DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: TET0

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I -	TO BE COMPI	LETED BY	THE STAT	TE SURVEY A	GENCY		Facility	/ ID: 00967	
MEDICARE/MEDICAID PROVID (L1) 245317		3. NAME AND AL (L3) GOOD SAM	IARITAN SO		OMFORCARE		4. TYPE OF	_	7 (L8) Recertification	n
2.STATE VENDOR OR MEDICAID (L2) 692515400	NO.	(L4) 1201 17TH S (L5) AUSTIN, M			(L6) 5	55912	3. Terminat 5. Validatio 7. On-Site	on 6.	CHOW Complaint Other	
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	8. Full Surv			
 6. DATE OF SURVEY 06/0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 	02/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF D 15 ASC 16 HOSPICE		FISCAL YEAF		TE: (L35	i)
2 AOA 3 Other										
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY		AS:	. 1/0 .	11111 000	T			
From (a):		X A. In Complia	nce With equirements			nical Personnel	The Following Re	equirements: be of Services l	Limit	
To (b):			e Based On:		3. 24 Ho	our RN	7. Med	lical Director	Limit	
12.Total Facility Beds	45 (L18)	1. A	cceptable POC		4. 7-Day 5. Life S	/ RN (Rural SN Safety Code	F) 8. Pation 8. Bed	ent Room Size		
13.Total Certified Beds	45 (L17)		npliance with Pro ents and/or Appl			<u>*</u>	(L12)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY ME	EETS				
18 SNF 18/19 SNF 45	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L1	5)		
(L37) (L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):						
On June 2, 2015, a 2nd P	CR was comple	eted. This surve	ey found all	deficienci	ies corrected.	Please refe	r to the CMS	2567.		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	VEY AGENCY	APPROVAL	D	Date:	
Marietta Lee, HFE NE II		0	6/16/2015	(L19)	a <u>mala Fiske-I</u>	Downing, E	nforcement	Specialist	07/14/2015	5 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA R	EGIONAI	L OFFICE OR	SINGLE S	TATE AGEN	CY		
19. DETERMINATION OF ELIGIBI X 1. Facility is Eligible to			IPLIANCE WIT HTS ACT:	'H CIVIL	2. Ov		ncial Solvency (HC		1513)	
2. Facility is not Eligibl	•				<i>3.</i> Bo	on or the Above				
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREE	MENT	26. TERMINAT	ION ACTION:		(L30)		
OF PARTICIPATION 06/01/1986	BEGINNING	DATE	ENDING DA	ATE	VOLUNTARY 01-Merger, Closu			VOLUNTARY -Fail to Meet H	=	
(L24)	(L41)		(L25)		02-Dissatisfaction			-Fail to Meet A	greement	
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS of Admissions:			03-Risk of Involur 04-Other Reason f	=	07	THER -Provider Statu	is Change	
(L27)	B. Rescind Su	spension Date:	(L44) (L45)				00	-Active		
28. TERMINATION DATE:	20	. INTERMEDIARY/			30. REMARKS					
20. TERMINALION DATE:	29		CARRIER NO.		JU. KEWIAKKS					
	(L28)	00140		(L31)						
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVA	L DATE	Posted 07/1	5/2015 Co.				

(L33)

DETERMINATION APPROVAL

(L32)



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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

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



RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On June 2, 2015,	
I, Sara Falk , Adm (Name)(Please Print) the Notice of Penalty Assessment dated June 2, 2015	(Title)(Please Print) and licensing orders issued to:
Good Samaritan Society - Comforcare 1201 17th Street Ne Austin, MN 55912	
The Penalty Assessments and licensing orders attached	ed hereto have been corrected as of June 2, 2015.
Signed: <u>Marie HA Lee</u> , <u>Nurse</u> (Name)(Please Print)	(Title)(Please Print)
DELIVERY OF LICENSING PEN	VALTY ASSESSMENT NOTICE
On June 2, 2015,	
I,,,,,,,	, of the Division of (Title)(Please Print) [ealth, delivered the Notice of Penalty Assessment
Good Samaritan Society - Comforcare 1201 17th Street Ne Austin, MN 55912	
The Notice of Penalty Assessment was handed to	nme)(Please Print)
Title)(Please Print)	ane)(Flease Fint)
Signed:,,,,,,,	, Date
(Name)(Please Print)	(Title)(Please Print)
	** 11 ** 1.1 **1.11



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

Good Samaritan Society - Comforcare June 16, 2015 Page 2

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, Program Specialist

Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

Kumalu Fiske Downing

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

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 245317	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 6/2/2015
Name	of Facility		Street Address, City, State, Zip Code	
GC	OOD SAMARITAN SOCIETY - COMF	ORCARE	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	(Y	5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item		Y5)	Date
ID Prefix Reg. # LSC	483.25(I)	Correction Completed 05/29/2015	ID Prefix Reg. # LSC		Correction Completed		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix _ Reg. # LSC _		Correction Completed		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix _ Reg. # _ LSC _		Correction Completed		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix _ Reg. # _ LSC _		Correction Completed		ID Prefix Reg. # LSC			Correction Completed
Reviewed E State Agend Reviewed E CMS RO	cy GPN/k	fd	Date: 06/16/2015 Date:	Signature of Sur Manetts Lee Signature of Sur	HFE Nu	neZj	periole	it #	Date: 6-2 Date:	-15
Followup t	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



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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Division of Compliance Monitoring

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

State Form: Revisit Report

ld	Provider / Supplier / CLIA / dentification Number 0967	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 6/2/2015
Name of	f Facility		Street Address, City, State, Zip Code	
GOO	D SAMARITAN SOCIETY - COMF	1201 17TH STREET NE		

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).

AUSTIN, MN 55912

(Y4) Item		(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix Reg. # LSC	21535 MN Rule4658.1315	0	correction completed 5/29/2015	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		C	orrection completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		C	orrection ompleted	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC			orrection	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
Reviewed B State Agence Reviewed B CMS RO	y GPN/l	wed B		Date: 06/16/2015 Date:	Signature of Surv Manath Lee Signature of Surv	HEE New	a zpecisla	Date:	-15
Followup to Survey Completed on: 3/12/2015					Check for any Uncor				NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: TET0

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I -	TO BE COMPI	LETED BY T	THE STA	TE SURVEY AGENCY	•	Fa	acility ID: 00967
1. MEDICARE/MEDICAID PROVID (L1) 245317 2.STATE VENDOR OR MEDICAID (L2) 692515400		3. NAME AND AI (L3) GOOD SAM (L4) 1201 17TH S (L5) AUSTIN, M	IARITAN SOO STREET NE		OMFORCARE (L6) 55912	1. Init	mination	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA		Site Visit Survey After (9. Other Complaint
6. DATE OF SURVEY 05/08. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	06/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE		YEAR ENDING	G DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	45 (L18) 45 (L17)	Complianc1. A X B. Not in Con	nce With equirements e Based On: cceptable POC	gram	And/Or Approved Waivers 2. Technical Person 3. 24 Hour RN 4. 7-Day RN (Rural 5. Life Safety Code * Code: B	6. 7. 8.	ng Requirement Scope of Serv Medical Direct Patient Room Beds/Room	vices Limit
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1)	:	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM See Attached Remarks	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION :	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGEN	ICY APPROVAL	,	Date:
Marietta Lee, HFE	NE II	0	05/18/2015	(L19)	K <u>amala Fiske-Downin</u>	ng, Enforcen	nent Specia	alist 06/16/2015 (L20
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONA	L OFFICE OR SINGLI	E STATE AG	ENCY	
19. DETERMINATION OF ELIGIBLE _X 1. Facility is Eligible to 2. Facility is not Eligible	Participate		IPLIANCE WITI HTS ACT:	H CIVIL	21. I. Statement of F2. Ownership/Cc3. Both of the Ab	ontrol Interest Dis		
22. ORIGINAL DATE	23. LTC AGREEI	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	ON:	(I	_30)
OF PARTICIPATION 06/01/1986	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Closure	00	INVOLUNT 05-Fail to M	ΓΑRY leet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimb		06-Fail to M	leet Agreement
25. LTC EXTENSION DATE: (L27)	_	n of Admissions:	(L44)		03-Risk of Involuntary Termin 04-Other Reason for Withdray		OTHER 07-Provider 00-Active	Status Change
(221)	B. Rescind Si	aspension Date:	(L45)					
28. TERMINATION DATE:	29). INTERMEDIARY/			30. REMARKS			
		00140						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	DETERMINATION	OF APPROVAL	LDATE				
	(L32)	04/14/2015		(L33)	DETERMINATION A	PPROVAL		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Facility ID: 00967

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(1) -- 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.



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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

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



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(1) -- 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.

Good Samaritan Society - Comforcare May 18, 2015 Page 2

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:

Good Samaritan Society - Comforcare May 18, 2015 Page 3

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

Good Samaritan Society - Comforcare May 18, 2015 Page 5

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 Weath

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

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 245317	(Y2) Multiple Construction A. Building B. Wing	A. Building	
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
			Correction					Correction					Correction
ID Dester	50044		Completed		ID Dester	F00.40		Completed		ID Desfer	E0050		Completed
ID Prefix			05/06/2015		ID Prefix			05/06/2015		ID Prefix			05/06/2015
Reg. # LSC	483.15(a)				Reg. # LSC	483.15(b)					483.15(h)(2)		_
				-					_		-		_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0282		05/06/2015		ID Prefix	F0312		05/06/2015		ID Prefix	F0332		05/06/2015
ŭ	483.20(k)(3)(ii)				•	483.25(a)(3)				•	483.25(m)(1)		_
LSC					LSC					LSC			_
			0					0					0
			Correction Completed					Correction Completed					Correction Completed
ID Prefix	F0425		05/06/2015		ID Prefix	F0431		05/06/2015		ID Prefix	F0441		05/06/2015
Reg. #	483.60(a),(b)				Reg.#	483.60(b), (d), (e)				Reg. #	483.65		
LSC					LSC					LSC			-
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg.#								_
LSC										LSC			 _
			Correction					Correction					Correction
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Reg. # LSC					Reg. # LSC					Reg. # LSC			_
				-					+				
Reviewed By	Revi	iewed E	Зу	Da	te:	Signature of	Surve	yor:				Date:	
State Agency	, G	PN/n	nm	0	5/18/20	15		31221				05/	06/2015
Reviewed By	Revi	iewed E	 Зу	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed of	on:			_	Check fo	or any	Uncorrected	Defic	ciencies. Was	a Summary of		
	3/12/2015	5				Unco	rrecte	d Deficiencies	(CN	IS-2567) Sent	to the Facility?	YES	NO

PRINTED: 06/16/2015 FORM APPROVED OMB NO. 0938-0391

	IENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245317	B. WING		05	R / 06/2015
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1201 17TH STREET NE AUSTIN, MN 55912		700/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000 I	NITIAL COMMENT	TS .	FO	00		
F 329}	completed on May sertification tags that ound on the CMS2 hat were not found were issued at the tocated on the CMS3. Because you are ensignature is not requage of the CMS-29 submission of the Everification of computations of the Everification of computations has been as a compression of the Everification of computations has been as a compression of the Everification of the Everification of the Everification of computations has been as a compression of the Everification of the Everificati	prolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as diance. acceptable electronic POC, ander facility will be conducted to ential compliance with the en attained in accordance with EGIMEN IS FREE FROM RUGS g regimen must be free from an annecessary drug is any excessive dose (including or for excessive duration; or ionitoring; or without adequate se; or in the presence of inces which indicate the dose or discontinued; or any	{F 32	Z9}		5/29/15

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

(X6) DATE

Electronically Signed 05/22/2015

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245317	B. WING				ີ 06/ 2015
	PROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE 201 17TH STREET NE USTIN, MN 55912	05/(J6/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 329}	record; and residen drugs receive gradu behavioral intervent contraindicated, in a drugs.	age 1 documented in the clinical lats who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these	{F 3.	29}			
	by: Based on observatoreview, the facility for comprehensive phy gradual dose reduct contraindicated at the analysis and antidepressant than one for 1 of 3 unnecessary medic comprehensively of depression/insomniand antidepressant care plan intervention insomnia and identiand insomnia sympantidepressant and residents (R134) remedications. Findings include: Lack of GDR or phythe GDR is contrained.	tion, interview and document ailed to ensure a visician justification as to why a stion (GDR) was his time when a psychotropic medication is used for more residents (R52) reviewed for eations; and failed to			Resident 52 had a GDR dose redu on 5/15/15 with physician justification Resident 134 was discharged on 5/home. Facility will review and identification ther residents on a psychotropic at antidepressant medication to ensurappropriate documentation and behinterventions are being used according state regulations. DON will complete re-education to all nursing staff by 5/29/15. Interdisciplinary team (sociservices, nurse manager, DON and nursing staff) will monitor and put appropriate interventions into place residents on psychotropic and antidepressant medications. Audits conducted on new residents and chocurrent resident is psychotropic medications and GDR will be compined the Quality Assurance Performant Improvement Committee for further recommendations.	on. 17/15 to 17/15 to 17/15 to 17/15 to 17/15 to 18/16	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245317	B. WING				ີ 06/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- COMFORCARE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE AUSTIN, MN 55912	1 00/1	55/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 329}	R52 had been up la now. Review of the quart dated 2/3/15 indica interview of mental cognitively impaired scale) of 2 or no de no behaviors during The quarterly MDS exhibited no behaviors PHQ-9 score of 2 or Physician notes of continue Celexa (as Seroquel (antipsychology) and que needed. The physician with a received Celexa 10 two years) and que needed. The physic pharmacist note da stable. It worsened However, the physic comprehensive and reduction was not a minimum include at reduction and if this attempt and holikely impair the residistressed behavior on 3/27/15 the conthe physician with a received Seroquel	detical nurse (LPN)-A stated ate last night so was sleeping sterly Minimum Data Set (MDS) ted R52 had a BIMS (brief status) of 2 or severely d, had a PHQ-9 (depression expression, and had displayed to the assessment time period. dated 4/28/15 indicated R52 for and continued to have a for no depression. 4/11/15 noted a plan to entidepressant) 10 mg daily and enotic) 50 mg 1 ½ tabs twice a sultant pharmacist provided a note that indicated R52 had a mg daily since 2/19/13 (over stioned of a reduction was being on 3/11/15 replied to the sted 2/26/15, "No, behavior is in past with decrease." cian 's justification lacked a falysis of why the gradual dose attempted at this time which at do the dates of the last attempt arget behaviors worsened at we this the reduction would dident 's function or increase	{F 3:	29}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	` ′	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245317	B. WING				R 06/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY			STREET ADDRESS, CITY, STATE, Z 1201 17TH STREET NE AUSTIN, MN 55912	IP CODE	03/1	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
{F 329}	that said no reductive behavior. Again the lacked a comprehe gradual dose reductivities time which at a previous attempts at this time, also how or increase distress. The director of nurs at 4:09 p.m. and state had contacted the restrainment of sprimary physicial rationale for ongoin would pursue this contacted the respective of the restriction of the	sician wrote a note on 4/6/15 on and stable dementia physician 's justification nsive analysis of why the tion was contraindicated at minimum needs to include at a GDR and what occurred at it may impair functional status sed behavior/s. Sing was interviewed on 5/6/15 ated she thought the facility medical director regarding R52 n not providing a detailed g use of the medications and ourse if not. Sive depression and sleep entifying resident specific omnia symptoms to determine a ffective or not: on 4/21/15 and had an heron, (antidepressant) on d on 5/6/15 at 4:18 p.m. R134 iner with feet elevated a stated that last night they 00 p.m. so did not sleep so at some nights he slept okay did not. R134 stated that he	{F 3:	29}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245317	B. WING				ີ 06/ 2015	
	PROVIDER OR SUPPLIER		,	1	TREET ADDRESS, CITY, STATE, ZIP CODE 201 17TH STREET NE AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 329}	9) Continued From page 4		{F 3	29}				
	increase in the Re diagnoses as depr The physician doc depressed since d R134's health iss	es dated 4/29/15 indicated an meron to 15 mg and listed the ession/insomnia/poor appetite. umented R134 was more aughter died this spring and ues. The physician stated the d that he had not slept well and d 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							

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION		E SURVEY PLETED
		045047			·		R
		245317	B. WING		· · · · · · · · · · · · · · · · · · ·	05/0	06/2015
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S/	AMARITAN SOCIETY	- COMEORCARE		•	1201 17TH STREET NE		
GOOD 3F	AWANTAN SOCIETT	- COMI ONCANE		4	AUSTIN, MN 55912		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFI	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
{F 329}	Continued From pa	ge 5	{F 3:	29}			
	verify the physician	listed diagnoses as	,	-			
	no sleep assessme	nt had been completed and if					
		one it would have been in the					
	nursing notes.						
	The facility 's policy						
	• • •	bservations of mood					
	symptoms or behav	viors that cause the resident					
		nse to interventions used. If					
		der to indicate the effect the					
		the behavior. " The policy also					
		dual dose reduction must be					
	verify the physician depression/insomnino sleep assessme sleep monitoring do nursing notes. The facility 's policy Psychopharmacolog Sedative/Hypnotics The policy directed non-emergency psysedative/hypnotics documentation of or symptoms or behave distress and responsite medication is a is to be completed. administration of the medications "moor must continue in or medication has on the directed that a grade done according to finally be indicated with condition has improunderlying causes of have resolved and/or	listed diagnoses as ia/appetite loss. RN-B stated inthad been completed and if one it would have been in the or entitled gical Medications and dated 3/15 was reviewed. That before administration of orchopharmacological and/or there was to be bservations of mood or interventions used. If hypnotic, a sleep assessment as to interventions used. If hypnotic, a sleep assessment Throughout the psychopharmacological dand behavior documentation der to indicate the effect the the behavior. "The policy also	{F 3:	29)			

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 245317	(Y2) Multiple Constru A. Building B. Wing	T IN 2007	(Y3) Date of Revisit 4/24/2015
Name	of Facility		Street Address, City, State, Zip Code	
G	OOD SAMARITAN SOCIETY - COMFORC	ARE	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	(Y	1) Item	((Y5)	Date
			Correction					Correction					Correction
ID Desfer			Completed		ID Dester			Completed		ID Dester			Completed
ID Prefix			04/14/2015					04/21/2015					_
•	NFPA 101				-	NFPA 101				Reg. #			_
	K0050	_		ļ	LSC	K0141							_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	-		•		ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			_
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg.#			•		Reg.#			-		Reg. #			
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			Correction					Correction					Correction
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LSC				<u> </u>	LSC					LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			_
Reviewed By	Review	ed E	Ву	Da	te:	Signature of	Surve	yor:				Date:	
State Agency	, PS/	mm	1	C	5/18/20)15		12424				04/2	24/2015
Reviewed By	Review	ed E	Зу	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed on:						-			ciencies. Was	•		
	3/10/2015					Unco	rrecte	d Deficiencies	(C	MS-2567) Sent	to the Facility?	YES	NO



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.

