were obtained based off the daughter ' s request. A nursing note dated 2/22/15 indicated a physician ordered Cipro 250 milligrams (mg) two times per day for 10 days. The note read, " The analysis showed white blood cells and bacteria, the sample will be cultured, if the culture shows anything different a new med [medication] can be started." Nursing notes were read from 2/22/15 to 3/11/15 and it was noted that no further mention of symptoms of UTI experienced by the resident since the nursing note dated 2/22/15. Nursing notes also did not address clarification of during of antibiotic or clarification on the bacterium culture report as there was a discrepancy between the two physicians.	21390		

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21390	Continued From page 13 R106 was admitted to the facility on 1/27/15 according to the admission record with diagnoses that included but not limited to, diabetes and generalized muscle weakness. R106's physician orders included the use of an indwelling Foley catheter. A nursing note dated 2/26/15 indicated R106 had brown tea/amber colored urine, small blood clots, with some cloudiness and no odor was present. Nursing note dated 2/27/15 indicated urine continued to be cloudy and blood tinged and a urine specimen was obtained for analysis in the absence of another symptom other than urine integrity. Nursing note dated 2/28/15 indicated a physician ordered Cipro 250 mg twice per day for ten days and R106's urine continued to be dark amber and cloudy. This note lacked mention of what the urinalysis revealed. Nursing notes dated 3/1/15 and 3/2/15 indicated R106's urine was clear. The next nursing note dated 3/5/15 acknowledged monitoring of UTI or antibiotic use was on 3/5/15; the note indicated the color of urine was yellow, red and clear. Nursing note dated 3/7/15 explained R106 was experiencing back pain, the urine had foul odor, medium size blood clots were present, and urine was blood tinged. The author of the note indicated a call placed to a clinic nurse who reported the urine culture and sensitivity report indicated the bacteria causing infection was Methicillin Resistant Staphylococcus Aureus (MRSA) and the Cipro was resistant. A follow up nursing note indicated new orders from the physician that included Doxycycline 100 mg twice per day for ten days and Amoxicillin 500 mg three times a day for 10 days.	21390		

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21390	Continued From page 14 However, the MRSA was not an organism that was identified or included on the facility's infection control log nor interventions to prevent spread developed. R108 was admitted to the facility on 2/11/15 according to the admission record with diagnoses that included but was not limited to diverticulitis, C-Diff. R108's admission physician orders included Flagyl 500 mg four times a day for 14 days related to C-Diff (last dose 2/25/15) and Cipro 500 mg twice per day for 10 days related to diverticulitis (last dose 2/21/15). Nursing notes from 2/11/15 through 2/16/15 indicated R108 was on isolation precautions and continued to have episodes of loose stools. Nursing notes from 2/17/15 through 2/24/15 did not reflect consistent monitoring of effectiveness of antibiotic treatment or R108's symptoms or lack thereof. A nursing note dated 2/26/15 indicated R108 continued to have loose stools twice per day. No mention of follow-up or monitoring was done. Nursing note dated 2/28/15 indicated R108 was having more loose stools with abdominal cramping. The note read, "Will need to monitor and notify primary care physician if this persist or worsens." Nursing notes dated from 3/1/15 through 3/6/15 indicated R108 continued to episodes of loose stools. Documentation reflected R108 disclosing she had been lactose intolerant and facility accommodating diet type. Nursing noted dated on 3/10/15 indicated R108 continued to have episodes of loose stools and a physician order had been obtained to repeat the	21390		

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21390	Continued From page 15 C-Diff culture. A nursing note on 3/11/15 indicated stool sample was obtained and delivered for testing. Nursing note dated on 3/12/15 indicated a physician order was given for Flagyl 500 mg three times per day for 14 days to treat C-Diff even though culture results were still pending. During an interview on 3/12/15, at 12:35 p.m. with registered nurse (RN)-I designated infection control officer explained she had started with the facility about two months ago and she had to catch-up the infection control logs because they had been behind. RN-I and the director of nursing (DON) both explained physicians do not always take urine cultures even in the absence of three symptoms despite encouragement of facility staff. A facility policy infection control policies/procedures Surveillance last revised November 2014 read, " Outcome surveillance is designed to identify and report evidence of infection collecting, documenting and analyzing data will be done by the infection preventionist or designated staff." A facility policy infection control policies/procedure surveillance/report forms last revised November 2014 explained components of surveillance and indicated forms to use, however this policy did not give direction on how to track or record infections so trending and infection control rate could be analyzed for outcome or intervention. LACK OF GLOVES FOR BLOOD GLUCOSE CHECKS: During observation of medication administration, on 3/11/15 at 11:38 a.m., registered nurse (RN)-A prepared to check R1 blood glucose using an	21390		

