DEPARTMENT OF H	IEALTH AND HUMA	N SERVICES		CENTERS FOR MEI	DICARE & MEDICAID SERVICES
		RE/MEDICAID CERTIFI			ID: U683
1. MEDICARE/MEDICAID (L1) 245568 2.STATE VENDOR OR MEI (L2) 060743600	PROVIDER NO.	TO BE COMPLETED BY 3. NAME AND ADDRESS OF F4 (L3) GOOD SAMARITAN SC (L4) 110 SOUTH WALNUT A (L5) LUVERNE, MN	ACILITY D CIETY - N		Facility ID: 00575 4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHAR (L9)	NGE OF OWNERSHIP	7. PROVIDER/SUPPLIER CATE 01 Hospital 05 HHA	EGORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
 DATE OF SURVEY ACCREDITATION STAT 0 Unaccredited 2 AOA 	11/14/2014 (L34) US: (L10) 1 TJC 3 Other	02 SNF/NF/Dual06 PRTF03 SNF/NF/Distinct07 X-Ray04 SNF08 OPT/SP	10 NF 11 ICF/II 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
 11. LTC PERIOD OF CERTIFIER From (a): To (b): 12.Total Facility Beds 	51 (L18)	10.THE FACILITY IS CERTIFIED X A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
13.Total Certified Beds	51 (L17)	 B. Not in Compliance with Pr Requirements and/or App 		: * Code: A	(L12)
14. LTC CERTIFIED BED B	REAKDOWN			15. FACILITY MEETS	
18 SNF 18	/19 SNF 19 SNF	ICF IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37)	51 (L38) (L39)	(L42) (L43))		
16. STATE SURVEY AGEN See Attached Remarks	CY REMARKS (IF APPLICA	BLE SHOW LTC CANCELLATION	N DATE):		
17. SURVEYOR SIGNATU	RE	Date :		18. STATE SURVEY AGENCY	APPROVAL Date:
Jodi Johnso	on, HFE NE II	11/18/2014	(L19)	K <u>amala Fiske-Downing,</u>	Enforcement Specialist 11/19/2014 (L20)
	PART II - TO BE	COMPLETED BY HCFA R	REGIONA	L OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF _X1. Facility is El 2. Facility is n	igible to Participate	20. COMPLIANCE WI RIGHTS ACT:	TH CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24. LTC AGREE	EMENT	26. TERMINATION ACTION:	: (L30)
OF PARTICIPATION 07/01/1991	BEGINNINC	DATE ENDING D	ATE	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	
(L24)	(L41)	(L25)		02-Dissatisfaction W/ Reimburse	
25. LTC EXTENSION DAT				03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER
((1.27)	n of Admissions: (L44) Ispension Date:			07-Provider Status Change 00-Active
		(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/CARRIER NO).	30. REMARKS	
		00140			
	(L28)		(L31)		
31. RO RECEIPT OF CMS-1	539 32	. DETERMINATION OF APPROVA	AL DATE		
	(L32)	09/22/2014	(L33)	DETERMINATION APPI	ROVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: U683 PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00575

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN-24-5568

On 11/14/14, a Post Certification Revisit (PCR) was completed by the Department of Health. Based on the PCR, it has been determined that the facility has achieved substantial compliance pursuant to the 08/21/2014 standard survey, effective 11/3/2014. Refer to the CMS 2567b.

Effective 11/3/2014, the facility is certified for 51 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245568

November 19, 2014

Mr. Philip Samuelson, Administrator Good Samaritan Society - Mary Jane Brown 110 South Walnut Avenue Luverne, Minnesota 56156

Dear Mr. Samuelson:

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

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

Effective November 3, 2014 the above facility is certified for:

51 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 51 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.

Good Samaritan Society - Mary Jane Brown November 19, 2014 Page 2

Sincerely,

Kumala Fiske Downing

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered November 19, 2014

Mr. Philip Samuelson, Administrator Good Samaritan Society - Mary Jane Brown 110 South Walnut Avenue Luverne, Minnesota 56156

RE: Project Number S5568024

Dear Mr. Samuelson:

On October 21, 2014, we informed you that the following enforcement remedies were being imposed:

• State Monitoring effective October 26, 2014. (42 CFR 488.422)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective November 21, 2014. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on August 21, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on October 16, 2014. 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 November 14, 2014, 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 October 16, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 16, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on October 16, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective November 3, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 21, 2014. 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 November 21, 2014, be rescinded. (42 CFR 488.417 (b))

Good Samaritan Society - Mary Jane Brown November 19, 2014 Page 2

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 21, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 21, 2014, is to be rescinded.