Good Samaritan Society - Comforcare June 5, 2015 Page 2

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.

Good Samaritan Society - Comforcare June 5, 2015 Page 3

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

Sincerely,

mark Weath

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

		Ctato I cimi Ito		
(Y1)	Provider / Supplier / CLIA / Identification Number 00967	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 5/6/2015
Name	of Facility		Street Address, City, State, Zip Code	
G	OOD SAMARITAN SOCIETY - COMFORC	ARE	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	(Y4)	Item			(Y5)	Date	(Y4) Item		(Y5) D	ate
			Correction						Correction					Correction
ID Prefix	20302		Completed 05/07/2015		ID Prefix	20565			Completed 05/07/2015		ID Prefix	20860		Completed 05/07/2015
Reg.#	MN State Statute 144.6	503			Reg. #	MN Rule	4658.0405	Subp. 3	3		Reg. #	MN Rule 465	8.0520 Subp.	- 2 F.
LSC					LSC						LSC			
		(Correction						Correction					Correction
ID Prefix	21390		Completed 05/07/2015		ID Prefix	21426			Completed 05/07/2015		ID Prefix	21545		Completed 05/07/2015
•	MN Rule 4658.0800 Su	bp. 4	A- l		•	MN St. S	Statute 144A	.04 Sul	od. (ŭ	MN Rule 465	8.1320 A.B.C	-
LSC				-	LSC					-	LSC			·
		(Correction						Correction					Correction
ID Prefix	21600		Completed 05/07/2015		ID Prefix	21630			Completed 05/07/2015		ID Prefix	21695		Completed 05/07/2015
Reg. #	MN Rule 4658.1335 Su	bp. 2			Reg. #	MN Rule	4658.1350 \$	Subp. 2	2 A.I		Reg. #	MN Rule 465	8.1415 Subp.	4
LSC					LSC						LSC			<u>. </u>
		(Correction						Correction					Correction
ID Prefix	21830		Completed 05/07/2015		ID Prefix				Completed		ID Prefix			Completed
Reg. #	MN St. Statute 144.651	Sub	d. 1		Reg. #						Reg. #			
LSC					LSC						LSC			
		(Correction						Correction					Correction
ID Prefix			Completed		ID Prefix				Completed		ID Prefix			Completed
Reg. #					Reg. #									-
LSC					LSC						Reg. # LSC			-
Reviewed By	Review	red B	у	Da	ate:	5	Signature of	Surve	or:				Date:	
State Agency	GP	N/m	m		06/05/2	015			31221				05/06	6/2015
Reviewed By CMS RO	Review	ed B	у	Da	ate:		Signature of	Surve	yor:				Date:	
Followup to Survey Completed on: 3/12/2015		Check for any Uncorrected Deficiencies. Was a Summa Uncorrected Deficiencies (CMS-2567) Sent to the Fac							NO					
STATE FORM	: REVISIT REPORT	(5/	90)				Page 1 of 1					Event ID:	TFT012	

PRINTED: 06/16/2015

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

		00967		B. WING		05/06/	2015
NAME OF F	PROVIDER OR SUPPLIER			DRESS, CITY, ST			
GOOD S	AMARITAN SOCIETY	- COMFORCARE		ISTREET NE IN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER	3				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has be	sued I, it is ed Iolation Ince le of een Colow. e to ered Doon e will ne item				
	that may result from orders provided tha the Department with	hearing on any assessment non-compliance with tool to written request is making 15 days of receipt of the for non-compliance.	hese ade to				
	and 6, 2015. During determined there at not been corrected	rs: visit was completed on g this onsite visit it was re licensing orders that at the time of this licens	have sing				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

Electronically Signed 05/22/15

STATE FORM If continuation sheet 1 of 7 TET012

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER				E CONSTRUCTION	(X3) DATE COMPI	
		2002			F	
		00967	B. WING		05/0	6/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE	HSTREET N MN 55912	E		
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2 000	Continued From pa	ge 1	2 000			
	possible penalty as	sessment/s.				
{21535}	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary	{21535}			
	must be free from L unnecessary drug is A. in excessive therapy; B. for excessive C. without aded D. in the prese which indicate the of discontinued. In addition to the d part 4658.1310, the with provisions in the Code of Federal Re 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Finance This standard is ind available through the	quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in e nursing home must comply ne Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for acilities, published by the Ith and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan te Law Library. It is not				
	by: Based on observati review, the facility facomprehensive phy gradual dose reduce contraindicated at tand antidepressant	sician justification as to why a				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
					F			
		00967	B. WING		05/0	6/2015		
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE, ZIP CODE					
GOOD S	AMARITAN SOCIETY	- COMEORCARE	H STREET N MN 55912	E				
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PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE		
{21535}	Continued From page 2							
	unnecessary medic comprehensively of depression/insomn and antidepressant care plan interventi insomnia and identi and insomnia symp Remeron was affect specific target symp antidepressant and residents (R134) re medications.	cations; and failed to complete a ia assessment before starting then developing temporary ons to treat depression and ify resident specific depression by the stive or not for identify resident otoms for the use of the failed to complete 1 of 3 eviewed for unnecessary						
	the GDR is contrain R52 was observed	ysician's justification as to why ndicated at this time: on 5/6/15 at 4:51 p.m. R52						
	door. Licensed pra	th head turned away from the actical nurse (LPN)-A stated ate last night so was sleeping						
	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.							
	continue Celexa (ai	4/11/15 noted a plan to ntidepressant) 10 mg daily and notic) 50 mg 1 ½ tabs twice a						
		sultant pharmacist provided a note that indicated R52 had						

Minnesota Department of Health

STATE FORM 6899 TET012 If continuation sheet 3 of 7

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00967		B. WING			R 06/2015		
NAME OF		00307	CTDEET AD	ADDRESS, CITY, STATE, ZIP CODE					
NAME OF	PROVIDER OR SUPPLIER			H STREET N					
GOOD S	AMARITAN SOCIETY	- COMFORCARE	_	MN 55912	-				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE		
{21535}	received Celexa 10 two years) and quere needed. The physic pharmacist note da stable. It worsened However, the physic comprehensive and reduction was not a a minimum included at reduction and if this attempt and holikely impair the residistressed behavior. On 3/27/15 the consthe physician with a received Seroquel 7/16/13 and asked reduction. The physician with a received Seroquel 7/16/13 and asked reduction. The physician with a received Seroquel 7/16/13 and asked reduction. Again the lacked a compreheigradual dose reductions time which at a previous attempts a this time, also how or increase distress. The director of nurse at 4:09 p.m. and stabad contacted the residuence of the stabad contacted the residuenc	mg daily since 2/19 stioned of a reduction of a red	on was ed to the behavior is se." acked a dual dose e which at st attempt sened at would increase orovided R52 had ince se on 4/6/15 ntia sation by the sated at include occurred at onal status I on 5/6/15 e facility arding R52 tailed tions and	{21535}					
	depression and inso if medication was a		determine						

6899

Minnesota Department of Health STATE FORM

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00967	B. WING			R 06/2015	
	PROVIDER OR SUPPLIER	- COMFORCARE 1201 17	DDRESS, CITY, S TH STREET N MN 55912	STATE, ZIP CODE E			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
{21535}	R134 was admitted increase in the Ren 4/29/15. R134 was observed was sitting in a recli watching TV. R134 gave him a pill at 7: well. R134 said that and sometimes he did use sleeping me The admission minimindicated a BIMS (bof 13 or no impairm feeling down/deprespoor appetite. The physician notes increase in the Ren diagnoses as depresed since da R134's health issueresident mentioned did not have a good R134's nursing no had been resting quindicated residents note on 4/28/15 not signs of depression symptoms displayer 5/2/15 the nursing rappeared to be sleed during night. The nunegative mood or be signed to the signs of depression symptoms displayer 5/2/15 the nursing rappeared to be sleed during night. The nunegative mood or be signed to the signs of depression symptoms displayer 5/2/15 the nursing rappeared to be sleed during night. The nunegative mood or be signed to the signs of depression symptoms displayer 5/2/15 the nursing rappeared to be sleed during night. The nunegative mood or be signed to the signs of t	on 4/21/15 and had an heron, (antidepressant) on d on 5/6/15 at 4:18 p.m. R134 iner with feet elevated a stated that last night they 00 p.m. so did not sleep so at some nights he slept okay did not. R134 stated that he edication at home. Imum data set dated 4/27/15 orief interview of mental status arent and mood symptoms of essed, no trouble sleeping, and essed, no trouble sleeping, and essed, no trouble sleeping and less. The physician stated the that he had not slept well and appetite. Ites dated 4/24/15 stated he usely. On 4/28/15 the notes at tated feels better. Another red resident showing more in (but did not identify the did). On 4/29/15, 5/1/15, and notes stated the resident eping when checked by staff cursing note of 5/3/15 noted no					

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMBER. A. BUILDING:	
00967 B. WING 05/06	6/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD SAMARITAN SOCIETY - COMFORCARE 1201 17TH STREET NE AUSTIN, MN 55912	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(21535) Continued From page 5 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. "Tappering	

Minnesota Department of Health

D. WING	R
00967 B. WING 09	/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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(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.	

Minnesota Department of Health

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID:	IEIU
Faci	lity ID: 00967

1. MEDICARE/MEDICAID PROVIDE (L1) 245317 2.STATE VENDOR OR MEDICAID N (L2) 692515400 5. EFFECTIVE DATE CHANGE OF	3. NAME AND ADDRESS OF FACILITY (L3) GOOD SAMARITAN SOCIETY - CO (L4) 1201 17TH STREET NE (L5) AUSTIN, MN 7. PROVIDER/SUPPLIER CATEGORY			(L6) 559		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		
(L9) 6. DATE OF SURVEY 03/1 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2/2015 (L34) (L10)	01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray	09 ESRD 10 NF 11 ICF/IID 12 RHC	14 CORF	2 CLIA	FISCAL YEAR END	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	45 (L18) 45 (L17)	Compliance1. Accept Acce		ım	And/Or Approved2. Technica3. 24 Hour4. 7-Day R!5. Life Safe * Code: B	l Personnel RN N (Rural SNF) ty Code	e Following Require 6. Scope of S 7. Medical E 8. Patient Ro 9. Beds/Roo	Services Limit birector om Size
14. LTC CERTIFIED BED BREAKDO	OWN 19 SNF	ICF	IID	:	15. FACILITY MEET 1861 (e) (1) or 186		(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION DA	ATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY	Y AGENCY A	PPROVAL	Date:
Marietta Lee, HFE NE II		0	3/30/2015	(L19) K	amala Fiske-Do	wning, Er	nforcement Spec	cialist 04/09/2015 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA REG	GIONAL	OFFICE OR SI	NGLE ST	ATE AGENCY	
DETERMINATION OF ELIGIBIE 1. Facility is Eligible to I 2. Facility is not Eligible	Participate		PLIANCE WITH (ITS ACT:	CIVIL	2. Owne		ial Solvency (HCFA-2. Interest Disclosure Stri	
22. ORIGINAL DATE OF PARTICIPATION	23. LTC AGREEN BEGINNING		LTC AGREEME		26. TERMINATION	N ACTION:	INVOLU	(L30) JNTARY
06/01/1986 (L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	(L25)		01-Merger, Closure 02-Dissatisfaction W 03-Risk of Involuntary 04-Other Reason for V	y Termination	onent 06-Fail to OTHER	o Meet Health/Safety o Meet Agreement der Status Change e
(L27)	B. Rescind Su	uspension Date:	(L45)					
28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO.				30. REMARKS				
	(L28)	00140		(L31)				
31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE								
31. RO RECEIPT OF CMS-1539		. DETERMINATION	OF APPROVAL D	DATE				



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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.

Good Samaritan Society - Comforcare March 20, 2015 Page 4

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

Good Samaritan Society - Comforcare March 20, 2015 Page 5

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

Good Samaritan Society - Comforcare March 20, 2015 Page 6

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Kamala Fishe Downing

Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

 $\underline{Kamala.Fiske\text{-}Downing@state.mn.us}$

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245317	B. WING	B. WING		03/	12/2015
	PROVIDER OR SUPPLIER	- COMFORCARE		STREET ADDR 1201 17TH ST AUSTIN, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD S-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000		of correction (POC) will serve of compliance upon the	F0	00			
	Department's accepenrolled in ePOC, yat the bottom of the	otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will					
	on-site revisit of you validate that substate regulations has been your verification. 483.15(a) DIGNITY	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with	F 2	41			4/21/15
SS=D	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.					
	by: Based on observative review, the facility for promptly removing after personal carestreviewed for activitive Findings include: R106's admission of dated 2/3/15, identic cognitive impairments	NT is not met as evidenced cion, interview, and document ailed to promote dignity by soiled incontinence products of for 1 of 3 residents (R106) es of daily living. Minimum Data Set (MDS), fied R106 had moderate nt, and required extensive eting and personal hygiene.		the soile room. So been orded products residents all staff of and more staff on a being followeekly and Market products and more staff on a being followeekly and Market products are staff on a being followeekly and market products are staff on a being followeekly and market products are staff on a being followeekly and a being followeekly and a being followeekly are staff or a being followed by the staff of the staff	nt 106 was corrected immeded bag was removed from the mall black garbage bags had been for soiled incontinent as so it will not affect any other. Re-education was provided and a soiled incontinent and a soiled incontinent and a soiled was provided and a soiled was a soiled and a soiled was a soiled and a soiled was	he ave led to 4/15 nursing lignity is lucted t the	
ABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	1	TITLE		(X6) DATE

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

TITLE

Electronically Signed

03/30/2015

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

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	245317	B. WING		·····	03/12/2015	
PROVIDER OR SUPPLIER AMARITAN SOCIETY	- COMFORCARE		1:	201 17TH STREET NE		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
During general obsea.m. R106 was seat television. A clear is hallway on R106's vyellow incontinence containing a brown several used wet wo vanity next to the clincontinence product. When interviewed on ursing assistant (Not incontinent of stool that day, and added been left on the varithey pass by the root During interview on member (FM)-C states staff to leave soiled R106's room before occur, "No, that show the work of th	ervation on 3/11/15, at 9:22 ted in his room watching bag was visible from the vanity, which contained a brief, and several wipes substance (stool). In addition, ashcloths were sitting on the ear bag containing soiled cts. on 3/11/15, at 9:26 a.m. JA)-A stated R106 had been during morning cares earlier d the bag should not have hity, visible to the public as om, "I know better." 3/11/14, at 2:26 p.m., family ated she had never observed incontinence products in e, but that it should never buildn't be." on 3/12/15, at 12:19 p.m. the DON) stated the soiled cts should have been removed mmediately after care, and a concern for R106's dignity. dded, "I wouldn't like it if it Dignity policy, dated 2/2013, e of, "To maintain the dignity of her, the policy directed, "The care for residents in a manner ent that maintains of	F 2	241	Director will be responsible for ensithis standard is met.	uring	
483.15(b) SELF-DE	TERMINATION - RIGHT TO	F 2	42			4/21/15
	Continued From pa During general obsea.m. R106 was sea television. A clear is hallway on R106's vyellow incontinence containing a brown several used wet wo vanity next to the clincontinence product when interviewed on ursing assistant (Nincontinent of stool that day, and added been left on the varithey pass by the root During interview on member (FM)-C stastaff to leave soiled R106's room before occur, "No, that show when interviewed of incontinence production of the pass by the root During interview on member (FM)-C stastaff to leave soiled R106's room before occur, "No, that show when interviewed of incontinence production R106's room is failing to do so was Further, the DON as were me." A facility Resident Edidentified a purpose all residents." Furth center will promote and in an environm enhances each residents and in an environm enhances each residents.	AMARITAN SOCIETY - COMFORCARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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." 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F 242 SS=D	MAKE CHOICES The resident has the schedules, and he her interests, asses interact with membinside and outside about aspects of hare significant to the significant t	ne right to choose activities, alth care consistent with his or ssments, and plans of care; pers of the community both the facility; and make choices is or her life in the facility that he resident. NT is not met as evidenced tion, interview, and document failed to ensure each resident's ing up in the morning was facility failed to ensure that preference was provided for 104) who was reviewed for Minimum Data Set (MDS) hitified but not limited to ear, thyroid disorder and quired physical help in part of son physical assist. R104's nental status (BIMS) score of	F 2	Resident 104 discharged or residents Medical records wor interviews conducted to staff is honoring their prefer to get up in the morning and bathing. Facility will provide to nursing staff on 4/3/15 re resident choices and followifor honoring those choices. conducted weekly for 4 week be presented at the QAPI in further recommendations. services Director will be resensuring this standard is medical to the conducted weekly for the conducted we	will be reviewed determine if rence for time of frequency of d re-education egarding ing GSS policy Audits will be eks; they will neeting for Social eponsible for		