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21390	Continued From page 16 Accucheck device (machine that reads blood glucose when a sample of blood is applied). RN-A wiped R1's finger with an alcohol preparation pad, and pierced R1 ' s skin using a lancet exposing blood. However, RN-A did not have gloves on while checking R1's blood glucose. RN-A then placed the Accucheck machine in R1's cabinet, then applied gloves, and administered R1 her scheduled insulin. When interviewed on 3/11/15, at 11:46 a.m. RN-A stated she normally wears gloves when checking a residents blood glucose because of the risk of infection when exposed to blood, "I normally have them on." During interview on 3/11/15, at 1:48 p.m. RN-E stated the facility had policies and procedures that were to be followed for checking a residents blood glucose, and RN-A should have had gloves on when checking R1's blood glucose "for everybody's protection." When interviewed on 3/11/15, at 4:11 p.m. the director of nursing (DON) stated gloves should be worn if handling any blood or bodily fluids, "You should put your gloves on to protect yourself." A facility Blood Glucose Monitoring policy, dated 9/2012, read, "Perform hand hygiene and put on gloves", before piercing the skin and exposing blood. SUGGESTED METHOD OF CORRECTION: The director of nursing could develop an infection control program that included monitoring, surveillance and trending of infections. The director of nursing could review and revise policies to ensure proper infection control procedures were followed during resident cares.	21390		

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21390	Continued From page 17 The director of nursing could educate nursing staff on infection control procedures. The director of nursing could monitor staff compliance. An audit could be developed and the results reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a facility Tuberculosis	21426	Administrator will ensure the Tuberculosis Prevention and Control guidelines will be	4/21/15

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21426	Continued From page 18 (TB) risk assessment according to the current Centers for Disease Control (CDC) guidelines for preventing the transmission of Tuberculosis. Findings include: The facility TB risk assessment had been completed on June 6, 2012 and not reviewed to update by June 2014. The TB Risk Assessment information dated June 6, 2012, indicated the facility was at low risk and the assessment would be conducted or updated yearly. Minnesota Department of Health (MDH) recommends that medium-risk health care settings update their risk assessment worksheet yearly and low-risk health care settings update their worksheet every other year. The facility was asked on 3/11/15 for the last completed TB risk assessment. A TB risk assessment was provided by the infection control nurse (IFN)-I from the facility on 3/12/15 and was dated for 3/11/15. The TB risk assessment indicated the facility was at low risk and the assessment would be conducted or updated annually. The facility did complete an updated TB risk assessment on 3/11/15. The assessment indicated the facility was at low risk and the assessment would be conducted or updated annually. The updated assessment was obtained on 3/12/15 after it was asked for on 3/11/15 from the infection control registered nurse-I. A facility policy tuberculosis control plan for healthcare workers issued on June 2012 was read but did not include current low risk recommendations for doing TB risk assessment every two years at a minimum. SUGGESTED METHOD OF CORRECTION: The administrator could review and revise policies and procedures to ensure the Minnesota Department of Health Tuberculosis Prevention and Control Guidelines were followed. The	21426	followed according to state regulations. The risk assessment has been completed for 2015; the Administrator will ensure the assessment will be completed each year.	

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21426	Continued From page 19 administrator could complete and periodically review a tuberculosis risk assessment. The administrator could educate staff and monitor compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
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 by: Based on interview and document review, the	21535	Resident 108 was discharged on 3/19/15.	4/21/15

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21535	Continued From page 20 facility failed to identify indications for use of and antipsychotic medication (Risperidone) or identify clinical symptoms to determine if the medication was effective; and did not complete a comprehensive sleep study to determine the need for the use of Mirtazapine, Melatonin ordered for insomnia for 1 of 5 residents (R108) reviewed for unnecessary medications; and failed to justify the ongoing use and did not attempt a mandatory gradual dose reduction of antipsychotic medications for 1 of 5 residents reviewed for unnecessary medications (R52). Findings Include: R108's admission record revealed R108 was admitted on 2/11/15 with diagnoses that included but were not limited to anxiety state and hypothyroidism. The admission Minimum Data Assessment (MDS) dated 2/18/15, indicated R108 did not display behavior problems or difficulty sleeping according, feeling tired or having little energy. R108 currently received Risperidone (antipsychotic) 0.5 milligrams (mg) one time a day for generalized anxiety. The current physician's orders reflected a start date for Risperidone as 2/19/15 and the resident had received the medication daily since then. R108's medical record review revealed targeted behaviors had not been determined and behavior monitoring for the effectiveness and continued use of the Risperidone had not been initiated for R108 since admission which was over thirty days. R108 ' s physician certification progress note dated 3/11/15 read, " ...Depression, insomnia, anxiety with previous paranoia. Resolved with	21535	Resident 52 had a dose reduction of Seroquel and Celexa in June of 2013, at the consultant pharmacist□s request. The consultant pharmacy will continue to make GDR recommendations, even though the physician has declined further GDR for resident. Nurse Manager and DON will consult with the facility□s medical director to work with the resident□s physician. The Nurse Manager will set up target behavior monitoring for resident 52 on antipsychotic medication. All residents taking antiemetics, antianxiety agents, antidepressants, antipsychotic/antimanic agents and hypnotics will be reviewed for appropriate monitoring and GDR reductions per GSS policy and procedures. Re- education will be provided to nursing staff regarding GSS policy and procedure on 4/3/15. Monthly medication reviews will be conducted by consultant pharmacist and reviewed at QAPI meeting. All residents with above mentioned medications will be audited weekly for 1 month to ensure appropriate monitoring and use of these medications. Results will be taken to QAPI meeting for further recommendations. Director of Nursing will be responsible to ensure this standard is met.	