In our letter of October 21, 2014, 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 November 21, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 3, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of :

• Mandatory denial of payment for new Medicare and Medicaid admissions effective November 21, 2014 be rescinded effective November 3, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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,

Kumalu Fiske Downing

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

Enclosure

cc: Licensing and Certification File

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 245568	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/14/2014			
Nam	e of Facility		Street Address, City, State, Zip Code				
GOOD SAMARITAN SOCIETY - MARY JANE BROWN		JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156				

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix Reg. #	F0329 483.25(l)		Correction Completed 11/03/2014	ID Prefix Reg. #	F0428 483.60(c)		Correction Completed 11/03/2014				
				LSC					LSC		
Reg. #			Correction Completed	Rea. #			Correction Completed		Deg #		Correction Completed
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed		Reg. #		Correction Completed
ID Prefix Reg. # LSC			Correction Completed				Correction Completed				Correction Completed
Reg. #			Correction Completed	.					D		
Reviewed B	By Revie	wed	Ву	Date:	Signature	e of Sur	veyor:			Date:	
State Agen	cy KS/	KFD	1	11/18/20	14		3	356	4		11/14/2014
Reviewed E CMS RO	3y Revie	wed	Ву	Date:	Signature	e of Sur	veyor:			Date:	
Followup t	o Survey Complete 8/21/2014	d on	:		Check for an Uncorrect		rected Defic iencies (CM			YES	NO

DEPARTMENT OF HEALTH	I AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES	
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION	AND TRANSMITTAL	ID: U683	
	PART I -	TO BE COMPI	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00575	
1. MEDICARE/MEDICAID PROVIDE (L1) 245568 2.STATE VENDOR OR MEDICAID N (L2) 060743600		3. NAME AND AE (L3) GOOD SAM (L4) 110 SOUTH (L5) LUVERNE,	IARITAN SOC WALNUT AV	CIETY - N	IARY JANE BROWN (L6) 56156	4. TYPE OF ACTION: 7(L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint	
5. EFFECTIVE DATE CHANGE OF C (L9)	WNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint	
6. DATE OF SURVEY 10/10 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	5/2014 (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	FISCAL YEAR ENDING DATE: (L35) 12/31	
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 	51 (L18)	Complianc		AS:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director	
13. Total Certified Beds	51 (L17)	X B. Not in Com Requireme	pliance with Prog ents and/or Appli		* Code: B	(L12)	
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS		
18 SNF 18/19 SNF 51	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:	
Mary Whitlock, HFE NI	EII	1	1/03/20144	(L19)	K <u>amala Fiske-Downing,</u>	Enforcement Specialist 11/14/2014 (L20	3)
PAR	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONA	L OFFICE OR SINGLE S	STATE AGENCY	
 19. DETERMINATION OF ELIGIBILI <u>X</u> 1. Facility is Eligible to Paralleligible 2. Facility is not Eligible 			IPLIANCE WITH ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	/IENT	26. TERMINATION ACTION	: (L30)	
OF PARTICIPATION 07/01/1991	BEGINNINC	G DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure	0 INVOLUNTARY 05-Fail to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		
25. LTC EXTENSION DATE: (L27)	-	n of Admissions:	(L44)		03-Risk of Involuntary Terminatic 04-Other Reason for Withdrawal	on <u>OTHER</u> 07-Provider Status Change 00-Active	
	B. Rescind St	spension Date:					
	20		(L45)		20 DEMADIZO		
28. TERMINATION DATE:	29	0. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
	(L28)	00140		(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE			
	(L32)	09/22/2014		(L33)	DETERMINATION APP	ROVAL	—

DEPARTMENT OF HEALTH AND HUMAN SERVICES	CENTERS FOR MEDICARE & MEDI	CAID SERVICES
MEDICARE/MEDICAID CERTIFICATION AN	D TRANSMITTAL	ID: U683
PART I - TO BE COMPLETED BY THE STATE	SURVEY AGENCY	Facility ID: 00575