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F 242	times a week you to responded, "No, I veriday." When ask one shower or bath would like at least foold staff she would a bath each week foold no. R104's Nursing Add dated 2/18/14 indictime was 8:00 a.m. R104 up as early a room thinking and one ded to be woke and gotten ready for wait an hour before on 3/12/15 at 8:42 stated she helped for helped her with mo 7:00 a.m. NA-E stamorning between 6 R104 was easy goi and ask her if she worth on thinking and ask her if she worth on the state of the she worth of the she worth of the state of the she worth of the state	ake a bath or shower?" R104 was told one time a week on ed if she would like more than a week, R104 stated she live. When asked if she had I like more than one shower or R104 stated she had and was mit Re-admit Data Collection ated residents usual waking However, the staff was getting s 6:45 a.m. I d on 3/12/15 at 7:13 a.m. to be he day and sitting in her from. R104 stated staff came in eat morning at approximately ted she was just sitting in her did not understand why she in up at that "ungodly hour" or the day and then you have to	F 2	42			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 242	request. NA-E was than one bath or shon 3/12/15 at 10:5 stated upon admiss what time they wou and this was docur Re-Admit Data Colverified R104's Nur Collection dated 2/waking time was 8 how wake times protostaff, RN-F stated RN-F stated staff is on the residents' downwald like to get uppromote resident owe are on a time of therapy will get upstated nurse mananeeded to be up be RN-F stated there residents based or facility. RN-F stated admission what dascheduled for and if that was ok. RN-residents how man a bath or shower. On 3/12/15 at 11:3 (DON) stated here are asked what the frequency and asking the get up in the mornistated she would eup as close as they stated if a resident' 8:00 a.m., she wouresident up between	unaware R104 preferred more	F 2	242			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	B) DATE SURVEY COMPLETED	
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F 242	a.m. to get them rea	ady for the day would be too that had a preference of	F 242		
F 253 SS=D	483.15(h)(2) HOUS MAINTENANCE SE	EKEEPING &	F 253		4/21/15
	maintenance service	ovide housekeeping and ses necessary to maintain a ad comfortable interior.			
	by: Based on observate failed to ensure who sanitary for 2 of 2 reference from the sanitary for 2 of 2 reference failed to ensure who sanitary for 2 of 2 reference failed to ensure for the sanitary for 2 of 2 reference failed for the sanitary for 2 of 2 reference failed for the sanitary failed for the sanitary failed for the sanitary failed fa	cility's wheelchair washing reelchair was scheduled to be vs and R47's wheelchair was		Resident 33 and 47 were cleaned immediately. All chairs have been washed. A new cleaning schedule will posted and implemented for the nursi staff. Re-education will be done with a nursing staff on 4/3/15. Audits will be conducted daily for 2 weeks; which wi ensure all wheelchairs are being clear two times during those two weeks. As will be conducted randomly for 1 mon. The audits will be reported to QAPI for further recommendation. Nurse Mana in each area will be responsible for ensuring this standard is met.	ng III ned udits th.

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 253 F 282 SS=D	nursing assistant (Noteaned once a week stated, "During the sisted, "During the sisted, "During an interview director of environmexplained the overnithe wheelchairs on stated, if the wheel would notify him an washed. A policy on maintent equipment was requipment was requipment was requipment was requipment was requipment was requipment was provided by accordance with eacure. The services provided by accordance with eacure. This REQUIREMENT by: Based on observative review, the facility fainterventions for skill were followed by standard interventions for skill were followed by standard include: LACK of SKIN PROBLEM SK	on 3/12/15, at 8:02 a.m. IA)-B stated wheel chair are ext by the overnight shift. NA-B day when we see if something f." on 3/12/15, at 2:30 p.m. nental services (DES)-H hight nursing assistance clean weekly schedule. DES-H chairs were heavily soiled they d chairs would then be power ance of resident care uested and not provided by RVICES BY QUALIFIED ARE PLAN led or arranged by the facility y qualified persons in ch resident's written plan of NT is not met as evidenced ion, interview, and document ailed to ensure care planned in protection and nail care aff for 2 of 3 residents (R106, activities of daily living. OTECTION: Minimum Data Set (MDS),	F 282	Resident 106 and 33 had nails trim immediately. Protective skin care we provided to resident 106 immediate putting heels up off the bed as directive the care plan. All resident is not were checked to ensure nails were trimmed and clean. All residents ne protective skin care were checked to ensure the care plan was being followed to all number of the care policy and provided to all number of the care of the care th	vas ly by cted ails eding o owed. care sing	
	ualeu 2/3/15, Identi	fied R106 had moderate		staff on 4/3/15. Audits will be condu	uciea	

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F 282	assistance with per R106's Therapy Do 1/28/15, identified, heel when in bed with plan, dated 1/29/15 skin impairment or intervention of, "elekhis risk of further properties of further properties of further properties of the surveyor. NA-D resurveyor.	ent, and required extensive resonal hygiene. Decumentation Notes, dated "Elevate feet + (and) protect with cushion." R106's care 5, identified R106 had a current of his coccyx, and identified an evate heels off bed", to reduce ressure ulcer development. In of morning cares, on 3/12/15, ag assistant (NA)-D entered from the provide care with the moved the white linen covering from pair of cotton socks. I lying directly on the bed, not ad by the care plan. A blue of (used to help elevate heels is lying on the floor, propped up of the foot of R106's bed. On 3/12/15, at 8:20 a.m. NA)-D verified R106's heels when she entered the room to care. Further, R106's care been followed, and his heels elevated as directed. In 3/12/15, at 8:48 a.m. licensed in N)-B stated R106 was at risk in on his heels, and the care should have been followed by On 3/12/15, at 12:19 p.m. the (DON) stated a resident's care, and	F 283	weekly for 1 month. The audits reported to QAPI. Director of N be responsible to ensure this s met.	Nursing will	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 282	identified, "The carand development of that the resident wiservices." LACK of NAIL CAF R33 was observed 3/11/15, at 8:52 a.m. a.m. revealed R33 hands and dried brothen ails. The facility admissis admitted to the facilincluded diagnoses anxiety, and Parkin R33's quarterly Mir 12/16/15 indicated with a Brief Intervies score of 3 and requistaff members to personning tasks. R33's most recent facility on 3/12/15 in care weekly on bat During an interview nursing assistant (Inursing assistant is provided nail care for "Sometimes me and out, or we will do it NA-B explained na and in the case of report to the nurse."	policy, dated 2/2013, e plan will emphasize the care of the whole person ensuring II receive appropriate care and RE: on 3/10/15, at 9:28 a.m., n., and on 3/12/15, at 7:55 had long finger nails on both own debris was underneath on record indicated R33 was ality on 11/25/2013 and so fo but not limited to dementia, ason's disease. Simum Data Set (MDS) dated severe cognitive impairment of Mental Status (BIMS) wired extensive assist from two rovide personal hygiene and care plan provided by the enstructed staff to provide nail h day and as needed. From 3/12/15, at 7:56 a.m. NA)-B stated the restorative of the primary person that for residents. NA-B stated, at the other aide will do to help if we notice the nails are dirty." its are checked on shower day, resident refusal NA's would	F 2	82		
	NA-C (worked as the assistant) stated, "I	on 3/12/15, at 8:03 a.m. ne restorative nursing provide nail care the majority week on bath days, but it's not				

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F 312 SS=D	it." During an interview registered nurse (R long and dirty and sexplained R33 used RN-A then stated sigot trimmed and cle A facility procedure November 2013 did often nail care shou 483.25(a)(3) ADL C DEPENDENT RES A resident who is undaily living receives	on 3/12/15, at 8:07 a.m. N)-A verified R33 nails were should be cleaned. RN-A also dhis hands quite a bit to eat. he would make sure the nails eaned. nail care last reviewed on an anot give direction on how ald be provided. EARE PROVIDED FOR	F 2			4/21/15
	by: Based on observatoreview, the facility for dependent resident 1 of 3 residents (R3 daily living. Findings included: R33 was observed 3/11/15, at 8:52 a.m. a.m. revealed R33 hands and dried brothe nails. The facility admissional admitted to the facility admissional revealed R3cility admissional residence in the facility admissional reverse revealed R3cility admissional residence in the facility admissional reverse	ion, interview, and document ailed to provide nail care for a according to the care plan for 33) reviewed for activities of on 3/10/15, at 9:28 a.m., and on 3/12/15, at 7:55 had long finger nails on both own debris was underneath on record indicated R33 was lity on 11/25/2013 and of but not limited to dementia,		Resident 33 had nails trimmed immediately. All resident s nail checked to ensure nails were tr and clean. Nail care policy and will be provided to all nursing st 4/3/15. Audits will be conducter for 1 month. The audits will be QAPI for further recommendation Director of Nursing will be responsive this standard is met.	immed education aff on d weekly reported to on.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245317	B. WING			03/1	2/2015
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F 312	anxiety, and Parkin R33's quarterly Min 12/16/15 indicated with a Brief Intervie score of 3 and requistaff members to progrooming tasks. R33's most recent of facility on 3/12/15 in care weekly on bath care plan did not incoming an interview nursing assistant (In nursing assistant is provided nail care for "Sometimes me and out, or we will do it NA-B explained nail and in the case of report to the nurse. During an interview NA-C (worked as the assistant) stated, "I of the time, once a not just up to me. The do it." During an interview registered nurse (R long and dirty and sexplained R33 used RN-A then stated sigot trimmed and clean facility procedure November 2013 did often nail care should a supplementation of the state o	imum Data Set (MDS) dated severe cognitive impairment w of Mental Status (BIMS) ired extensive assist from two rovide personal hygiene and care plan provided by the astructed staff to provide nail anday and as needed. The dicate when R33's bath was. on 3/12/15, at 7:56 a.m. IA)-B stated the restorative the primary person that for residents. NA-B stated, different the other aide will do to help if we notice the nails are dirty." Is are checked on shower day, esident refusal NAs would on 3/12/15, at 8:03 a.m. he restorative nursing provide nail care the majority week on bath days, but it 's he nurses and the aides also on 3/12/15, at 8:07 a.m. N)-A verified R33 nails were should be cleaned. RN-A also define hands quite a bit to eat. The would make sure the nails beaned. In an	F 3				4/21/15
92=D	UNINECESSANT D	nodo					

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F 329	unnecessary drugs drug when used in duplicate therapy); without adequate r indications for its u adverse conseque should be reduced combinations of the Based on a compresident, the facility who have not used given these drugs therapy is necessars as diagnosed and record; and resided drugs receive grad behavioral interver	ug regimen must be free from s. An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nces which indicate the dose or discontinued; or any	F3	329			
	by: Based on interview facility failed to ide antipsychotic mediclinical symptoms was effective; and comprehensive sleneed for the use of ordered for insommereviewed for unnecessity.	tep study to determine the Mirtazapine, Melatonin hia for 1 of 5 residents (R108) ressary medications; and failed ang use and did not attempt a		Resident 108 was discharge Resident 52 had a dose reduction of the consultant pharmacist of the consultant pharmacy with make GDR recommendation though the physician has de GDR for resident. Nurse Mad DON will consult with the fact medical director to work with resident of sphysician. The Name of the sident o	uction of e of 2013, at s request. Il continue to ns, even clined further anager and cility s the		

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F 329	reviewed for unner Findings Include: R108's admission admitted on 2/11/1 but were not limited hypothyroidism. The Assessment (MDS R108 did not display difficulty sleeping and having little energy R108 currently received (antipsychotic) 0.5 for generalized an orders reflected an 2/19/15 and the remedication daily shaving little energy R108's medical rebehaviors had not monitoring for the use of the Risperior R108 ince admis R108's physician dated 3/11/15 read anxiety with previous low-dose Risperid review in the past that this has been dose in the outpat on melatonin (horn Remeron (antidep R108 currently received R108 currently	record revealed R108 was 15 with diagnoses that included ad to anxiety state and The admission Minimum Data 3) dated 2/18/15, indicated ay behavior problems or according, feeling tired or y. ceived Risperidone in milligrams (mg) one time a day xiety. The current physician's start date for Risperidone as esident had received the ince then. cord review revealed targeted been determined and behavior effectiveness and continued done had not been initiated for sion which was over thirty days. I certification progress note d, "Depression, insomnia, ous paranoia. Resolved with one and extensive psychiatry. Continue low-dose and has felt weaned to the lowest effective ient setting. She also continues mone to regulate sleep) and	F3	329	will set up target behavior monitorice resident 52 on antipsychotic medical All residents taking antiemetics, antianxiety agents, antidepressant antipsychotic/antimanic agents and hypnotics will be reviewed for approximation and GDR reductions perpolicy and procedures. Re-educate provided to nursing staff regard GSS policy and procedure on 4/3/1 Monthly medication reviews will be conducted by consultant pharmacic reviewed at QAPI meeting. All residuith above mentioned medications audited weekly for 1 month to ensurappropriate monitoring and use of medications. Results will be taken QAPI meeting for further recommendations. Director of Nursibe responsible to ensure this standard.	eation. s, d opriate er GSS ation will ing 15. st and dents s will be ure these to sing will	

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(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE	
and Melatonin 3 m current physician's for Mirtazapine as Melatonin as 2/11/ R108's medical redocumentation of scomprehensive sless On 3/12/15 at 11:2 stated R108 did not behavioral concerr the Risperidone for comprehensive sless completed since as facility did not iden use of Risperidone for the effectivenes antipsychotic medi implemented. On 3/12/15 at 11:5 (DON) stated her expected would have determined have had deverted monitoring for the effectiveness of the ongoing use of the DON stated reside comprehensive sless establish a baselin the facility on medical transport of the Psychopharm Sedative/Hypnotics	g at bedtime for sleep. The orders reflected a start date 2/12/15 and a start date for 15. cord review revealed a lack of sleep pattern and eep assessment. 1 a.m. registered nurse (RN)-For the display any mood or as. RN-F stated R108 received a sleep and verified a sep assessment had not been dission. RN-F verified the tify targeted behaviors for the eand behavior and monitoring as and continued use of the cation had not been decation and need for the antipsychotic. In addition, the not should have a dep assessment completed to decation to help with sleep. accological Medications and spolicy revised 3/15 read, "	F 3:	29			
	PROVIDER OR SUPPLIER AMARITAN SOCIETY SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From pa and Melatonin 3 m current physician's for Mirtazapine as Melatonin as 2/11/2 R108's medical reducumentation of scomprehensive sle comprehensive sle comprehensive sle completed since and facility did not identuse of Risperidone for the effectivenes antipsychotic meditimplemented. On 3/12/15 at 11:5 (DON) stated her expould have determined and have had devert and have had have	PROVIDER OR SUPPLIER AMARITAN SOCIETY - COMFORCARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 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	A BUILDII 245317 PROVIDER OR SUPPLIER AMARITAN SOCIETY - COMFORCARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 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. 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The Psychopharmacological Medications and Sedative/Hypnotics policy revised 3/15 read, "Non-Emergency Administration If the resident is experiencing sleep disturbance, complete the Sleep Assessment5. If the physician prescribes	PROVIDER OR SUPPLIER AMARITAN SOCIETY - COMFORCARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DOREICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYMG INFORMATION) Continued From page 13 and Melatonin 3 mg at bedtime for sleep. The current physician's orders reflected a start date for Mirtazapine 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. 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F 329	Medication Assessi Involuntary Movemadministration of the medications and set following must be obehavior document indicate the effect the behavior" R52 received an argreater than a year reduction (GDR) was a physician 's justific contraindicated at the R52 according to the was admitted on 11 included but were redisease, major dependementia with behare R52's quarterly Min 2/13/15 indicated swith a Brief Interview had minimal depression screen no behaviors. R52's annual MDS severe cognitive im 3, had minimal depression screen no behaviors. R52's most recent of facility on 3/12/15 in problem and behaviore you" related to depression. The callose observe for signs a irritability and depression instructed staff	ge 14 te the initial Antipsychotic ment and The Abnormal ent Scale9. Throughout the e psychopharmacological edative/hypnotic drugs the ompleteda. Mood and ation must continue in order to the medication has on the atipsychotic (Seroquel) for and no gradual dose as not attempted nor was there is ation why the GDR was his time documented. The facility admission record /9/12 and had diagnoses that not limited to: Alzheimer's ressive disorder, and avioral disturbances. Immum Data Set (MDS) dated evere cognitive impairment who for Mental Status score of 2, asion according to the PHQ-9 er) with a score of 1, and had dated 8/26/14 indicated pairment with a BIMS score of ression according to the endicated R52 had a mood dioral symptoms such as ions "of where do I go and I alzheimer's disease and re plan directed staff to and symptoms of increased essive symptoms. The care of to minimize behaviors by opriate methods of interacting, or such as interacting, or such as interacting to the care of the minimize behaviors by opriate methods of interacting, or such as interacting and interacting or such as interacting and interac	F3	329			

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F 329	redirect resident sh verbalizations (take snack, or visit). R52's monthly nurs assessment dated have a current behaproblem. R52's monthly nurs assessment dated behavioral sympton indicated behavioral sympton indicated behavioral toward others and in verbalization and in most of the time. The address revision of assessment indicates showers and routin of nursing notes, or on 9/18/14, no furth pertaining to being assessment period R52's physician's of included Celexa 10 major depressive devery a.m. and p.m. disorder. A pharmacy recommendation was 0 on 12/23/13 and 02/19/13, for demendisturbances and major the recommendation and the attempetation and the increase in berecommendation was commendation was commendation was recommendation was recommendation.	e make repetitive for a walk, offer coffee or ing documentation 2/13/15 indicated R52 did not avioral symptom/mood ing documentation 11/9/15 indicated R52 had n/mood problems and al symptoms were not directed ndicated R52 made repetitive terventions were not effective ne assessment did not the interventions. The ed R52 can be combative with e cares, however after review ne instance was documented are documentation was found combative during this rders reviewed on 3/11/15 milligrams (mg) daily for isorder and Seroquel 75 mg for major depressive mendation dated 1/13/14 read, peroquel 75 mg twice daily Celexa 10 mg daily since	F3	329		

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F 329	managing the increase The consulting phare recommendation for (GDR) of Seroquel the physician declire either medication. The consulting pharecommendation for February 2015. The and indicated the rebehaviors. The note evaluation of behaviors. The note evaluation of behaviors and indicated the rebehaviors of behaviors and indicated the rebehaviors. The note evaluation of behavior read "Behavior is snappy to family at A physician visit nomention of behavior read, "Discussed medications for now mg] tablets twice aslowly and steadilacked description medication was connon-pharmacologic A physician note damention of behavior read, "Alzheimer' worsening demention of services and services a	s were or how the facility was ease in behaviors. Immacist made a or a gradual dose reduction in September 2014 however, ned to attempt the GDR for a GDR of Seroquel in the MD declined to attempt GDR eason was disruptive to lacked assessment and viors. In were reviewed since January the dated 4/7/14 that included with a lacked assessment and viors. In the control behavior options of slowly discontinuing with a control behavior ly losing weight." The note of what the behavior the introlling or use/plan for	F3	329		
	mention of behavio read, "No anxiety, changes/concerns	clearly demented." ated 8/29/14 that included ral disturbance or depression depression, or memoryPatient is more agitated bleasant and cooperative ".				