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21535	Continued From page 21 low-dose Risperidone and extensive psychiatry review in the past. Continue low-dose and has felt that this has been weaned to the lowest effective dose in the outpatient setting. She also continues on melatonin (hormone to regulate sleep) and Remeron (antidepressant)... " R108 currently received Mirtazapine (antidepressant) 15 mg one time a day for sleep and Melatonin 3 mg at bedtime for sleep. The current physician's orders reflected a start date for Mirtazapine as 2/12/15 and a start date for Melatonin as 2/11/15. R108's medical record review revealed a lack of documentation of sleep pattern and comprehensive sleep assessment. On 3/12/15 at 11:21 a.m. registered nurse (RN)-F stated R108 did not display any mood or behavioral concerns. RN-F stated R108 received the Risperidone for sleep and verified a comprehensive sleep assessment had not been completed since admission. RN-F verified the facility did not identify targeted behaviors for the use of Risperidone and behavior and monitoring for the effectiveness and continued use of the antipsychotic medication had not been implemented. On 3/12/15 at 11:52 a.m. the director of nursing (DON) stated her expectation was the facility would have determined the justification for use and have had developed targeted behavior monitoring for the Risperidone to determine the effectiveness of the medication and need for the ongoing use of the antipsychotic. In addition, the DON stated residents should have a comprehensive sleep assessment completed to establish a baseline of sleep when admitted to	21535		

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21535	Continued From page 22 the facility on medication to help with sleep. The Psychopharmacological Medications and Sedative/Hypnotics policy revised 3/15 read, " Non-Emergency Administration ...c. If the resident is experiencing sleep disturbance, complete the Sleep Assessment ...5. If the physician prescribes an antipsychotic for the resident, a registered nurse must complete the initial Antipsychotic Medication Assessment and The Abnormal Involuntary Movement Scale ...9. Throughout the administration of the psychopharmacological medications and sedative/hypnotic drugs the following must be completed ...a. Mood and behavior documentation must continue in order to indicate the effect the medication has on the behavior ..." R52 received an antipsychotic (Seroquel) for greater than a year and no gradual dose reduction (GDR) was not attempted nor was there a physician ' s justification why the GDR was contraindicated at this time documented. R52 according to the facility admission record was admitted on 11/9/12 and had diagnoses that included but were not limited to: Alzheimer ' s disease, major depressive disorder, and dementia with behavioral disturbances. R52's quarterly Minimum Data Set (MDS) dated 2/13/15 indicated severe cognitive impairment with a Brief Interview for Mental Status score of 2, had minimal depression according to the PHQ-9 (depression screener) with a score of 1, and had no behaviors. R52's annual MDS dated 8/26/14 indicated severe cognitive impairment with a BIMS score of 3, had minimal depression according to the PHQ-9 with a score of 1, and had no behaviors. R52's most recent care plan provided by the facility on 3/12/15 indicated R52 had a mood	21535		

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problem and behavioral symptoms such as repetitive verbalizations "of where do I go and I love you" related to Alzheimer's disease and depression. The care plan directed staff to observe for signs and symptoms of increased irritability and depressive symptoms. The care plan instructed staff to minimize behaviors by develop more appropriate methods of interacting, redirect resident she make repetitive verbalizations (take for a walk, offer coffee or snack, or visit).
R52's monthly nursing documentation assessment dated 2/13/15 indicated R52 did not have a current behavioral symptom/mood problem.
R52's monthly nursing documentation assessment dated 11/9/15 indicated R52 had behavioral symptom/mood problems and indicated behavioral symptoms were not directed toward others and indicated R52 made repetitive verbalization and interventions were not effective most of the time. The assessment did not address revision of the interventions. The assessment indicated R52 can be combative with showers and routine cares, however after review of nursing notes, one instance was documented on 9/18/14, no further documentation was found pertaining to being combative during this assessment period.
R52's physician's orders reviewed on 3/11/15 included Celexa 10 milligrams (mg) daily for major depressive disorder and Seroquel 75 mg every a.m. and p.m. for major depressive disorder.
A pharmacy recommendation dated 1/13/14 read, ".has been taking Seroquel 75 mg twice daily since 7/16/13 and Celexa 10 mg daily since 2/19/13, for dementia with behavioral disturbances and major depressive disorder." The recommendation also advised the PHQ-9