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F 329	A physician note da mention of behavio read, "Worsening worsened dementia be angry and irritab quiet and tolerates she will refuse her decreased but activ weight is stable." A physician note da mention of behavio read, "Alzheimer' worse [does not ela worse] and "der stable, behaviors at movement disorder medication]." A physician note da mention of behavio read, " she has belouder with yelling a "I love you." Physician notes fat assessment and evassociated behavior dementia that would Seroquel and Celex A nursing note date R52 had behaviora indicate what the befrequency, and evanon-pharmacologic During an interview presence of facility consultant explaine GDR of Seroquel a the facility consider related to increased	atted 11/18/14 that included redisturbance or depression Alzheimer disease with a and decreased activitycan alle at times, but most times is her cares. There are times shower or cleaning. Appetite is vity level was decreased, so atted 11/28/14 that included real disturbance or depression is disease is stable to slightly aborate on how disease is mentia is stable, moods are restableno evidence of a side effect from psychotropic atted 2/6/15 that included real disturbance or depression come less activeat times is at other people; her main yell is a stable to address clinical require on-going use a at the same regimen. In a side 2/11/15 included mention of a disturbances however did not behavioral disturbances were, luation of	F3	129			

	OF CORRECTION I DENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 329	physician declined. there was not enourational to continue without attempting consultant also star wanted a dose reductions and set as March 2015 read, be done according Tapering may be sclinical condition nonpharmacologieffective in reducin must attempt GDR at least one month clinically contrainding the policy gave dir consider GDR's cowho received antippsychiatric disorder and read, consider physician has docuted for why any attemporal likely to impair the psychiatric instability underlying medical resident's target sy after the most received reduction within the documented the clinicallity"	Addations even though the Pharmacy consultant verified and documented clinical same doses of medication GDR. The pharmacy ted R52's family had not action of either medication. All the psychopharmacological edative/hypnotics last revised and action dose reductions must to federal regulations indicated when the resident' has improved or stabilized ical interventions have been attempts, unless cated." The ection to physicians to entraindicated for resident's sychotic medications to treat are (major depressive disorder) contraindication if, "the emented the clinical rationale ted dose reduction would be resident's function or cause ty by exacerbating an or psychiatric disorder, or the entraindical rational for why any dose reduction would likely is function or cause psychiatric	F3			4/21/15
F 332 SS=D	483.25(m)(1) FREE RATES OF 5% OR	E OF MEDICATION ERROR MORE	F3	32		4/21/15

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F 332	The facility must er medication error ra This REQUIREMED by: Based on observareview, the facility fresidents (R31, R3 accordance with phenomenaturer's guident medication error ra Findings include: R31's signed Order 3/4/15 had identifie "Fish Oil Capsule 5 Fatty Acids) Give 1	nsure that it is free of tes of five percent or greater. NT is not met as evidenced tion, interview, and document ailed to ensure 2 of 10 3) was given medication in	F 332	Medication times for Resident 31 h been changed to give her calcium vitamin D and C-Omega capsules t given with meals; all residents with medications were reviewed to ensumedication administration time was appropriate. A note was added to the MAR instructing nurses to give medications with food. For Resider note was added to the MAR to instructing nurses not to crush extended releamedications. All residents taking extended release medications were reviewed and notes added to their lease.	with to be similar ure the at 33, a ruct se	
	LIPOID METABOL "Citrucel/Vitamin D tablet by mouth two AFTERCARE HEA FRACTURE OTHE During observation on 3/10/15 at 4:03 (LPN)-A prepared F LPN-A removed a c along with a Sea-O supplement) for ad labels read, " w/ (w explained each me administered the m When interviewed in	SMTake with meals" and; Tablet 250-200 mg Give 1 to times a day related to LING TRAUMATIC IR BONEwith meals." of medication administration, o.m., licensed practical nurse R31's medications in her room. calcium with vitamin D tablet, mega capsule (a fish oil ministration. The medication vith) meals." LPN-B then dication to R31 and		are to not crush medication. A curr of medications that are not to be cr will be placed at the nurse s statio each area by 4/3/15. Facility will co medication pass audit on each shift weekly (3 audits per week) for 4 we and results will be reported to QAP results for further recommendations. Director of Nursing will be responsi ensure this standard is met.	rent list ushed n in nduct 1 t eeks I on s.	

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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE AUSTIN, MN 55912	, 33	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 332	p.m., LPN-A stated snack when she ta verified she had no "This is an un-norm she thought R31 ha around 2:30 p.m., he would eat was not LPN-A added, the rigiven with meals as orders and medica. R33's signed Orde 1/30/15, identified to "Tylenol Arthritis Pa 650 mg (Acetamina Give 1 tablet by morelated to AFTERC R33's signed order to crush R33's extended to AFTERC R33's signed order to crush R33's extended to RN)-A remodations for additional times and a signed to the hallway. RN-A including the Tylenol applesauce, and as RN-A stated she will the tylenol ER medications that are physician order direction should Further, LPN-C sai	R31 normally is eating a kes the medications, but of been during the observation, hal day today." LPN-B stated ad a cookie earlier that day, but verified the next meal R31 until after 5:00 p.m. Further, medications should have been as directed by the physician tion labels. Treat Summary Report, dated the following order: ain Tablet Extended Release ophen ER [extended release]) buth in the morning for Pain ARE FOLLOW SURGERY" as did not identify any guidance ended release medications. Deservation of medication 3/11/15 at 8:37 a.m., registered a bottle of Tylenol from a om, and prepared his ministration at a mobile cart in crushed R33's medications, of ER, mixed them with dministered them to R33. as aware she had crushed the tion, but always does so	F 332			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245317	B. WING		03/	12/2015
	PROVIDER OR SUPPLIER	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE AUSTIN, MN 55912	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 332	R33's medical doctor should be given as "ordered that way for was unaware R33's crushed, and stated medication should have been good been good by the policy of medication after very administration by coto the Medication A facility Administration by coto the Medication A fact the policy of medications after very administration by coto the Medication A fact three times after the policy of the Medication A fact three times after the policy of the Medication A fact three times after the policy of the Medication A fact three times after the policy of the Medication A fact three times after the policy of the Medication A fact three times after the policy of the Medication A fact three times after the policy of the Medication A fact three times after the policy of the Medication A fact three times after the policy of the Medication A fact three times after the policy of the Medication A fact three times after the policy of the Medication A fact three times after the policy of the Medication A fact three times after the policy of the Medication A fact three times after the policy of the Medication A fact three times after the policy of the Medication A fact three times after the policy of the Medication A fact three times after the policy of the Medication A fact three times after the policy of the Medication A fact three times are three thre	of. 3/11/15, at 2:35 p.m. R31 and or (MD) stated medications ordered as they are written, or a reason." Further, the MD ER medication was being an order to crush ER nave been obtained before on 3/11/15, at 3:48 p.m., the sist (CP) stated she was g staff was crushing R33's ER denol should not have been wes the extended release ages the way it is absorbed by the CP stated all MD orders and R31's medications given with meals as directed. 3/11/15, at 4:11 p.m. the DON) stated all MD orders	F3	32		
F 425		RMACEUTICAL SVC -	F 4	25		4/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245317	B. WING	B. WING		03/12/2015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP COD 1201 17TH STREET NE AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 425 SS=D	ACCURATE PROC The facility must prodrugs and biological them under an agre §483.75(h) of this punlicensed personnel law permits, but on supervision of a lice. A facility must prove (including procedur acquiring, receiving administering of all the needs of each in the facility must error a licensed pharmace.	ovide routine and emergency als to its residents, or obtain element described in part. The facility may permit all to administer drugs if State by under the general ensed nurse. Ide pharmaceutical services es that assure the accurate plants, and drugs and biologicals) to meet resident.	F	425			
	by: Based on observareview, the facility femergency medical of 1 facility emerge to affect all 44 residuation. In addition correct medication (R33) observed to Findings include:	tion, interview, and document ailed to have non-expired tion readily available for use in gency kits. This had potential dents in the facility that could redication in an emergent on, the facility failed to ensure labeling for 1 of 10 residents receive medication pass.		Emergency medication kit was by pharmacy and a new one w to the facility on 3/10/15; no exmedications were given to resi Resident 33, the physician claimedication pass time and the was relabeled and put in the M correctly for the physician order According to the pharmacy conthis medication can be given a the day. All medications were ensure correct labeling. Re-Edbe provided to all nurses on contents.	as provided pired dents. For iffied the medication AR r. nsultant, ny time of checked to ducation will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245317	B. WING			03/	12/2015
	PROVIDER OR SUPPLIER			12	REET ADDRESS, CITY, STATE, ZIP CODE 201 17TH STREET NE USTIN, MN 55912	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOL		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	with registered nup.m., the only facisupply of medicate emergency situatismedications. RN-been delivered by week. The kit was were checked for following three meexpired: Two vials of 1 ml used for severe prour tablets of 0.5 (an anti-psychotic 1/31/15. Two tablets of 0.1 high blood pressured when interviewed checked and verifications and verifications are replied, "No During interview of stated the medication RN-D replied, "No stated the medication and process to more the emergency kit dispensing pharm medications. When interviewed the medications.	redication storage in the facility rse (RN)-D, on 3/9/15 at 6:49 lity emergency kit (a small ions kept on hand in-case of an on) was checked for outdated D stated it had just recently the pharmacy the previous sopened, and the medications outdated medications and the edications were found to be (milliliter) morphine (medication ain), expired on 2/2015. If medication, expired on 1/7/15. If on 3/9/15, at 7:13 p.m., RN-D ied the three medications in the re expired, and available for asking RN-D if a system for ations for outdates was in place is used in the emergency kit lot that I am aware of at least." If on 3/9/15, at 7:21 p.m. RN-C tions in the emergency kit ired, and verified the facility had not for expired medications in the acy to check for outdated. If on 3/10/15, at 2:23 p.m. the acist (CP) stated the emergency	F	125	entry by 4/3/15. Facility will conduct medication pass audits on each she weekly (3 audits per week) for 4 wand results will be reported to QAF results. Director of Nursing will be responsible to ensure this standard met.	iift eeks 1 on	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		245317	B. WING		03	/12/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 1201 17TH STREET NE AUSTIN, MN 55912	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 425	an investigation we the expired medical facility in the past of there should not be emergency kit. During interview of Pharmacy the displayed found in the emergency (3/10/15), but were medications had esending to the facility emergency (3/10/15), but were medications had esending to the facility. When interviewed director of nursing should be tracking emergency kit for to do it." Further, medications in the allowed to expire bresident use. MISLABELED ME During an observate administration on a prepared R33's medical in the past of the pa	y Sterling Pharmacy, and that ould be completed regarding ations as this kit was sent to the week. Further, CP said that e expired medications in the on 3/10/15, at 2:35 p.m., Sterling pensing pharmacy (DP) was not the expired medications gency kit they supplied to the week. The DP stated the kit had been replaced that day e unaware how some of the expired and not replaced before lity. DP-A then added, by error." The DP-A stated they red medications would be ending the emergency kit to the expiration, "I expect them just the DON stated the hexpiration, "I expect them just the DON stated the kit should not have been because they were available for DICATION: Ition of medication 3/11/15, at 8:37 a.m. RN-A edications at a mobile cart in dication package was provided	F 4	25		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245317	B. WING			03/	12/2015
	PROVIDER OR SUPPLIER			120	REET ADDRESS, CITY, STATE, ZIP CODE D1 17TH STREET NE JSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	[milligrams] TAK EVERY NIGHT AT the medications ar When interviewed stated R33 had alvin the morning, degive it at bedtime. next to the label, be when that had bee Further, the facility packaging system other medications pharmacy that was R33's signed Order 1/30/15, identified Capsule 0.4 mg [Tacapsule by mouth UNSPECIFIED REDURING Interview or consulting pharmacy in the consulting pharmacy i	CAP [capsule] 0.4 MG IE 1 CAPSULE BY MOUTH BEDTIME." RN-D prepared and administered them to R33. On 3/11/15, at 8:45 a.m. RN-A ways been given the medication spite the label identifying to Staff had written, "AM [a.m.]" at RN-A was not sure who, nor an written on the package. had just switched to a new for their medications and had recently come from the smislabeled. If Summary Report, dated the following order, "Flomax amsulosin HCL) Give 1 in the morning related to ETENTION OF URINE" In 3/11/15, at 3:48 p.m. the cist stated tamsulosin could be with a sticker directing staff to orders. A mislabeled ead to an error, and the facility cted the pharmacy to have the	F	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(×	(X3) DATE SURVEY COMPLETED	
		245317	B. WING			03/	12/2015
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - COMFORCARE				STREET ADDRESS, CITY, STATE, ZIP CO 1201 17TH STREET NE AUSTIN, MN 55912)DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BI		(X5) COMPLETION DATE
F 425	"Medications are la facility requirement. Only the dispensing change prescription directed staff, "If the change or the label place a "change of MAR [medication a the container indicadirections for use 483.60(b), (d), (e) LABEL/STORE DR The facility must enalicensed pharmacof records of receip controlled drugs in accurate reconciliar records are in orde controlled drugs is reconciled. Drugs and biological abeled in accordar professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartment.	Medication Labels policy read, beled in accordance with and state and federal laws. It is pharmacy can modify or a labels." Further, the policy is physician's directions for use is inaccurate, the nurse may order-check chart" or "see dministration record]" label on atting there is a change in "DRUG RECORDS, RUGS & BIOLOGICALS and disposition of all sufficient detail to enable and tion; and determines that drug and that an account of all maintained and periodically als used in the facility must be not with currently accepted oles, and include the ory and cautionary e expiration date when State and Federal laws, the all drugs and biologicals in the sunder proper temperature to only authorized personnel to	F 4	431			4/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245317	B. WING _		03/	12/2015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP COL 1201 17TH STREET NE AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 431	permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distri quantity stored is more be readily detected. This REQUIREMENT by: Based on observatoreview, the facility for controlled drugs list.	ovide separately locked, I compartments for storage of red in Schedule II of the rug Abuse Prevention and and other drugs subject to rug the facility uses single unit bution systems in which the inimal and a missing dose can NT is not met as evidenced ion, interview, and document ailed to implement policies and	F 4:	The updated facility procedur Fentanyl patch destruction wa	as provided		
	of Fentanyl (a narco duragesic patches of This had potential to (R18, R6, R104, and orders for Fentanyl facility. Findings include: During review of The room, on 3/9/15 at (RN)-D opened a local resident narcotic modes were observed facility protocol for opatches was and Reprotocol is." RN-D personal practice wit to a piece of paper medication room under the served served and the served ser	ntil another nurse could help ng, "Not everybody does it that		for licensed nursing staff. Nur- re-educated on how to find up nursing policies and what the for destruction of Fentanyl pat 4/3/15. Nurses will be audited month on correct destruction of patches and results will be giv QAPI committee for further recommendations. Director of be responsible to ensure this met.	odated new policy is tches on weekly for 1 of Fentanyl ven to the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245317	B. WING			03/	12/2015
	PROVIDER OR SUPPLIER			1201	EET ADDRESS, CITY, STATE, ZIP CODE I 17TH STREET NE STIN, MN 55912	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	on 3/9/15 at 7:51 pcabinet containing and Fentanyl patel stated Fentanyl patel stated Fentanyl patel placed in a sharps removable lid that objects) and that he facility "since I star stated she had newhow to dispose of stating, "I can't reconstruction of the facility stated she had newhow to dispose of stating, "I can't reconstruction of the facility of the facility, and had accomplished the facility, and had accomplished the facility, and had accomplished the facility of the facility of the facility, and had accomplished the facility of the facility o	he Garden medication room, o.m., RN-A opened a locked resident narcotic medications, on boxes were observed. RN-A tches were to be folded and container (a container with a is used to dispose of sharp and been the practice of the ted here." Further, RN-A ver received any education on used Fentanyl patches by all anything on it." The Lodge medication room, on I., licensed practical nurse locked cabinet containing medications, and Fentanyl patch ved. LPN-G stated she started lity about a month prior, and I Fentanyl patches for residents in the sharps container. I know, that is the policy." The stated she was not provided any a facility on how to dispose of the then said, "I have to get to inquiring what the facility cruction of Fentanyl patches. The stive orders for Fentanyl	F	131			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245317	B. WING _		03/	/12/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441 SS=F	facility used to disp When interviewed of director of nursing of the facility, but was used Fentanyl patc containers by statin Further, the DON s should be followed, them to follow it." The facility Transded dated 9/2012, ident "When removing a caution to protect s the medicated side a plastic bag for tradisposal. It is not a in a sharps contain contains a controlled disposed of and was substance. The FE duragesic patches. nurses always sign patches." 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Prisafe, sanitary and of the prevent the of disease and infection Control.	hat policy or procedure the ose of their patches. on 3/10/15, at 2:46 p.m. the (DON) stated she was new to aware staff was disposing of hes in the facility sharps g, "That is the practice here." tated policies and procedures "If I write a policy, I expect ermal Patch Application policy, ified a procedure including, previously used patch, use kin. Fold the patch in two with stogether. Place old patch in insport to medication room for cceptable to put used patches er." Further, "If the patch disubstance it must be sted as any controlled DA recommends flushing A best practice is that two for destruction of narcotic I CONTROL, PREVENT tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control	F 44			4/21/15

AND DUAN OF CODDECTION INDESTRUCTION NUMBER.		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245317	B. WING			03/-	12/2015
	PROVIDER OR SUPPLIER			12	TREET ADDRESS, CITY, STATE, ZIP CODE 201 17TH STREET NE USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	in the facility; (2) Decides what personnel must had a policided. (3) Maintains a reconstruction actions related to in the interest of the int	controls, and prevents infections or occedures, such as isolation, to an individual resident; and cord of incidents and corrective infections. ead of Infection oction Control Program resident needs isolation to dof infection, the facility must it. In the infection of infection of infection of infection, the facility must it. In the infection of infectio	F 4	.41			
	by: Based on observareview, the facility infection control prosurveillance of moinfection organism putting timely interinfection/s. This in and R108 with cur	exion, interview and document failed to operationalize their rogram that included consistent onitoring and tracking of s, monitoring symptoms, and ventions to prevent spread of cluded residents (R36, R106 rent significant infections and o affect all residents living in the			Resident 36 and 106 is healed from infection; resident 108 was dischart 3/19/15. All nursing staff will be re-educated on appropriate use of (PPE) when testing blood glucose monitoring per GSS Infection Contraction procedure on 4/3/15. Facility will fo GSS policy and procedure on infection tracking and trending for	ged on gloves fol llow	

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	PROVIDER OR SUPPLIER			12	TREET ADDRESS, CITY, STATE, ZIP CODE 201 17TH STREET NE .USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	facility also the factor adequate personal (gloves) when post glucose testing for observed to have the served were obtained. The facility 's more record were obtained to lack date resident room local and trending of spontrol precautions infection, whether obtained (or ration differentiation of which resident and analysis, and if cull identify organisms infection and appropriate that had a antibiotics used durinfections. During the month indicated the facility of those were one was on the Gainfections (UTI) s. were treated with santibiotics). The month of the server one was on the Gainfections (UTI) s. were treated with santibiotics). The month of the server of the server one was on the Gainfections (UTI) s. were treated with santibiotics). The month of the server of t	ility failed to ensure staff wore I protective equipment (PPE) sible contact with blood during r 1 of 2 residents (R1) their blood glucose checked.	F 4	141	infections. Audits will be conducted randomly for using proper PPE who blood contamination is possible for month. Results will be shared at the QAPI committee for further recommendations. Nurse Manage be responsible to ensure this standard.	en 1 ie ers will	

AND BLAN OF CORRECTION IN IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245317	B. WING		····	03/12/2015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- COMFORCARE		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 201 17TH STREET NE NUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	was treated with the Azithromycin, Doxy the summary lacke location of resident infection and sympt was treated with whused to prevent the summary record als sensitivity of the infresolution date of ir monthly summary lof infections, antibio organisms. During the month of summary of infection the Healing Grace and one on the Garfour of the infection Ciprofloxacin were the infection case was skin infection (shing and one gastroente (CDIFF)) case was Again the summary location of resident symptoms of infection which resident was and culture and ser organism, and resomething summary in the reduce or prever ongoing evaluation	ge 32 ower respiratory infection that ese three antibiotics cycline, and Teflaro. However, d date of onset of infections, associated symptoms of the om analysis, which resident nich antibiotic, and precautions spread of infection. The so failed to identify culture and ection causing organism, and ection. Also the facility acked evaluation and analysis otic usage trend, and prevalent of February 2015 the monthly ons record indicated the total s were six; three infections on unit, two on the Lodge unit, den unit. The record revealed s were UTIs; Amoxicillin and the antibiotics used to treat lower respiratory tract treated with Azithromycin, one eles) treated with Acyclovir, writis (Clostridium Difficile treated with Ciprofloxacin. Trecord failed to identify to onset of infection, associated on and symptom analysis, treated with which antibiotic, estivity of the infection causing lution date of infection. The eport also lacked interventions of infection, and analysis of infections and the trend, and prevalent	F	141			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		TE SURVEY MPLETED
		245317	B. WING _		03	/12/2015
	PROVIDER OR SUPPLIER	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP CO 1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	facility admission reincluded diverticulity Parkinson's disease. A nursing note date daughter requested urinary urgency and based off the dauge. A nursing note date physician ordered times per day for 1 analysis showed withe sample will be anything different a started." Nursing notes were and it was noted the symptoms of UTI esince the nursing motes also did not a of antibiotic or clariculture report as the between the two plens of the according to the accor	on 10/27/14 according to the ecord with diagnoses that tis of the colon, dementia, e, and congestive heart failure. ed 2/21/15 indicated R36's d a urinalysis related R36's d an order were obtained hter's request. ed 2/22/15 indicated a Cipro 250 milligrams (mg) two 0 days. The note read, "The hite blood cells and bacteria, cultured, if the culture shows a new med [medication] can be a read from 2/22/15 to 3/11/15 at no further mention of experienced by the resident tote dated 2/22/15. Nursing address clarification of during fication on the bacterium ere was a discrepancy hysicians. If to the facility on 1/27/15 dmission record with diagnoses of limited to, diabetes and exweakness.	F 44			

_	ND DI AN OF CODDECTION IN IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245317	B. WING			03/-	12/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- COMFORCARE		120	REET ADDRESS, CITY, STATE, ZIP CODE D1 17TH STREET NE USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		BE	(X5) COMPLETION DATE
F 441	urine specimen wa absence of anothe integrity. Nursing n physician ordered of ten days and R106 amber and cloudy. What the urinalysis 3/1/15 and 3/2/15 i clear. The next nursing n acknowledged morwas on 3/5/15; the urine was yellow, rodated 3/7/15 explaiback pain, the urine blood clots were pringed. The author placed to a clinic noculture and sensitive bacteria causing in Resistant Staphylo the Cipro was resist indicated new order included Doxycycliaten days and Amox day for 10 days. However, the MRS was identified or in control log nor interdeveloped. R108 was admitted according to the acco	budy and blood tinged and a sobtained for analysis in the resymptom other than urine ote dated 2/28/15 indicated a Cipro 250 mg twice per day for 's urine continued to be dark. This note lacked mention of revealed. Nursing notes dated indicated R106's urine was	F	141			

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

	OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED	
		245317	B. WING		03/	12/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIES OF THE AP	ILD BE	(X5) COMPLETION DATE
F 441	Flagyl 500 mg four related to C-Diff (last 500 mg twice per didiverticulitis (last do Nursing notes from indicated R108 was continued to have a Nursing notes from not reflect consister of antibiotic treatmed lack thereof. A nursing note date continued to have low mention of follow-up Nursing note dated having more loose cramping. The note and notify primary of worsens." Nursing inthrough 3/6/15 indicepisodes of loose sereflected R108 discriptional intolerant and facilit Nursing noted date continued to have a physician order had C-Diff culture. A nursing note string. Nursing note that continued to have a physician order was times per day for 14 though culture resured. During an interview registered nurse (R	ohysician orders included times a day for 14 days st dose 2/25/15) and Cipro ay for 10 days related to	F4	41		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

AND DUAN OF CORRECTION IN INDER CONTRACTOR OF CORRECTION OF CORECTION OF CORRECTION OF CORRECTION OF CORRECTION OF CORRECTION OF		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245317	B. WING _		03	/12/2015
	PROVIDER OR SUPPLIER	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP COE 1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	catch-up the infect had been behind. If (DON) both explair take urine cultures symptoms despite A facility policy infer policies/procedures. November 2014 redesigned to identify infection collecting data will be done be designated staff." A facility policy infer policies/procedure revised November surveillance and in this policy did not grecord infections surveillance and in this policy did not grecord infections surveillance and in this policy did not grecord infections surveillance and in this policy did not grecord infections. LACK OF GLOVES CHECKS: During observation on 3/11/15 at 11:38 prepared to check Accucheck device glucose when a sat RN-A wiped R1's firm preparation pad, at lancet exposing blothave gloves on whiglucose. RN-A the machine in R1's care	nonths ago and she had to tion control logs because they RN-I and the director of nursing ned physicians do not always even in the absence of three encouragement of facility staff. ction control is Surveillance last revised ad, "Outcome surveillance is y and report evidence of adocumenting and analyzing the infection preventionist or	F 44			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245317	B. WING			03 /	12/2015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- COMFORCARE		120	REET ADDRESS, CITY, STATE, ZIP CODE 11 17TH STREET NE STIN, MN 55912		-,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 441	stated she normally a residents blood ginfection when exported them on." During interview on stated the facility has that were to be followed blood glucose, and on when checking feverybody's protect. When interviewed of director of nursing (worn if handling any should put your glowed and	on 3/11/15, at 11:46 a.m. RN-A wears gloves when checking lucose because of the risk of osed to blood, "I normally have 3/11/15, at 1:48 p.m. RN-E ad policies and procedures owed for checking a residents RN-A should have had gloves R1's blood glucose "for	F 4	141				

PRINTED: 03/30/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	30 25		E CONSTRUCTION 12 - BUILT IN 2007		E SURVEY IPLETED
		245317	B. WING			03/	10/2015
	PROVIDER OR SUPPLIER	- COMFORCARE		12	REET ADDRESS, CITY, STATE, ZIP CODE 101 17TH STREET NE USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE	(X5) COMPLETIC DATE
K.000	INITIAL COMMEN	TS	K	000			
	FIRE SAFETY						
	ALLEGATION OF DEPARTMENT'S ASIGNATURE AT THE PAGE OF THE CM VERIFICATION OF UPON RECEIPT CON-SITE REVISIT CONDUCTED TO SUBSTANTIAL COREGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE					
	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				EPOC		
	DEFICIENCIES						

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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION 02 - BUILT IN 2007	COMPLETED		
		245317	B. WING			03/	10/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- COMFORCARE		1.	TREET ADDRESS, CITY, STATE, ZIP CODE 201 17TH STREET NE NUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Angela.Kappenmar	.Whitney@state.mn.us and	K	000			
	DEFICIENCY MUS FOLLOWING INFO	T INCLUDE ALL OF THE PRMATION: what has been, or will be, done					
	2. The actual, or pro3. The name and/or responsible for corre	pposed, completion date.		:			
	building with no bas	ciety Comforcare, is a 1-story ement. The building was and was determined to be of ction.					
	fire alarm system widetection, spaces of monitored for autom notification. There i rooms that are mon	sprinklered. The facility has a lith full corridor smoke pen to the corridors that is natic fire department s smoke alarm in all resident itored by the nurse call eside each resident room.					
	census of 44 at the	42 CFR, Subpart 483.70(a) is				•	***************************************

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION D2 - BUILT IN 2007		SURVEY PLETED
		045047	B. WING			026	10/2015
NAME OF E	PROVIDER OR SUPPLIER	245317	D. WING		FREET ADDRESS, CITY, STATE, ZIP CODE	U3/	10/2015
	AMARITAN SOCIETY	- COMFORCARE			201 17TH STREET NE USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 050 K 050 SS=D	Fire drills are held a varying conditions, The staff is familiar that drills are part of Responsibility for passigned only to coqualified to exercise conducted between	age 2 FETY CODE STANDARD at unexpected times under at least quarterly on each shift. with procedures and is aware of established routine. lanning and conducting drills is empetent persons who are the leadership. Where drills are of 9 PM and 6 AM a coded by be used instead of audible	;)50)50			4/14/ 15
	Based on review o interview, it was de to conduct the requeach shift in the las accordance with NF	s not met as evidenced by: f reports and records and termined that the facility failed ired number of fire drills for it 12-month period in FPA 101 LSC (00) Section ient practice could affect how ent of a fire.			A new schedule was created to en Fire Drills are completed on a monbasis for each shift. The Evening sold drill was conducted during the first quarter of 2015. The completion dathis will be schedule will be April 14. The person to monitor and ensure being completed is the Environment Services Director.	thly shift fire ate for 1, 2015. this is	
	1:00 PM on 03/10/2 available document drills have not been per quarter basis.	our between 09:00 AM and 2015, based on review of tation it was reveled that fire a conducted on a one per shift to Evening conducted during the 4th			The results of these fire drills will be reported to the Safety Committee a QAPI committee each month.		
K 141	facility Environment time of discovery.	ice was confirmed by the tal Service Director (PC) at the FETY CODE STANDARD	K ·	141			4/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - BUILT IN 2007	(X3) DATE SURVEY COMPLETED		
		245317	B. WING		03/1	0/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- COMFORCARE	1	TREET ADDRESS, CITY, STATE, ZIP CODE 201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 141 SS=C	where oxygen is us with 18.3.2.4, NFPA This STANDARD is Observations reversions reversions and oxygen storage coupatients, guests and Findings include: During the facility to 1:00 PM on 03/10/2 oxygen was being a Room across from Room South wing, door stating "CAUT STORED WITHIN.	no smoking signs in areas sed or stored are in accordance A 99, 8.6.4.2. Is not met as evidenced by: aled that the two oxygen not have proper safe-guard rs. Failure to properly sign ald poses a hazard to the d staff. Our between 09:00 AM and 2015, observation reveled that stored in Oxygen Storage the IT room & Oxygen Storage without proper signage on the TON - OXIDIZING GASES - NO SMOKING" as required	K 141	New signs will be placed at each of storage room by April 21st, 2015. Environmental Services Director was responsible for ensuring the signs posted. The results will be shared at the Q Committee meeting.	The ill be are	
		edition) 8-3.1.11.3: ice was confirmed by the tal Service Director (PC) at the				



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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.

Good Samaritan Society - Comforcare March 20, 2015 Page 2

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, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Kumalu Fishe Downing

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 04/17/2015 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00967 03/12/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE **GOOD SAMARITAN SOCIETY - COMFORCARE** AUSTIN, MN 55912 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to

INITIAL COMMENTS:

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota

the Department within 15 days of receipt of a notice of assessment for non-compliance.

Minnesota Department of Health

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

TITLE

(X6) DATE

Electronically Signed

03/30/15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 BOILBING.			
		00967	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- COMPORCARE	H STREET N MN 55912	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Department's sand the following or Please indicate in your and identify the dat Minnesota Department's the State Licensing federal software. To assigned to Minnesota Department's sand the following or Please indicate in your and identify the dat Minnesota Department of the State Licensing federal software. To assigned to Minnesota Department estate Licensing federal software. To assigned to Minnesota Department of the State Licensing federal software. To sassigned the minnesota Department of the State Licensing federal software. To sassigned the Minnesota Department of the State Licensing federal software. To sassigned the Minnesota Department of the State Licensing federal software. To sassigned the Minnesota Department of the State Licensing federal software. The assigned tag in the State Licensing federal software in the State Licensing federal software. The sassigned to Minnesota Department of the State Licensing federal software. The sassigned to Minnesota Department of the State Licensing federal software. The sassigned tag in the State Licensing federal software in the State Licensing federal software. The sassigned to Minnesota Department of the State Licensing federal software. The same software in the State Licensing federal software in the State	alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading le date your orders will be electronically submitting to the ment of Health. 1, and 12, 2015, surveyors of staff, visited the above provider orrection orders are issued. Your electronic plan of have reviewed these orders, he when they will be completed. The enem of Health is documenting agr numbers have been sota state statutes/rules for the state statutes for the enem of Deficiencies" column for Comply" portion of the his column also includes the in violation of the state statute for the surveyors findings method of Correction and trection. ARD THE HEADING OF THE				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00967		B. WING		03/	12/2015
NAME OF I	PROVIDER OR SUPPLIER			DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE	-	MN 55912	L		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCII / MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 000	Continued From page 2			2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.						
2 302	MN State Statute 14 or related disorder t		s disease	2 302			4/21/15
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144.	ING:	D				
	(a) If a nursing facil Alzheimer's disease or related of segregated or gene care staff and their supervisor care.	disorders, whether in eral unit, the facility's	n a s direct				
	(b) Areas of require (1) an explanation of related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequent	of Alzheimer's disea activities of daily livi with challenging be skills. provide to consume form a description be categories of emp	ing; haviors; ers in of the bloyees				
	topics covered. (d) The facility shall this section. This MN Requirements:	·					

Minnesota Department of Health

STATE FORM 6899 TET011 If continuation sheet 3 of 45

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	
		00967	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- COMFORCARE	STREET N	E		
	AMAIIITAN OOOILIT	AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 3	2 302			
	Based on interview and document review, the facility failed to provide required staff training for Alzheimer's disease and related dementia education.			Director of Nursing will be responsensuring direct care staff have the training for dementia type behavio according to state regulations.	correct	
	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.					
	care staff and their	sing could in-service all direct supervisors on how to work ementia type behavior. This				