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was 0 on 12/23/13 and no mood or behaviors during the assessment period. R52's doctor declined the attempt at gradual dose reduction of either medication and wrote ".Previous decrease led to increase in behavior symptoms. The recommendation was signed by the MD on 2/11/14. The note lacked what the increase in behavior symptoms were or how the facility was managing the increase in behaviors.
The consulting pharmacist made a recommendation for a gradual dose reduction (GDR) of Seroquel in September 2014 however, the physician declined to attempt the GDR for either medication.
The consulting pharmacist made a recommendation for a GDR of Seroquel in February 2015. The MD declined to attempt GDR and indicated the reason was disruptive behaviors. The note lacked assessment and evaluation of behaviors.
Physician visit notes were reviewed since January 2014.
A physician visit note dated 4/7/14 that included mention of behavioral disturbances or depression read " Behavior is stable ....Can be somewhat snappy to family at times."
A physician note dated 6/27/14 that included mention of behavioral disturbance or depression read, " Discussed options of slowly discontinuing medications for now ....Seroquel 50 mg 1-1/2 [75 mg] tablets twice a day to control behavior ...slowly and steadily losing weight." The note lacked description of what the behavior the medication was controlling or use/plan for non-pharmacological interventions.
A physician note dated 8/8/14 that included mention of behavioral disturbance or depression read, " Alzheimer ' s disease with slowly worsening dementia ...calm and alert ....has become less active ...affect is appropriate

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21535	Continued From page 25 ...cooperative, but clearly demented." A physician note dated 8/29/14 that included mention of behavioral disturbance or depression read, " No anxiety, depression, or memory changes/concerns ...Patient is more agitated today but still was pleasant and cooperative " . A physician note dated 11/18/14 that included mention of behavior disturbance or depression read, " Worsening Alzheimer disease with worsened dementia and decreased activity ....can be angry and irritable at times, but most times is quiet and tolerates her cares. There are times she will refuse her shower or cleaning. Appetite is decreased but activity level was decreased, so weight is stable. " A physician note dated 11/28/14 that included mention of behavioral disturbance or depression read, " Alzheimer ' s disease is stable to slightly worse [does not elaborate on how disease is worse] ... and " dementia is stable, moods are stable, behaviors are stable ...no evidence of movement disorder [side effect from psychotropic medication]." A physician note dated 2/6/15 that included mention of behavioral disturbance or depression read, " she has become less active ....at times is louder with yelling at other people; her main yell is " I love you." Physician notes failed to address clinical assessment and evaluation of depression and associated behavioral disturbances related to dementia that would require on-going use Seroquel and Celexa at the same regimen. A nursing note dated 2/11/15 included mention of R52 had behavioral disturbances however did not indicate what the behavioral disturbances were, frequency, and evaluation of non-pharmacological interventions. During an interview on 3/12/15, at 1:25 p.m. in the presence of facility administrator, pharmacy	21535		

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21535	Continued From page 26 consultant explained, the last time R52 had a GDR of Seroquel and Celexa was June 2013 and the facility considered it a failed dose reduction related to increased behaviors. The pharmacy consultant stated she would continue to make GDR ' s recommendations even though the physician declined. Pharmacy consultant verified there was not enough documented clinical rational to continue same doses of medication without attempting GDR. The pharmacy consultant also stated R52 ' s family had not wanted a dose reduction of either medication. A facility policy entitled psychopharmacological medications and sedative/hypnotics last revised March 2015 read, "Gradual dose reductions must be done according to federal regulations ....Tapering may be indicated when the resident ' s clinical condition has improved or stabilized ...nonpharmacological interventions have been effective in reducing the symptoms ....the center must attempt GDR in two separate quarters with at least one month between attempts, unless clinically contraindicated." The policy gave direction to physicians to consider GDR's contraindicated for resident's who received antipsychotic medications to treat psychiatric disorders (major depressive disorder) and read, consider contraindication if, "....the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder, or the resident's target symptoms returned or worsened after the most recent attempt at a gradual dose reduction within the center and the physician has documented the clinical rational for why any additional attempted dose reduction would likely impair the resident's function or cause psychiatric instability ...."	21535		