Minnesota Department of Health

STATE FORM 6899 TET011 If continuation sheet 4 of 45

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N		, ,	E CONSTRUCTION	(X3) DATE COMPI	
		00967		B. WING	·····	03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE		H STREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI / MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 302 2 565	Continued From pa should at a minimu Alzheimer's disease assistance with acti solving with challen communication skil could maintain a lis frequency of trainin could monitor staff TIME PERIOD FOR (21) days.	m include explanaties and related disordivities of daily living, ging behaviors, and ls. The director of not of staff attendance g. The director of not compliance. R CORRECTION: T	lers, problem d ursing e and ursing	2 302			4/21/15
	Plan of Care; Use Subp. 3. Use. A comust be used by all care of the resident This MN Requirement	omprehensive plan I personnel involved i.	of care I in the				
	by: Based on observation review, the facility for interventions for skip were followed by stransition reviewed for a stransition for skip were followed by stransition for skip were for skip	ailed to ensure care in protection and na aff for 2 of 3 resider activities of daily living DTECTION: Minimum Data Set (fied R106 had modult, and required ext	e planned ail care nts (R106, ng. MDS), erate		Resident 106 and 33 had nails trim immediately. Protective skin care is provided to resident 106 immediate putting heels up off the bed as direction the care plan. All resident is risked to ensure nails were trimmed and clean. All residents not protective skin care were checked ensure the care plan was being foll Nail care policy and protective skin education will be provided to all nurstaff on 4/3/15. Audits will be condition weekly for 1 month. The audits will reported to QAPI. Director of Nursibe responsible to ensure this standard	was ely by cted nails eeding to lowed. care rsing ucted I be ing will	

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00967	B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE	H STREET N MN 55912	IE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 5	2 565			
	1/28/15, identified, heel when in bed w plan, dated 1/29/15 skin impairment on intervention of, "ele his risk of further properties of the	cumentation Notes, dated "Elevate feet + (and) protect ith cushion." R106's care, identified R106 had a curren his coccyx, and identified an vate heels off bed", to reduce ressure ulcer development. of morning cares, on 3/12/15, g assistant (NA)-D entered from to provide care with the moved the white linen covering the pair of cotton socks. Ilying directly on the bed, not d by the care plan. A blue (used to help elevate heels is lying on the floor, propped up the foot of R106's bed.	1	met.		
	were not elevated we complete morning of plan should have been end of the should have	NA)-D verified R106's heels when she entered the room to care. Further, R106's care een followed, and his heels elevated as directed. 3/12/15, at 8:48 a.m. licensed N)-B stated R106 was at risk on his heels, and the care should have been followed by on 3/12/15, at 12:19 p.m. the (DON) stated a resident 's to guide a resident's care, and followed. policy, dated 2/2013,				
	identified, "The care	policy, dated 2/2013, e plan will emphasize the care f the whole person ensuring				

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-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00967		B. WING		03/	12/2015
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE		H STREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 565	that the resident will services." LACK of NAIL CAR R33 was observed 3/11/15, at 8:52 a.m a.m. revealed R33 hands and dried brothe nails. The facility admissical admitted to the facility admissical admitted to the facility and Parkin R33's quarterly Min 12/16/15 indicated with a Brief Intervies score of 3 and requistaff members to progrooming tasks. R33's most recent of facility on 3/12/15 in care weekly on bath During an interview nursing assistant (Norwing assistant is provided nail care for "Sometimes me and out, or we will do it NA-B explained nail and in the case of report to the nurse. During an interview NA-C (worked as the assistant) stated, "I of the time, once a just up to me. The rit." During an interview registered nurse (R	Il receive appropriate E: on 3/10/15, at 9:28 and, and on 3/12/15, and and an allong finger nails own debris was under on record indicated lity on 11/25/2013 are of but not limited to son's disease. imum Data Set (MD severe cognitive implementation of Mental Status (allowed extensive assistation or residents as needed on 3/12/15, at 7:56 NA)-B stated the rest the primary person or residents. NA-B sed the other aide will allowed in the sident refusal NA's esident refusal NA's	a.m., t 7:55 on both erneath R33 was ad dementia, S) dated vairment BIMS) t from two ene and y the vide nail d. a.m. orative that tated, do to help are dirty." nower day, would a.m. g e majority but it's not s also do a.m. uils were	2 565			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMPI	
		00967	B. WING		03/12/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE 1201 17TH AUSTIN, M	ISTREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565 2 860	explained R33 used RN-A then stated sigot trimmed and cle A facility procedure November 2013 did often nail care show SUGGESTED MET The director of nursipolicies to ensure signification policies. Director of staff to provide care the director of nursicompliance. TIME PERIOD FOR (21) days. MN Rule 4658.0520	d his hands quite a bit to eat. he would make sure the nails eaned. nail care last reviewed on and not give direction on how ald be provided. HOD OF CORRECTION: sing could review and revise taff provided care according to nursing could inservice all e according to the care plan. Sing could monitor staff R CORRECTION: Twenty-one	2 565			4/21/15
	Proper Nursing Car Subp. 2. Criteria for proper care. The cadequate and proper. Proper care and attringernails and toe trimmed. This MN Requirements: Based on observation review, the facility for dependent resident 1 of 3 residents (R3 daily living. Findings included: R33 was observed.	e; Hands-Feet or determining adequate and riteria for determining		Resident 33 had nails trimmed immediately. All resident s nails we checked to ensure nails were trimmed to all nursing staff on a Audits will be conducted weekly for month. The audits will be reported QAPI for further recommendation. of Nursing will be responsible to en	med and on will 4/3/15. r 1 I to Director	

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				71. 5012511143.			
		00967		B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- COMFORCARE		H STREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 860	Continued From pa	age 8		2 860			
2 860	a.m. revealed R33 hands and dried br the nails. The facility admissi admitted to the faci included diagnoses anxiety, and Parkin R33's quarterly Mir 12/16/15 indicated with a Brief Intervies core of 3 and requistaff members to purious grooming tasks. R33's most recent facility on 3/12/15 in care weekly on bat care plan did not in During an interview nursing assistant (Inursing assistant is provided nail care for "Sometimes me and out, or we will do it NA-B explained na and in the case of report to the nurse. During an interview NA-C (worked as the assistant) stated, "I of the time, once a not just up to me. To do it." During an interview registered nurse (Flong and dirty and sexplained R33 user RN-A then stated sigot trimmed and clean control of the stated sigot trimmed and clean care in the province of the stated sigot trimmed and clean care in the province of the stated sigot trimmed and clean care in the province of the stated sigot trimmed and clean care in the province of the stated sigot trimmed and clean care in the province of the stated sigot trimmed and clean care in the province of the stated sigot trimmed and clean care in the province of the stated sigot trimmed and clean care in the province of the stated sigot trimmed and clean care in the province of the stated sigot trimmed and clean care in the province of the stated sigot trimmed and clean care in the province of the stated sigot trimmed and clean care in the province of the stated sigot trimmed and clean care in the province of the stated sigot trimmed and clean care in the province of the stated significant sta	had long finger nails own debris was under the control indicated extensive assist the control indicated the control indicated the control indicated the control indicated indicated the control indicated	erneath R33 was and a dementia, PS) dated pairment (BIMS) at from two ene and and and the point of the path was. a.m. torative that stated, do to help are dirty." hower day, would a.m. g e majority but it 's aides also a.m. aills were RN-A also bit to eat. at the nails	2 860	this standard is met.		

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00967	B. WING		03/1	03/12/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- COMFORCARE	H STREET N	E			
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	MN 55912	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE	
2 860	Continued From page 9		2 860				
	The director of nurs policies to ensure n residents. The dire staff to provide nail director of nursing of	ald be provided. THOD OF CORRECTION: sing could review and revise rail care was provided to all rector of nursing could inservice care according to policy. The could monitor compliance. R CORRECTION: Twenty-one					
	. , ,						
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and con E. a resident he immunization progr defined in part 465 procedures of resid the prevention and F. the development of the procedures of resident procedures, including defined in part 4656 G. a system for H. a system for	ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 3.0815; r reviewing antibiotic use; r review and evaluation of lect infection control, such as eptics, gloves, and	21390			4/21/15	

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	
		00967	B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE 1201 17TH AUSTIN, M	H STREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	0 Continued From page 10		21390			
	I. methods for maintaining awareness of current standards of practice in infection control.					
	by: Based on observation review, the facility for infection control prosurveillance of more infection organisms putting timely intervinfection/s. This incompand R108 with current had the potential to facility also the facility a	ent is not met as evidenced on, interview and document ailed to operationalize their ogram that included consistent nitoring and tracking of a, monitoring symptoms, and entions to prevent spread of luded residents (R36, R106 ent significant infections and affect all residents living in the ity failed to ensure staff wore protective equipment (PPE) ible contact with blood during 1 of 2 residents (R1) neir blood glucose checked.		Resident 36 and 106 is healed fro infection; resident 108 was discha 3/19/15. All nursing staff will be re-educated on appropriate use of (PPE) when testing blood glucose monitoring per GSS Infection Con procedure on 4/3/15. Facility will for GSS policy and procedure on infecontrol tracking and trending infect Audits will be conducted randomly using proper PPE when blood contamination is possible for 1 mc Results will be shared at the QAP committee for further recommend. Nurse Managers will be responsible ensure this standard is met.	rged on gloves trol bllow ction tions. for both.	
	record were obtained. February 2015. The noted to lack date or resident room locat and trending of spreading control precautions infection, whether cobtained (or rational differentiation of which resident and analysis, and if cultidentify organisms to infection and appro-	hly summary of infections" ed from January 2015 and e record was reviewed and of onset of infection, specific ion that would enable tracking ead of infection, infection used to prevent the spread of culture of organism was all if not performed), sich antibiotic was used to treat which organisms, symptom ures had been obtained to to prevent the spread of priate antibiotic use. The logs er of infection(s), site or body				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00967	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOODS	SAMARITAN SOCIETY	- COMFORCARE	H STREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	system of infection(per unit that had an antibiotics used dur infections. During the month or indicated the facility five of those were or one was on the Gar infections were ider infections (UTI) s. The were treated with Contibiotics. The modificated there had infection and one lowest reated with the Azithromycin, Doxythe summary lacker location of resident, infection and sympt was treated with whoused to prevent the summary record also sensitivity of the infection date of immonthly summary lacker infections, antibic organisms. During the month or summary of infection the Healing Grace and one on the Gar four of the infection. One infection case was skin infection (shing system).	f January 2015 the log rhad a total of six infections; on the Healing Grace unit and rden unit. Four of the six infield as urinary tract The log indicated the UTIs eftin and Amoxicillin (both onthly infection summary also been one upper respiratory of the times and the times of the log indicated the UTIs eftin and Amoxicillin (both onthly infection summary also been one upper respiratory ower respiratory infection that				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION		E SURVEY PLETED
		00967	B. WING		03/	12/2015
	PROVIDER OR SUPPLIER	1201 17	ADDRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE	, MN 55912	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21390	(CDIFF)) case was Again the summary location of resident, symptoms of infecti which resident was and culture and ser organism, and reso monthly summary reto reduce or preven ongoing evaluation rate, antibiotic usagorganisms. R36 was admitted of facility admission reincluded diverticuliti Parkinson's diseased. A nursing note date daughter requested urinary urgency and based off the daugh. A nursing note date physician ordered of times per day for 10 analysis showed with the sample will be anything different a started." Nursing notes were and it was noted that symptoms of UTI exince the nursing notes also did not a of antibiotic or clarif	treated with Ciprofloxacin. It record failed to identify It onset of infection, associate on and symptom analysis, treated with which antibiotic, nsitivity of the infection causir lution date of infection. The eport also lacked intervention ting spread of infection, and analysis of infections and e trend, and prevalent on 10/27/14 according to the ecord with diagnoses that is of the colon, dementia, e, and congestive heart failure d 2/21/15 indicated R36's a urinalysis related R36's a urinalysis related R36's a urinalysis related R36's an order were obtained enter's request. d 2/22/15 indicated a Cipro 250 milligrams (mg) two d days. The note read, "The nite blood cells and bacteria, cultured, if the culture shows new med [medication] can b eread from 2/22/15 to 3/11/15 eat no further mention of experienced by the resident of dated 2/22/15. Nursing didress clarification of during ication on the bacterium ere was a discrepancy	9 de se de s			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00967	B. WING		03/1	2/2015
	PROVIDER OR SUPPLIER	- COMFORCARE 1201 17TH	DRESS, CITY, S H STREET N MN 55912	STATE, ZIP CODE E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	R106 was admitted according to the ad that included but no generalized muscle R106's physician or indwelling Foley cat A nursing note date brown tea/amber cowith some cloudine Nursing note dated continued to be clourine specimen was absence of another integrity. Nursing not physician ordered to ten days and R106' amber and cloudy. what the urinalysis 3/1/15 and 3/2/15 in clear. The next nursing not acknowledged monwas on 3/5/15; the urine was yellow, redated 3/7/15 explain back pain, the urine blood clots were pretinged. The author oplaced to a clinic nuculture and sensitiv bacteria causing inf Resistant Staphyloot the Cipro was resis indicated new order included Doxycyclin	to the facility on 1/27/15 mission record with diagnoses of limited to, diabetes and weakness. Iders included the use of an inheter. Id 2/26/15 indicated R106 had blored urine, small blood clots, as and no odor was present. 2/27/15 indicated urine udy and blood tinged and a sobtained for analysis in the symptom other than urine be dated 2/28/15 indicated a cipro 250 mg twice per day for s urine continued to be dark. This note lacked mention of revealed. Nursing notes dated indicated R106's urine was	21390			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00967	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - COMFORCARE AUSTIN			H STREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 14	21390			
	was identified or inc control log nor inter developed. R108 was admitted	A was not an organism that cluded on the facility's infection ventions to prevent spread to the facility on 2/11/15 mission record with diagnoses				
	that included but was C-Diff.	as not limited to diverticulitis,				
	Flagyl 500 mg four related to C-Diff (la	ohysician orders included times a day for 14 days st dose 2/25/15) and Cipro ay for 10 days related to ose 2/21/15).				
	indicated R108 was continued to have a Nursing notes from not reflect consiste	2/11/15 through 2/16/15 s on isolation precautions and episodes of loose stools. 2/17/15 through 2/24/15 did nt monitoring of effectiveness ent or R108's symptoms or				
	continued to have lemention of follow-u Nursing note dated having more loose cramping. The note and notify primary ownsens." Nursing through 3/6/15 indicepisodes of loose sereflected R108 discintolerant and facility Nursing noted date continued to have expensed to have expensed to the serious continued to have the serious of following noted date continued to have the serious profile of the serious continued to have the ser	d 2/26/15 indicated R108 cose stools twice per day. No p or monitoring was done. 2/28/15 indicated R108 was stools with abdominal e read, "Will need to monitor care physician if this persist or notes dated from 3/1/15 cated R108 continued to ctools. Documentation closing she had been lactose by accommodating diet type. d on 3/10/15 indicated R108 depisodes of loose stools and a depen obtained to repeat the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. 501251110.			
		00967	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- COMPORCARE	H STREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21390	stool sample was of testing. Nursing not physician order was times per day for 14 though culture result though culture result registered nurse (Frontrol officer explains facility about two most catch-up the infect had been behind. From take urine cultures symptoms despite. A facility policy inferpolicies/procedures November 2014 readesigned to identify infection collecting, data will be done by designated staff." A facility policy inferpolicies/procedure revised November surveillance and incomplete the policies/procedure revised November surveillance and incomplete the policies of	rsing note on 3/11/15 indicated btained and delivered for the dated on 3/12/15 indicated as given for Flagyl 500 mg three 4 days to treat C-Diff even alts were still pending. If on 3/12/15, at 12:35 p.m. with the indicated she had started with the onths ago and she had to ion control logs because they RN-I and the director of nursing and physicians do not always even in the absence of three encouragement of facility staff. It is control is surveillance last revised and, "Outcome surveillance is and report evidence of documenting and analyzing the infection preventionist or control surveillance/report forms last 2014 explained components of dicated forms to use, however ive direction on how to track or or trending and infection control		DEFICIENCY)		
	on 3/11/15 at 11:38	of medication administration, a.m., registered nurse (RN)-A R1 blood glucose using an				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00967	B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	'-COMPORCARE	H STREET NI MN 55912	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	Accucheck device glucose when a sar RN-A wiped R1's fir preparation pad, ar lancet exposing blo have gloves on whi glucose. RN-A the machine in R1's ca administered R1 he when interviewed a stated she normally a residents blood ginfection when expetitem on." During interview on stated the facility hat were to be folloblood glucose, and on when checking everybody's protect. When interviewed director of nursing worn if handling an should put your glo A facility Blood Glue 9/2012, read, "Perfigloves", before pier blood. SUGGESTED MET The director of nursing a control program that surveillance and tredirector of nursing policies to ensure proposed to the same policies to ensure products.	(machine that reads blood mple of blood is applied). nger with an alcohol nd pierced R1 's skin using a bod. However, RN-A did not ille checking R1's blood in placed the Accucheck abinet, then applied gloves, ander scheduled insulin. on 3/11/15, at 11:46 a.m. RN-A y wears gloves when checking glucose because of the risk of osed to blood, "I normally have ad policies and procedures owed for checking a residents I RN-A should have had gloves R1's blood glucose "for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00967	B. WING		03/1	2/2015
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S I STREET N	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE AUSTIN, M		E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
21390	The director of nurs staff on infection co of nursing could me audit could be deve to the quality assur	sing could educate nursing ontrol procedures. The director onitor staff compliance. An eloped and the results reported	21390			
21426	(a) A nursing home maintain a comprel infection control procurrent tuberculosis issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme (b) Written compliable maintained by the This MN Requirem by: Based on interview	e provider must establish and hensive tuberculosis ogram according to the most is infection control guidelines distates Centers for Disease action (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines. In this subdivision must be nursing home.	21426	Administrator will ensure the Tuber		4/21/15
	by: Based on interview			Administrator will ensure the Tuber Prevention and Control guidelines		