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21535	Continued From page 27 SUGGESTED METHOD OF CORRECTION: The director of nursing and consultant pharmacist could review and revise policies for unnecessary medication, including comprehensive assessments, identification of target moods/behaviors, monitoring target moods/behaviors, gradual dose reduction, and comprehensive clinical rationale for lack of gradual dose reduction of medications. The director of nursing and consultant pharmacist could inservice staff on appropriate documentation of behaviors and interventions. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or	21545		4/21/15

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21545	Continued From page 28 safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 10 residents (R31, R33) was given medication in accordance with physician orders and manufacturer's guidelines, resulting in a facility medication error rate of 12 percent (%). Findings include: R31's signed Order Summary Report; dated 3/4/15 had identified the following orders:	21545	Medication times for Resident 31 have been changed to give her calcium with vitamin D and C-Omega capsules to be given with meals; all residents with similar medications were reviewed to ensure medication administration time was appropriate. A note was added to the MAR instructing nurses to give medications with food. For Resident 33, a note was added to the MAR to instruct nurses not to crush extended release medications. All	

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21545	Continued From page 29 "Fish Oil Capsule 500 mg [milligrams] (Omega-3 Fatty Acids) Give 1 capsule by mouth two times a day related to UNSPECIFIED DISORDER OF LIPOID METABOLISM...Take with meals" and; "Citrucel/Vitamin D Tablet 250-200 mg... Give 1 tablet by mouth two times a day related to AFTERCARE HEALING TRAUMATIC FRACTURE OTHER BONE...with meals." During observation of medication administration, on 3/10/15 at 4:03 p.m., licensed practical nurse (LPN)-A prepared R31's medications in her room. LPN-A removed a calcium with vitamin D tablet, along with a Sea-Omega capsule (a fish oil supplement) for administration. The medication labels read, " w/ (with) meals." LPN-B then explained each medication to R31 and administered the medications. When interviewed immediately after the medication administration, on 3/10/15 at 4:07 p.m., LPN-A stated R31 normally is eating a snack when she takes the medications, but verified she had not been during the observation, "This is an un-normal day today." LPN-B stated she thought R31 had a cookie earlier that day, around 2:30 p.m., but verified the next meal R31 would eat was not until after 5:00 p.m. Further, LPN-A added, the medications should have been given with meals as directed by the physician orders and medication labels. R33's signed Order Summary Report, dated 1/30/15, identified the following order: "Tylenol Arthritis Pain Tablet Extended Release 650 mg (Acetaminophen ER [extended release]) Give 1 tablet by mouth in the morning for Pain related to AFTERCARE FOLLOW SURGERY..." R33's signed orders did not identify any guidance to crush R33's extended release medications.	21545	residents taking extended release medications were reviewed and notes added to their MAR are to not crush medication. A current list of medications that are not to be crushed will be placed at the nurse□s station in each area by 4/3/15. Facility will conduct 1 medication pass audit on each shift weekly (3 audits per week) for 4 weeks and results will be reported to QAPI on results for further recommendations. Director of Nursing will be responsible to ensure this standard is met.	

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21545	Continued From page 30 During a different observation of medication administration, on 3/11/15 at 8:37 a.m., registered nurse (RN)-A removed a bottle of Tylenol from a cabinet in R33's room, and prepared his medications for administration at a mobile cart in the hallway. RN-A crushed R33's medications, including the Tylenol ER, mixed them with applesauce, and administered them to R33. RN-A stated she was aware she had crushed the Tylenol ER medication, but always does so because of R33's swallowing trouble. When interviewed on 3/11/14 at 11:30 a.m. LPN-C stated that extended release (ER) medications that are being crushed should have a physician order directing them to be, or the medication should be changed to a non-ER type. Further, LPN-C said that the facility staff receives formal training on oral medication administration that she was aware of. During interview on 3/11/15, at 2:35 p.m. R31 and R33's medical doctor (MD) stated medications should be given as ordered as they are written, "ordered that way for a reason." Further, the MD was unaware R33's ER medication was being crushed, and stated an order to crush ER medication should have been obtained before doing so. When interviewed on 3/11/15, at 3:48 p.m., the consulting pharmacist (CP) stated she was unaware the nursing staff was crushing R33's ER medication. The Tylenol should not have been crushed, as it removes the extended release properties and changes the way it is absorbed by the body. Further, the CP stated all MD orders should be followed, and R31's medications should have been given with meals as directed.	21545		

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21545	Continued From page 31 During interview on 3/11/15, at 4:11 p.m. the director of nursing (DON) stated all MD orders should be followed as written. A facility Administration of Medication policy, dated 9/2012, identified purposes that include, "promote therapeutic effects of prescribed medication", and, "To administer medications correctly using the center medication system." Further, the policy directed staff to administer medications after verifying the right time for administration by comparing the medication label to the Medication Administration Record (MAR), "at least three times..." The policy did not provide any guidance for staff regarding crushing ER medications. SUGGESTED METHOD OF CORRECTION: The administrator and consultant pharmacist could review and revise policies and procedures to ensure facility was free of medication errors. The consultant pharmacist could inservice licensed staff to provide medications without error. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		
21600	MN Rule 4658.1335 Subp. 2 Stock Medications; Emergency Supply Subp. 2. Emergency medication supply. A nursing home may have an emergency medication supply which must be approved by the QAA committee. The contents, maintenance, and use of the emergency medication supply must comply with part 6800.6700.	21600		4/21/15

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21600	Continued From page 32 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have non-expired emergency medication readily available for use in 1 of 1 facility emergency kits. This had potential to affect all 44 residents in the facility that could have needed the medication in an emergent situation. Findings include: EXPIRED MEDICATIONS IN EMERGENCY KIT: During a tour of medication storage in the facility with registered nurse (RN)-D, on 3/9/15 at 6:49 p.m., the only facility emergency kit (a small supply of medications kept on hand in-case of an emergency situation) was checked for outdated medications. RN-D stated it had just recently been delivered by the pharmacy the previous week. The kit was opened, and the medications were checked for outdated medications and the following three medications were found to be expired: Two vials of 1 ml (milliliter) morphine (medication used for severe pain), expired on 2/2015. Four tablets of 0.5 mg (milligram) f haloperidol (an anti-psychotic medication), expired on 1/31/15. Two tablets of 0.1 mg clonidine (a medication for high blood pressure), expired on 1/7/15. When interviewed on 3/9/15, at 7:13 p.m., RN-D checked and verified the three medications in the emergency kit were expired, and available for resident use. On asking RN-D if a system for monitoring medications for outdates was in place	21600	Emergency medication kit was picked up by pharmacy and a new one was provided to the facility on 3/10/15; no expired medications were given to residents. All medications will be checked by pharmacy and consultant pharmacist. In addition, staff will ensure medications are not expired when they open the kit. Director of Nursing will be responsible to ensure this standard is met.	

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21600	Continued From page 33 for the medications used in the emergency kit RN-D replied, " Not that I am aware of at least." During interview on 3/9/15, at 7:21 p.m. RN-C stated the medications in the emergency kit should not be expired, and verified the facility had no process to monitor for expired medications in the emergency kit, but rather relied on the dispensing pharmacy to check for outdated medications. When interviewed on 3/10/15, at 2:23 p.m. the consulting pharmacist (CP) stated the emergency kit was supplied by Sterling Pharmacy, and that an investigation would be completed regarding the expired medications as this kit was sent to the facility in the past week. Further, CP said that there should not be expired medications in the emergency kit. During interview on 3/10/15, at 2:35 p.m., Sterling Pharmacy the dispensing pharmacy (DP) was contacted regarding the expired medications found in the emergency kit they supplied to the facility in the past week. The DP stated the facility emergency kit had been replaced that day (3/10/15), but were unaware how some of the medications had expired and not replaced before sending to the facility. DP-A then added, "Probably pharmacy error." The DP-A stated they would ensure expired medications would be replaced before sending the emergency kit to the facility. When interviewed on 3/10/15, at 2:46 p.m. the director of nursing (DON) stated the pharmacy should be tracking the medications inside the emergency kit for expiration, "I expect them just to do it." Further, the DON stated the medications in the kit should not have been	21600		

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21600	Continued From page 34 allowed to expire because they were available for resident use. SUGGESTED METHOD OF CORRECTION: The administrator and consultant pharmacist could review and revise policies and procedures to ensure emergency box medications were not expired. The consultant pharmacist could inservice licensed staff to ensure emergency box medications were not expired. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21600		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of	21630		4/21/15

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21630	Continued From page 35 medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement policies and procedures to ensure the appropriate destruction of Fentanyl (a narcotic pain medication) duragesic patches to reduce the risk of diversion. This had potential to affect 4 of 44 residents (R18, R6, R104, and R102) who had current orders for Fentanyl duragesic patches in the facility. Findings include: During review of The Healing Grace medication room, on 3/9/15 at 6:49 p.m., registered nurse (RN)-D opened a locked cabinet containing resident narcotic medications, and Fentanyl patch boxes were observed. RN-D was asked what the facility protocol for destruction of Fentanyl patches was and RN-D stated, "I'm not sure what protocol is." RN-D went on to say that her personal practice was to remove the patch, apply it to a piece of paper and leave it in the medication room until another nurse could help her destroy it, adding, "Not everybody does it that way, but that is how I do it." During review of The Garden medication room, on 3/9/15 at 7:51 p.m., RN-A opened a locked cabinet containing resident narcotic medications, and Fentanyl patch boxes were observed. RN-A stated Fentanyl patches were to be folded and placed in a sharps container (a container with a	21630	The updated facility procedure for Fentanyl patch destruction was provided for licensed nursing staff. Nurses will be re-educated on how to find updated nursing policies and what the new policy is for destruction of Fentanyl patch on 4/3/15. Nurses will be audited weekly for 1 month on correct destruction of Fentanyl patches and results will be given to the QAPI committee for further recommendations. Director of Nursing will be responsible to ensure this standard is met.	