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - COMFORCARE STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE AUSTIN, MN 55912	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - COMFORCARE STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE AUSTIN, MN 55912	12/2015
GOOD SAMARITAN SOCIETY - COMFORCARE 1201 17TH STREET NE AUSTIN, MN 55912	12/2010
GOOD SAMARITAN SOCIETY - COMFORCARE AUSTIN, MN 55912	
OUR MAN DV OTATELIENT OF DEFINITION	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CON	(X5) COMPLETE DATE
21426 Continued From page 18 21426	
(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 worksheet every other year. The facility was asked on 3/11/15 for the last completed 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 on 3/11/15. The assessment indicated the facility was at low risk and the assessment on 3/11/15 for the assessment on 3/11/15 for the saccommendation of 3/11/15 for the saccommendation	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED		
		00967		B. WING		03/1	2/2015
	PROVIDER OR SUPPLIER	- COMFORCARE 120	17TH	DRESS, CITY, STREET N	STATE, ZIP CODE E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21426	review a tuberculos administrator could compliance.	ge 19 complete and periodicall is risk assessment. The educate staff and monito	or	21426			
21535	Subpart 1. General must be free from unnecessary drug is A. in excessive therapy; B. for excessive C. without adec D. in the prese which indicate the odiscontinued. In addition to the discontinued. In addition to the discontinued in addition to the discontinued in the continued in the co	al. A resident's drug reginunecessary drugs. An sany drug when used: dose, including duplicate e duration; quate indications for its usince of adverse consequedose should be reduced or rug regimen review require nursing home must conse Interpretive Guidelines egulations, title 42, section Appendix P of the State, Guidance to Surveyors acilities, published by the lith and Human Services, ing Administration, April corporated by reference. The Minitex interlibrary loar te Law Library. It is not	men e drug se; or ences or red in nply for on 1992. It is	21535			4/21/15
	by:	ent is not met as evidend and document review, the			Resident 108 was discharged on 3/	19/15.	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N			E CONSTRUCTION	(X3) DATE COMP	
		00967		B. WING		03/1	2/2015
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE	1201 17TH AUSTIN, I	H STREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCE MUST BE PRECEDED B SC IDENTIFYING INFORM	SY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From particular facility failed to identify antipsychotic medicular clinical symptoms to was effective; and comprehensive sleeneed for the use of ordered for insommere reviewed for unnect to justify the ongoin mandatory gradual antipsychotic medicular reviewed for unnect findings Include: R108's admission radmitted on 2/11/15 but were not limited hypothyroidism. The Assessment (MDS) R108 did not displad difficulty sleeping and having little energy. R108 currently rece (antipsychotic) 0.5 for generalized anx orders reflected a second 2/19/15 and the resemedication daily simulations and the medication daily simulations for the euse of the Risperide	ge 20 Itify indications for usation (Risperidone) determine if the modified not complete a sep study to determine Mirtazapine, Melatria for 1 of 5 resident essary medications gruse and did not adose reduction of sations for 1 of 5 resessary medications for 1 of 5 resessary medications descord revealed R10 with diagnoses that to anxiety state and the admission Minimus dated 2/18/15, independently the current photocording, feeling tires with the current photocording the condition of the current photocording the curre	use of and) or identify nedication ne the onin its (R108) ;; and failed attempt a sidents ; (R52). 28 was at included id ium Data icated is or ed or et time a day nysician's idone as the d targeted ind behavior ontinued	21535		of 013, at est. The to make ugh the R for N will director ian. The behavior sychotic imanic wed for e GSS onthly ted by ed at bove dited copriate cations. ting for	
	R108 since admiss R108 's physician odated 3/11/15 read, anxiety with previou	certification progres "Depression, in	ss note somnia,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00967	B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 03/1	2/2013
_		1201 17T	H STREET N			
GOOD S	AMARITAN SOCIETY	AUSTIN,	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	low-dose Risperido review in the past. It that this has been we dose in the outpatie on melatonin (horm Remeron (antidepressant) 15 and Melatonin 3 mg current physician's for Mirtazapine as 2 Melatonin as 2/11/1 R108's medical recomprehensive sleet on 3/12/15 at 11:2 stated R108 did not behavioral concern the Risperidone for comprehensive sleet completed since ac facility did not identification.	one and extensive psychiatry Continue low-dose and has felt weaned to the lowest effective ent setting. She also continues none to regulate sleep) and essant) " eived Mirtazapine o mg one time a day for sleep g at bedtime for sleep. The orders reflected a start date 2/12/15 and a start date for 15. cord review revealed a lack of sleep pattern and ep assessment. 1 a.m. registered nurse (RN)-F t display any mood or is. RN-F stated R108 received r sleep and verified a ep assessment had not been dmission. RN-F verified the cify targeted behaviors for the	21535			
	for the effectivenes	and behavior and monitoring as and continued use of the cation had not been				
	(DON) stated her e would have determ and have had deve monitoring for the F effectiveness of the ongoing use of the DON stated resider comprehensive slee	2 a.m. the director of nursing expectation was the facility ined the justification for use eloped targeted behavior. Risperidone to determine the emedication and need for the antipsychotic. In addition, the ints should have a ep assessment completed to e of sleep when admitted to				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00967	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE	STREET N	E		
040.15	CLIMMA DV CTA	AUSTIN, I		DDOVIDEDIS DI ANI OF CODDECTIO	DNI .	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 22	21535			
	the facility on medication to help with sleep.					
	Sedative/Hypnotics Non-Emergency Ac is experiencing slee Sleep Assessment an antipsychotic for nurse must comple Medication Assess Involuntary Movem administration of th medications and se following must be o behavior document	acological Medications and policy revised 3/15 read, "Iministrationc. If the resident ep disturbance, complete the5. If the physician prescribes the resident, a registered te the initial Antipsychotic ment and The Abnormal ent Scale9. Throughout the epsychopharmacological edative/hypnotic drugs the ompleteda. Mood and ation must continue in order to the medication has on the				
	greater than a year reduction (GDR) was a physician 's justif contraindicated at t R52 according to the was admitted on 11 included but were redisease, major dependementia with behar R52's quarterly Min 2/13/15 indicated swith a Brief Intervieh had minimal depression screen no behaviors. R52's annual MDS severe cognitive im 3, had minimal dep PHQ-9 with a score R52's most recent of the special screen of the second seco	ntipsychotic (Seroquel) for and no gradual dose as not attempted nor was there ication why the GDR was his time documented. The facility admission record /9/12 and had diagnoses that not limited to: Alzheimer's ressive disorder, and avioral disturbances. The facility impairment was for Mental Status score of 2, asion according to the PHQ-9 er) with a score of 1, and had dated 8/26/14 indicated pairment with a BIMS score of ression according to the er of 1, and had no behaviors. Care plan provided by the indicated R52 had a mood				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00967		B. WING		03/	12/2015
NAME OF PROVIDER OR SI	JPPLIER	•	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD SAMARITAN SO	CIETY	- COMFORCARE		H STREET N	E		
				MN 55912			
PREFIX (EACH DE	FICIENCY	TEMENT OF DEFICIENCE MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21535 Continued F	rom pa	ge 23		21535			
problem and repetitive versions of repetitive versions. The second of the address reversalization most of the address reversalization and problem. R52's physicincluded Cemajor depresevery a.m. addisorder. A pharmacy ".has been the since 7/16/12/19/13, for disturbance."	d behaverbalizated to The casigns a depression of takes o	ioral symptoms suctions "of where do land live ted stand symptoms of incessive symptoms. To for a walk, offer comparison of the make repetitive of for a walk, offer comparison of the make repetitive of for a walk, offer comparison of the make repetitive of for a walk, offer comparison of the make repetitive of for a walk, offer comparison of the make repetitive of the indicated Repetition of the intervention of the interventions were not assessment did the interventions. The ded R52 can be compared instance was doner documentation of the intervention of the in	I go and I se and ff to creased the care riors by interacting, offee or 52 did not cood 52 had not cood 552 had not cood 552 had not directed by the crepetitive of effective not 156 mbative with fter review cumented was found his 13/11/15 mg ive 13/14 read, the daily since coorder."	21535			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00967	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE	H STREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21535	was 0 on 12/23/13 during the assessm declined the attemp either medication a led to increase in b recommendation w 2/11/14. The note b behavior symptoms managing the incre The consulting pha recommendation for (GDR) of Seroquel the physician declir either medication. The consulting pha recommendation for February 2015. The and indicated the re behaviors. The note evaluation of behavior read "Behavior is snappy to family at A physician visit no mention of behavior read, "Discussed medications for nov mg] tablets twice aslowly and steadi lacked description medication was con non-pharmacologic A physician note da mention of behavior read, "Alzheimer' worsening dementi	and no mood or behaviors nent period. R52's doctor of at gradual dose reduction of and wrote ".Previous decrease ehavior symptoms. The as signed by the MD on acked what the increase in swere or how the facility was ase in behaviors. The ase in behaviors. The ase in behaviors are a gradual dose reduction in September 2014 however, and to attempt the GDR for the MD declined to attempt GDR ason was disruptive as lacked assessment and viors. The dated 4/7/14 that included a ral disturbances or depression astable Can be somewhat times." Intel 6/27/14 that included a ral disturbance or depression options of slowly discontinuing w Seroquel 50 mg 1-1/2 [75 day to control behavior ly losing weight." The note of what the behavior the introlling or use/plan for	21535			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00967	B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1201 17Th	STREET N	E		
GOODS	AMARITAN SOCIETY	- COMFORCARE AUSTIN, N	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	cooperative, but of A physician note day mention of behavioread, "No anxiety, changes/concerns today but still was publication of behavioread, "Worsening worsened dementiate and tolerates she will refuse here decreased but active weight is stable." A physician note day mention of behavioread, "Alzheimer' worse [does not elaworse] and "deretable, behaviors a movement disorder medication]." A physician note day mention of behavioread, "she has belouder with yelling as "I love you." Physician notes far assessment and evaluation and Celex A nursing note date R52 had behaviora indicate what the befrequency, and evaluation of the physician note date R52 had behaviora indicate what the befrequency, and evaluation of the physician note date R52 had behaviora indicate what the befrequency, and evaluation of the physician note date R52 had behaviora indicate what the befrequency, and evaluation of the physician note of the physician	clearly demented." Inted 8/29/14 that included ral disturbance or depression depression, or memoryPatient is more agitated bleasant and cooperative " Inted 11/18/14 that included ral disturbance or depression Alzheimer disease with a and decreased activity can ble at times, but most times is her cares. There are times shower or cleaning. Appetite is vity level was decreased, so atted 11/28/14 that included ral disturbance or depression is disease is stable to slightly aborate on how disease is mentia is stable, moods are restable no evidence of reside effect from psychotropic atted 2/6/15 that included ral disturbance or depression come less active at times is at other people; her main yell is diled to address clinical valuation of depression and oral disturbances related to depression and oral disturbances related to depression and oral disturbances related to depression depression and oral disturbances related to depression and oral disturbances related to depression depression and oral disturbances however did not behavioral disturbances were, luation of	21535	DETICIENCT)		
		al interventions. on 3/12/15, at 1:25 p.m. in the administrator, pharmacy				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00967	B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE 1201 17TH AUSTIN, M	ISTREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21535	consultant explaine GDR of Seroquel a the facility consider related to increased consultant stated stands of GDR's recomment physician declined. There was not enourational to continue without attempting consultant also stat wanted a dose reduction and set of March 2015 read, be done according Tapering may be sclinical condition nonpharmacological effective in reducing must attempt GDR at least one month clinically contrainding the policy gave directive in the policy	d, the last time R52 had a nd Celexa was June 2013 and ed it a failed dose reduction behaviors. The pharmacy he would continue to make dations even though the Pharmacy consultant verified gh documented clinical same doses of medication GDR. The pharmacy led R52's family had not action of either medication. Eled psychopharmacological edative/hypnotics last revised Gradual dose reductions must to federal regulations indicated when the resident has improved or stabilized cal interventions have been go the symptomsthe center in two separate quarters with between attempts, unless	21535			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILDING.			
		00967	B. WING	 	03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- COMPORCARE	TH STREET N , MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 27	21535			
	The director of nurse could review and remedication, includin assessments, identify moods/behaviors, of comprehensive clingradual dose reduction of nursing a could inservice staff documentation of both The director of nurse compliance.	tification of target monitoring target gradual dose reduction, and lical rationale for lack of stion of medications. The and consultant pharmacist				
21545	A nursing home mu A. Its medication percent as describe	O A.B.C Medication Errors ust ensure that: on error rate is less than five ed in the Interpretive e of Federal Regulations, title	21545			4/21/15
	42, section 483.25 the State Operation Surveyors for Long incorporated by refi purposes of this pa (1) a discrepal prescribed and wha administered to res (2) the administered to res (2) the administered to reserve a significant (1) an error	(m), found in Appendix P of as Manual, Guidance to -Term Care Facilities, which is erence in part 4658.1315. For a medication error means: ncy between what was at medications are actually idents in the nursing home; of stration of expired any significant medication medication error is: which causes the resident ardizes the resident's health or				

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		00967	B. WING		03/12/2015
	PROVIDER OR SUPPLIER	- COMFORCARE 1201 17	DDRESS, CITY, TH STREET N MN 55912	STATE, ZIP CODE IE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
21545	safety; or (2) medication requires the medication error comprecipitate a reoccut toxicity. All medication prescribed. An incomprescribed. An incomprescribed and the resident reactions of the physician or the filed occurs. Any signification resident reactions of physician or the resident represedulation.	on from a category that usually ation in the resident's blood to be cific blood level and a single audid alter that level and aurrence of symptoms or ions are administered as ident report or medication errors or must be reported to the ysician's designee and the dent's legal guardian or antative and an explanation error are administered as dent report or medication error that cant medication errors or must be reported to the ysician's designee and the dent's legal guardian or any medication error that cant medication errors or must be reported to the ysician's designee and the dent's legal guardian or antative and an explanation e resident's clinical record.	r		
	by: Based on observati review, the facility for residents (R31, R33) accordance with ph manufacturer's guid medication error rati Findings include: R31's signed Order	ent is not met as evidenced on, interview, and document ailed to ensure 2 of 10 3) was given medication in ysician orders and delines, resulting in a facility te of 12 percent (%).		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 simmedications were reviewed to ensure medication administration time was appropriate. A note was added to the instructing nurses to give medications food. For Resident 33, a note was added to the MAR to instruct nurses not to concept the material of the material	n De milar MAR with

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00967	B. WING		03/1	2/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- COMFORCARE 1201 17T	DDRESS, CITY, H STREET N MN 55912	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21545	"Fish Oil Capsule 5 Fatty Acids) Give 1 day related to UNSI LIPOID METABOLI "Citrucel/Vitamin D tablet by mouth two AFTERCARE HEAI FRACTURE OTHE During observation on 3/10/15 at 4:03 p (LPN)-A prepared F LPN-A removed a c along with a Sea-O supplement) for adi labels read, " w/ (w explained each mer administered the m When interviewed i medication adminis p.m., LPN-A stated snack when she tak verified she had no "This is an un-norm she thought R31 ha around 2:30 p.m., b would eat was not u LPN-A added, the n given with meals as orders and medicat R33's signed Order 1/30/15, identified to "Tylenol Arthritis Pa 650 mg (Acetamino Give 1 tablet by mo related to AFTERC, R33's signed orders	on mg [milligrams] (Omega-3 capsule by mouth two times a PECIFIED DISORDER OF SMTake with meals" and; Tablet 250-200 mg Give 1 times a day related to LING TRAUMATIC R BONEwith meals." of medication administration, o.m., licensed practical nurse 31's medications in her room. Calcium with vitamin D tablet, mega capsule (a fish oil ministration. The medication with) meals." LPN-B then dication to R31 and edications. mmediately after the stration, on 3/10/15 at 4:07 R31 normally is eating a kes the medications, but to been during the observation, all day today." LPN-B stated and a cookie earlier that day, but verified the next meal R31 until after 5:00 p.m. Further, medications should have been a directed by the physician tion labels.		residents taking extended releat medications were reviewed and added to their MAR are to not comedication. A current list of methat are not to be crushed will be the nurse of station in each are 4/3/15. Facility will conduct 1 methats audit on each shift weekly per week) for 4 weeks and resurreported to QAPI on results for recommendations. Director of will be responsible to ensure this is met.	notes rush dications e placed at a by edication (3 audits Its will be further Nursing	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00967	B. WING		03/	12/2015
	PROVIDER OR SUPPLIER	- COMFORCARE 1201 171	ODRESS, CITY, S TH STREET N MN 55912	STATE, ZIP CODE E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21545	During a different of administration, on 3 nurse (RN)-A remove cabinet in R33's roomedications for administrations for administrations for administrations for administration for admini	bservation of medication 8/11/15 at 8:37 a.m., registered yed a bottle of Tylenol from a om, and prepared his ministration at a mobile cart in crushed R33's medications, of ER, mixed them with alministered them to R33. as aware she had crushed the ion, but always does so wallowing trouble. On 3/11/14 at 11:30 a.m. extended release (ER) e being crushed should have a citing them to be, or the oe changed to a non-ER type. It is a start of the the facility staff receives ral medication administration				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00967	B. WING		03/1	2/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- COMFORCARE 1201 17	DDRESS, CITY, S T H STREET N MN 55912	STATE, ZIP CODE E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21545	During interview on director of nursing (should be followed.) A facility Administrated dated 9/2012, ident "promote therapeut medication", and, "Tourrectly using the correctly using the consultant place. Further, the policy of medications after we administration by control to the Medication At "at least three times provide any guidance ER medications. SUGGESTED MET The administrator a could review and reto ensure facility was the consultant phallicensed staff to pro-	3/11/15, at 4:11 p.m. the DON) stated all MD orders				
		R CORRECTION: Twenty-one				
21600	Subp. 2. Emergen nursing home may medication supply the QAA committee	cy medication supply. A have an emergency which must be approved by . The contents, maintenance rgency medication supply art 6800.6700.	21600			4/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00967		B. WING		03/1	2/2015
	PROVIDER OR SUPPLIER	- COMFORCARE	1201 17TI	DRESS, CITY, S H STREET N MN 55912	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21600	This MN Requirements: Based on observation review, the facility from the facility emergency medicands of 1 facility emergency medicands of 1 facility emergency to affect all 44 resides have needed the mostituation. Findings include: EXPIRED MEDICANDURING a tour of mewith registered nurse p.m., the only facility supply of medications emergency situation medications. RN-During a tour of mewith registered nurse p.m., the only facility supply of medications emergency situation medications. RN-During been delivered by the week. The kit was were checked for or following three medications of 1 ml (mused for severe pair Four tablets of 0.5 ml) (an anti-psychotic mused for severe pair four tablets of 0.1 ml) (an anti-psychotic mused for severe pair four tablets of 0.1 ml) (blood pressure) When interviewed of the checked and verified emergency kit were	ent is not met as evi- on, interview, and do ailed to have non-exp tion readily available gency kits. This had p dents in the facility that edication in an emer TIONS IN EMERGEI dication storage in the se (RN)-D, on 3/9/15 y emergency kit (a si ns kept on hand in-c n) was checked for o o stated it had just red the pharmacy the pre- opened, and the med utdated medications dications were found milliliter) morphine (m n), expired on 2/2015 mg (milligram) f halop nedication), expired on g clonidine (a medic e), expired on 1/7/15. The dication of the pre- opened and available sexpired, and available expired, and available sking RN-D if a system of the three medication	NCY KIT: ne facility at 6:49 mall ase of an utdated cently vious dications and the to be edication for cation for the forms in the ble for	21600	Emergency medication kit was p by pharmacy and a new one was to the facility on 3/10/15; no expir medications were given to reside medications will be checked by p and consultant pharmacist. In act staff will ensure medications are expired when they open the kit. I Nursing will be responsible to enstandard is met.	s provided red ents. All sharmacy ddition, not Director of	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00967	B. WING		03/	12/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- COMFORCARE 1201 171	DDRESS, CITY, S TH STREET NI MN 55912	ETATE, ZIP CODE E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21600	for the medications RN-D replied, "No During interview on stated the medications should not be expired to process to monit the emergency kit, I dispensing pharmack the medications. When interviewed to consulting pharmack the expired medications where should not be emergency kit. During interview on Pharmacy the dispensing to the past we facility in the past we facility emergency kit. During interview on Pharmacy the dispension of the past we facility in the past we facility in the past we facility emergency kit. During interview on Pharmacy the dispension of the past we facility in the past we facility emergency kit.	ge 33 used in the emergency kit that I am aware of at least." 3/9/15, at 7:21 p.m. RN-C ons in the emergency kit ed, and verified the facility had tor for expired medications in but rather relied on the cy to check for outdated on 3/10/15, at 2:23 p.m. the sist (CP) stated the emergency Sterling Pharmacy, and that uld be completed regarding tions as this kit was sent to the eek. Further, CP said that expired medications in the 3/10/15, at 2:35 p.m., Sterling ensing pharmacy (DP) was go the expired medications ency kit they supplied to the exit had been replaced that day unaware how some of the pired and not replaced before ty. DP-A then added, y error." The DP-A stated they are defined to the ending the emergency kit to the ending the emergency kit to the ending the emergency kit to the				
	director of nursing (should be tracking t emergency kit for e to do it." Further, th	DON) stated the pharmacy the medications inside the xpiration, "I expect them just				