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removable lid that is used to dispose of sharp objects) and that had been the practice of the facility "since I started here." Further, RN-A stated she had never received any education on how to dispose of used Fentanyl patches by stating, "I can't recall anything on it."

During review of The Lodge medication room, on 3/9/15 at 8:06 p.m., licensed practical nurse (LPN)-G opened a locked cabinet containing resident narcotic medications, and Fentanyl patch boxes were observed. LPN-G stated she started working at the facility about a month prior, and she removes used Fentanyl patches for residents and discards them in the sharps container adding, "As far as I know, that is the policy." Further, LPN-G stated she was not provided any education from the facility on how to dispose of used Fentanyl patches then said, "I have to get on that" in regards to inquiring what the facility policy was for destruction of Fentanyl patches.

A facility Order Listing Report, dated 3/10/15, identified R18, R6, R104, and R102 resided in the facility, and had active orders for Fentanyl duragesic patches.

When interviewed on 3/10/15, at 2:23 p.m. the consulting pharmacist (CP) stated current Food and Drug Administration (FDA) guidance was to fold used Fentanyl patches in half, and flush them down a drain to reduce the risk of diversion. The CP was unaware what policy or procedure the facility used to dispose of their patches.

When interviewed on 3/10/15, at 2:46 p.m. the director of nursing (DON) stated she was new to the facility, but was aware staff was disposing of used Fentanyl patches in the facility sharps containers by stating, "That is the practice here."

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21630	Continued From page 37 Further, the DON stated policies and procedures should be followed, "If I write a policy, I expect them to follow it." The facility Transdermal Patch Application policy, dated 9/2012, identified a procedure including, "When removing a previously used patch, use caution to protect skin. Fold the patch in two with the medicated sides together. Place old patch in a plastic bag for transport to medication room for disposal. It is not acceptable to put used patches in a sharps container." Further, "If the patch contains a controlled substance it must be disposed of and wasted as any controlled substance. The FDA recommends flushing duragesic patches...A best practice is that two nurses always sign for destruction of narcotic patches." SUGGESTED METHOD OF CORRECTION: The director of nursing and consultant pharmacist could review and revise policies and procedures to minimize the risk of diversion of narcotic medication. The consultant pharmacist could inservice licensed staff on the destruction of fentanyl patches. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21630		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting,	21695		4/21/15

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21695	Continued From page 38 and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure wheelchairs were clean and sanitary for 2 of 2 residents (R33 and R47). Findings included: R33 was observed on 3/10/15, at 9:38 a.m., on 3/11/15, at 1:03 p.m., and on 3/12/15, at 8:04 a.m. revealed R33's wheel chair had white crumbly debris on the seat cushion of the wheel chair and the left side had dried shiny film with a dried yellow crusted debris near the arm of the chair. R33 was to have wheel chair cleaned on Monday 3/9/15 according to the wheelchair washing schedule. An observation done on 3/10/15, at 2:30 p.m. revealed R47 had large particle flakes of white food debris on the seat cushion of their wheel chair. A family (F)-A member was present during this time and pointed the dirty wheelchair out to this surveyor. F-A stated, R47's is routinely dirty and has asked staff clean it frequently. According to the facility's wheelchair washing schedule, R33's wheelchair was scheduled to be cleaned on Mondays and R47's wheelchair was scheduled to be cleaned on Fridays. During an interview on 3/12/15, at 8:02 a.m. nursing assistant (NA)-B stated wheel chair are cleaned once a week by the overnight shift. NA-B stated, "During the day when we see if something is bad we wipe it off." During an interview on 3/12/15, at 2:30 p.m. director of environmental services (DES)-H explained the overnight nursing assistance clean the wheelchairs on weekly schedule. DES-H stated, if the wheel chairs were heavily soiled they	21695	Resident 33 and 47 were cleaned immediately. All chairs have been washed. A new cleaning schedule will be posted and implemented for the nursing staff. Re-education will be done with all nursing staff on 4/3/15. Audits will be conducted daily for 2 weeks; which will ensure all wheelchairs are being cleaned two times during those two weeks. Audits will be conducted randomly for 1 month. The audits will be reported to QAPI for further recommendation. Nurse Managers in each area will be responsible for ensuring this standard is met.	

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21695	Continued From page 39 would notify him and chairs would then be power washed. A policy on maintenance of resident care equipment was requested and not provided by the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure clean wheelchairs. The director of nursing could inservice all staff on maintaining clean wheelchairs. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in	21830		4/21/15

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an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a

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21830	Continued From page 41 family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure each resident's preference for waking up in the morning was respected and the facility failed to ensure that bathing frequency preference was provided for 1 of 3 residents (R104) who was reviewed for choices. Findings Include: R104's admission Minimum Data Set (MDS)	21830	Resident 104 discharged on 3/19/15. All residents Medical records will be reviewed or interviews conducted to determine if staff is honoring their preference for time to get up in the morning and frequency of bathing. Facility will provided re-education to nursing staff on 4/3/15 regarding resident choices and following GSS policy for honoring those choices. Audits will be conducted weekly for 4 weeks; they will be presented at the QAPI meeting for further	

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21830	Continued From page 42 dated 1/30/15, identified but not limited to diagnoses of cancer, thyroid disorder and depression, and required physical help in part of bathing of one person physical assist. R104's brief interview for mental status (BIMS) score of fifteen indicated intact cognition. R104 was interviewed on 3/10/15 at 1:53 p.m. in her room. When asked, "Do you choose when to get up in the morning?" R104 responded, "No, they [staff] come and wake me up and get me dressed. I would like to sleep in to about 9 a.m. " R104 stated she has not told them she would like to sleep in or that they were getting her up to early. When asked, "Do you choose how many times a week you take a bath or shower?" R104 responded, "No, I was told one time a week on Friday." When asked if she would like more than one shower or bath a week, R104 stated she would like at least five. When asked if she had told staff she would like more than one shower or a bath each week R104 stated she had and was told no. R104's Nursing Admit Re-admit Data Collection dated 2/18/14 indicated residents usual waking time was 8:00 a.m. However, the staff was getting R104 up as early as 6:45 a.m. R104 was observed on 3/12/15 at 7:13 a.m. to be dressed ready for the day and sitting in her wheelchair in her room. R104 stated staff came in and woke her up that morning at approximately 6:45 a.m. R104 stated she was just sitting in her room thinking and did not understand why she needed to be woken up at that "ungodly hour" and gotten ready for the day and then you have to wait an hour before breakfast. On 3/12/15 at 8:42 a.m. nursing assistant (NA)-E	21830	recommendations. Social services Director will be responsible for ensuring this standard is met.	

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21830	Continued From page 43 stated she helped R104 get up this morning and helped her with morning cares at approximately 7:00 a.m. NA-E stated R104 liked to get up in the morning between 6:30 and 7:00 a.m. and stated R104 was easy going and if we go in her room and ask her if she would like to get up, she will. NA-E verified she was unaware resident would prefer to sleep in till 8:00 a.m. NA-E stated nursing assistants were responsible for resident bathing. NA-E stated residents' bathing scheduled was determined by the room the resident was assigned upon admission. NA-E stated the facility did accommodate additional baths or showers if the resident or family made a request. NA-E was unaware R104 preferred more than one bath or shower a week. On 3/12/15 at 10:56 a.m. registered nurse (RN)-F stated upon admission the residents are asked what time they would like to get up in the morning and this was documented on the Nursing Admit Re-Admit Data Collection assessment. RN-F verified R104's Nursing Admit Re-admit Data Collection dated 2/18/15 indicated residents usual waking time was 8:00 a.m. When asked about how wake times preferences were communicated to staff, RN-F stated there was not a specific way. RN-F stated staff is pretty good about knocking on the residents' door and asking them if they would like to get up. RN-F stated we really try to promote resident choices, but stated sometimes we are on a time crunch from therapy and stated therapy will get upset if residents are not up and stated nurse management stated residents needed to be up before breakfast or 9:00 a.m. RN-F stated there was a scheduled bath day for residents based on their room assignment in the facility. RN-F stated residents are told upon admission what day their bath/shower was scheduled for and stated the resident was asked if that was ok. RN-F verified staff did not ask	21830		

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21830	Continued From page 44 residents how many times a week they would like a bath or shower. On 3/12/15 at 11:36 a.m. the director of nursing (DON) stated her expectations was the residents are asked what their preference for bathing frequency and asked what time they would like to get up in the morning upon admission. The DON stated she would expect staff to get the resident up as close as they could to their preference and stated if a resident's preference was to get up at 8:00 a.m., she would expect staff to get the resident up between 7:30 a.m. and 8:30 a.m. The DON verified waking a resident up at 6:45 a.m. to get them ready for the day would be too early for a resident that had a preference of waking up for the day at 8:00 a.m. SUGGESTED METHOD OF CORRECTION: The director of nursing and social worker could review and revise policies and procedures to ensure residents were offered choices for sleep and bathing. The social worker could inservice all staff to offer residents choices. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		