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STATEMEN	FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00967	B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - COMFORCARE			ISTREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21600	Continued From pa	ge 34	21600			
	allowed to expire be resident use.	ecause they were available for				
	The administrator a could review and re to ensure emergencexpired. The consuinservice licensed smedications were n	THOD OF CORRECTION: and consultant pharmacist evise policies and procedures cy box medications were not litant pharmacist could staff to ensure emergency box not expired. The director of tor staff compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21630	MN Rule 4658.1350 Medications; Destru	Subp. 2 A.B. Disposition of uction	21630			4/21/15
	remaining in the nu discharge of a reside prescribed, or any of discontinued permain manner recomment or the consultant pharmacist must furinstructions and for kept on file in the number of the second drugs remaining in death or discharge were prescribed or discontinued permain according to part 6 be returned to the permain second of the second of th	ions of controlled substances rsing home after death or dent for whom they were controlled substance anently must be destroyed in a ded by the Board of Pharmacy narmacist. The board or the rnish the necessary ms, a copy of which must be ursing home for two years. itions of other prescription the nursing home after the of the resident for whom they				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED		
		00967		B. WING		03/1	2/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- COMFORCARE		STREET N	STATE, ZIP CODE E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21630	medication, prescriperson destroying twitness to the destroyer the clinical record. This MN Requirements: Based on observation	ption number, signar the drugs, and signar fuction must be reco ent is not met as ev on, interview, and do	ture of the orded on idenced	21630	The updated facility procedure for		
	review, the facility facility facility for procedures to ensure of Fentanyl (a narcoduragesic patches of This had potential to (R18, R6, R104, and	ailed to implement p re the appropriate d otic pain medication) to reduce the risk of o affect 4 of 44 resion d R102) who had cu duragesic patches i	olicies and estruction diversion. lents irrent		Fentanyl patch destruction was p for licensed nursing staff. Nurses re-educated on how to find update nursing policies and what the new for destruction of Fentanyl patch of 4/3/15. Nurses will be audited we month on correct destruction of F patches and results will be given QAPI committee for further recommendations. Director of Nu	rovided will be ed r policy is on ekly for 1 entanyl to the	
	During review of Throom, on 3/9/15 at (RN)-D opened a loresident narcotic mboxes were observed facility protocol for opatches was and Rprotocol is." RN-Dpersonal practice wit to a piece of paper medication room urher destroy it, addir way, but that is how	the Healing Grace medicated cabinet contained and Fentied. RN-D was asked destruction of Fentian N-D stated, "I'm not went on to say that I was to remove the pater and leave it in the ntil another nurse cong, "Not everybody do I do it."	I nurse ning canyl patch d what the nyl sure what ner tch, apply uld help oes it that n room,		be responsible to ensure this star met.		
	cabinet containing and Fentanyl patch stated Fentanyl pat	m., RN-A opened a resident narcotic me boxes were observe ches were to be fold container (a container)	dications, ed. RN-A ed and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00967	B. WING		03/1	2/2015
NAME OF PROVI	IDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
GOOD SAMARITAN SOCIETY - COMFORCARE			H STREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
remobje faci stat how	ects) and that hat lility "since I startited she had never to dispose of uting, "I can't recarring review of Th/15 at 8:06 p.m., "N)-G opened a lident narcotic moves were observed in the facility as far as I ther, LPN-G startication from the ed Fentanyl patchet in the facility order Listing in regards to the facility order Listing in the facility, and had act agesic patches. I be interviewed to sulting pharmach or a drain to red was unaware whill used Fentanyl patchet in the facility or a drain to red was unaware whill used to dispose the interviewed of facility, but was the facility, but was the fentanyl patchet facility, but was the facility, but was the fentanyl patchet facility, but was the facility patchet.	ge 36 Is used to dispose of sharp and been the practice of the ed here." Further, RN-A er received any education on sed Fentanyl patches by all anything on it." The Lodge medication room, on licensed practical nurse locked cabinet containing edications, and Fentanyl patched. LPN-G stated she started the about a month prior, and Fentanyl patches for residents in the sharps container know, that is the policy." ted she was not provided any facility on how to dispose of the shen said, "I have to get to inquiring what the facility function of Fentanyl patches. The Report, dated 3/10/15, R104, and R102 resided in the site (CP) stated current Food ation (FDA) guidance was to patches in half, and flush them for the risk of diversion. The hat policy or procedure the cose of their patches. The DON) stated she was new to aware staff was disposing of the in the facility sharps g, "That is the practice here."		DETICIENCY)		

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	(X2) MULTIPLE CONSTRUCTION A. BUILDING: C (X3) D C		
B. WING		03/12/2015	
H STREET N	•		
ID PREFIX TAG		(X5) COMPLETE DATE	
21695		4/21/15	
	DDRESS, CITY, STH STREET N MN 55912 ID PREFIX TAG 21630	DDRESS, CITY, STATE, ZIP CODE TH STREET NE MN 55912 D	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
				A. BUILDING:			
		00967		B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE		H STREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCII / MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 38		21695			
	and furnishings.	J					
	and farmsmings.						
	by: Based on observatifailed to ensure whis sanitary for 2 of 2 references included: R33 was observed 3/11/15, at 1:03 p.n. a.m. revealed R33' crumbly debris on the chair and the left sidured yellow crusted chair. R33 was to Monday 3/9/15 acc washing schedule.	ent is not met as ever ion and interview the eelchairs were clear esidents (R33 and Formal on 3/10/15, at 9:38 n., and on 3/12/15, as wheel chair had whe seat cushion of the debris near the armave wheel chair cleording to the wheel continuation of the wheel ording to the wheel continuation of the wheel	e facility n and 1447). a.m., on at 8:04 hite he wheel ilm with a m of the eaned on chair		Resident 33 and 47 were cleaned immediately. All chairs have beer washed. A new cleaning schedule posted and implemented for the n staff. Re-education will be done w nursing staff on 4/3/15. Audits will conducted daily for 2 weeks; whice ensure all wheelchairs are being of two times during those two weeks will be conducted randomly for 1 m. The audits will be reported to QAF further recommendation. Nurse M in each area will be responsible for ensuring this standard is met.	will be ursing ith all be h will cleaned . Audits nonth. PI for anagers	
	An observation dor revealed R47 had I food debris on the chair. A family (F)-A this time and points	arge particle flakes arge particle flakes arge toushion of their armount of their armount of the different o	of white wheel ent during air out to				
	and has asked staf According to the fa schedule, R33's wh cleaned on Monday scheduled to be cle		ashing uled to be chair was				
	nursing assistant (Note a weather a stated, "During the is bad we wipe it of		chair are shift. NA-B something				
	director of environn explained the overr the wheelchairs on	on 3/12/15, at 2:30 nental services (DES night nursing assista weekly schedule. D chairs were heavily	S)-H Ince clean ES-H				

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STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	COM			TE SURVEY MPLETED	
			A. BUILDING:				
		00967	B. WING		03/1	2/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- COMEORCARE	H STREET N MN 55912	E			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21695	would notify him an washed. A policy on mainter equipment was req the facility. SUGGESTED MET The director of nurs policies and proced wheelchairs. The director all staff or wheelchairs. The complete monitor staff complete TIME PERIOD FOR (21) days.	d chairs would then be power nance of resident care uested and not provided by THOD OF CORRECTION: sing could review and revise dures to ensure clean director of nursing could in maintaining clean director of nursing could iance. R CORRECTION: Twenty-one	21695				
21830	Residents of HC Far Subd. 10. Particip notification of family (a) Residents sha in the planning of the includes the opport alternatives with incopportunity to reque care conferences, a family member or of both. In the event to present, a family members or conferences. (b) If a resident we unconscious or cor- communicate, the forest of the same required either a family members.	pation in planning treatment;	21830			4/21/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00967		B. WING		03/1	2/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE	_	H STREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21830	an emergency that admitted to the facilifamily member to p planning, unless the to believe the resided directive to the contispecified in writing immember included in notifying a family m family member to p planning, the facility efforts, consistent with practice, to determite executed an advance sident's health care this paragraph, "readigned (1) examining the resident; (2) examining the resident in the possion (3) inquiring of an family member continued whether the resident directive and whether the resident normally gowhether the resident designated emergemember to participate accordance with this liable to resident for the notification of the mergency contact family member was patient's privacy rig	the resident has beed lity. The facility shall articipate in treatment of facility knows or has ent has an effective that they do not wan a treatment planning ember but prior to a articipate in treatment must make reason with reasonable med one if the resident has ce directive relative redecisions. For pure asonable efforts included personal effects of the session of the facility of the personal effects of the session of the facility of the session of the session of the facility of the session of the	I allow the nt as reason advance esident has t a family. After able ical s to the rposes of ude: the the the ct or ction advance a y goes for a the n, advance ember or s a family ning in allity is not ounds that of the d the	21830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00967	B. WING		03/12/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE 1201 17TH AUSTIN, N	H STREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
21830	family member or of the facility shall attermembers or a design examining the person and the medical recognishms of the folial to notify a family memergency contact admission, the facility social service agency that the resulted facility has been member or designate county social service enforcement agency identifying and notified designated emerges service agency or lethat assists a facility subdivision is not lied amages on the grather family member.	designated emergency contact, empt to identify family gnated emergency contact by onal effects of the resident cords of the resident in the acility. If the facility is unable ember or designated within 24 hours after the lity shall notify the county cy or local law enforcement ident has been admitted and in unable to notify a family ated emergency contact. The ce agency and local law ey shall assist the facility in fying a family member or ency contact. A county social local law enforcement agency y in implementing this able to the resident for ounds that the notification of or emergency contact or the family member was improper	21830			
	by: Based on observat review, the facility f preference for wak respected and the bathing frequency	ent is not met as evidenced ion, interview, and document ailed to ensure each resident's ing up in the morning was facility failed to ensure that preference was provided for 1 4) who was reviewed for		Resident 104 discharged on 3/19/residents Medical records will be ror interviews conducted to determ staff is honoring their preference f to get up in the morning and frequibathing. Facility will provided re-ect on ursing staff on 4/3/15 regardin resident choices and following GS for honoring those choices. Audits	eviewed ine if or time ency of ducation g S policy will be	
	R104's admission I	Minimum Data Set (MDS)		conducted weekly for 4 weeks; the presented at the QAPI meeting for		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00967		B. WING		03/1	2/2015
_	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- COMFORCARE	1201 17TH	DRESS, CITY, S H STREET N MN 55912	STATE, ZIP CODE E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21830	dated 1/30/15, identiagnoses of canced depression, and reconstruction bathing of one personal brief interview for miffteen indicated into the R104 was interview her room. When as get up in the morning they [staff] come and dressed. I would like R104 stated she has to sleep in or that the early. When asked, times a week you tare sponded, "No, I we would like at least fit told staff she would a bath each week Fold no. R104's Nursing Adridated 2/18/14 indicating was 8:00 a.m. R104 up as early as R104 was observed dressed ready for the wheelchair in her roand woke her up the 6:45 a.m. R104 stat room thinking and coneeded to be woken.	tified but not limited in, thyroid disorder a quired physical help on physical assist. For ental status (BIMS) act cognition. The don 3/10/15 at 1:5 ked, "Do you choose in the deep in to about the state of the st	in part of R104's score of R104's score of S3 p.m. in e when to ed, "No, get me ut 9 a.m." would like up to w many r?" R104 week on more than ed she she had shower or land was collection lawaking was getting a.m. to be her aff came in eximately ing in her why she y hour"		recommendations. Social service Director will be responsible for earthis standard is met.		
	On 3/12/15 at 8:42	a.m. nursing assista	ant (NA)-E				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPI		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION N	IUMBER:	A. BUILDING:		COMP	LETED
		00967		B. WING		03/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER	1	OTDEET AD		STATE, ZIP CODE	<u>,I </u>	
NAME OF I	PROVIDER OR SUPPLIER						
GOOD S	AMARITAN SOCIETY	- COMFORCARE		H STREET N MN 55912	E		
	OUR MAA DV OTA	TEMENT OF BEFORENCE	-		PROVIDERIO PLANTOS CORRECTIV		
(X4) ID PREFIX		TEMENT OF DEFICIENC MUST BE PRECEDED E	-	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORI		TAG	CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
21830	Continued From pa	ge 43		21830			
	•	_					
	stated she helped F						
	helped her with mo						
	7:00 a.m. NA-E sta						
	morning between 6						
	R104 was easy goi						
	and ask her if she v						
	NA-E verified she w						
	prefer to sleep in til						
	nursing assistants						
	bathing. NA-E state						
	scheduled was dete						
	resident was assign						
	stated the facility di						
	baths or showers if						
	request. NA-E was		terrea more				
	than one bath or sh		(DNI) F				
	On 3/12/15 at 10:56						
	stated upon admiss						
	what time they wou						
	and this was docum		0				
	Re-Admit Data Coll						
	verified R104's Nur						
	Collection dated 2/						
	waking time was 8:						
	how wake times pre						
	to staff, RN-F state						
	RN-F stated staff is						
	on the residents' do	0	,				
	would like to get up						
	promote resident cl						
	we are on a time cr						
	therapy will get ups						
	stated nurse manag						
	needed to be up be						
	RN-F stated there v						
	residents based on						
	facility. RN-F stated						
	admission what day						
	scheduled for and s						
	if that was ok. RN-F	- verilled stall did n	บเ สรห				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00967	B. WING		03/1	2/2015
	PROVIDER OR SUPPLIER	1201 17TH	DRESS, CITY, S	STATE, ZIP CODE	•	
GOODS	AMARITAN SOCIETY	- COMFORCARE AUSTIN, N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21830	residents how many a bath or shower. On 3/12/15 at 11:36 (DON) stated her e are asked what the frequency and asked get up in the morning stated she would expect up as close as they stated if a resident's 8:00 a.m., she wouresident up betwee The DON verified wa.m. to get them reearly for a resident waking up for the d SUGGESTED MET The director of nurser review and revise pensure residents wand bathing. The all staff to offer residential residential staff to offer residential residential staff to offer residential residential residential staff to offer residential	y times a week they would like a.m. the director of nursing expectations was the residents in preference for bathing and what time they would like to any upon admission. The DON expect staff to get the resident a could to their preference and as preference was to get up at all dexpect staff to get the notation 7:30 a.m. and 8:30 a.m. waking a resident up at 6:45 ady for the day would be too that had a preference of	21830			

6899