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN-24-5568

On October 16, 2014, a Post Certification Revisit (PCR) was completed by the Department of Health and on October 7, 2014, the Minnesota Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility has not achieved substantial compliance pursuant to the August 8, 2014 standard survey. Refer to the CMS 2567 (For health), CMS 2567b for both health and life safety code.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

October 21, 2014

Mr. Philip Samuelson, Administrator Good Samaritan Society - Mary Jane Brown 110 South Walnut Avenue Luverne, Minnesota 56156

RE: Project Number S5568024

Dear Mr. Samuelson:

On September 2, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 21, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 16, 2014, the Minnesota Department of Health and on October 7, 2014, 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 August 21, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 30, 2014. 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 August 21, 2014. The deficiency(ies) not corrected is/are as follows:

F0329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs F0428 -- S/S: D -- 483.60(c) -- Drug Regimen Review, Report Irregular, Act On

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 October 26, 2014. (42 CFR 488.422)

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

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 21, 2014. (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 November 21, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 21, 2014. 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 - Mary Jane Brown is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 21, 2014. 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 determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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:

Kathryn Serie, Unit Supervisor Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 <u>Kathryn.serie@state.mn.us</u> Office: (507) 476-4233 Fax: (507) 537-7194

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 the following remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 21, 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 Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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

Enclosure

cc: Licensing and Certification File

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 245568	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/16/2014
Name of Facility			Street Address, City, State, Zip Code	
GOOD SAMARITAN SOCIETY - MARY JANE BROWN		JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156	

(Y4) Item		(Y5) Date	(Y4) Item		(Y5)	Date	(Y4)	Item	(Y5)	Date
	F0166 483.10(f)(2)	Correction Completed 10/16/2014		F0221 483.13(a)		Correction Completed 10/16/2014			F0241 483.15(a)	Correction Completed 10/16/2014
ID Prefix Reg. #		Correction Completed 10/16/2014	ID Prefix Reg. #			Correction Completed 10/16/2014		ID Prefix Reg. #		Correction Completed 10/16/2014
ID Prefix Reg. # LSC	F0371 483.35(i)	Correction Completed 10/16/2014	ID Prefix Reg. # LSC	F0520 483.75(o)(1)		Correction Completed 10/16/2014		Reg. #		
ID Prefix Reg. # LSC			Reg. #			Correction Completed		Reg. #		
ID Prefix Reg. # LSC			ID Prefix							
Reviewed I		viewed By CS/KFD	Date:	Signature	of Sur	veyor:	205	.00	Date	
State Agen Reviewed I CMS RO	-	viewed By	10/21/20 Date:	Signature	of Sur	veyor:	285	000	Date	<u>10/16/2014</u> ::
Followup t	to Survey Compl 8/21/20			Check for any Uncorrected					Summary of the Facility? YES	S NO

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.

• •	er / Supplier / CLIA / ication Number 8	(Y2) Multiple Cons A. Building B. Wing		N BUILDING 01	(Y3) Date of Revisit 10/7/2014					
Name of Facility				Street Address, City, State, Zip Code						
GOOD SAMARITAN SOCIETY - MARY JANE BROWN			110 SOUTH WALNUT AVENUE LUVERNE, MN 56156							

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix		(Correction Completed 09/30/2014	ID Prefix			Correction Completed 09/30/2014		ID Prefix			Correction Completed 09/30/2014
0	NFPA 101 K0011			U U	NFPA 101 K0029				0	NFPA 101 K0052		
	NFPA 101 K0062	(Correction Completed 19/30/2014	Reg. #			Correction Completed		_			Correction Completed
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed		Reg. #			Correction Completed
Reg. #			Correction Completed	Reg. #			Correction Completed					
Reg. #			Correction Completed	Reg. #					D.a. #			
Reviewed I	By Re	viewed l	Ву	Date:	Signatu	ire of Sur	veyor:				Date:	
State Agen Reviewed I CMS RO		S/KFE viewed l		10/21/2 Date:		ire of Sur		764			Date:	10/07/2014
	o Survey Comple 8/20/20									Summary of the Facility?	YES	NO

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 245568	(Y2) Multiple Cons A. Building B. Wing	1 ADDITION	(Y3) Date of Revisit 10/7/2014			
Name of Facility		Street Address, City, State, Zip Code				
GOOD SAMARITAN SOCIETY - MARY	JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156				

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date) ((Y4)	ltem		(Y5)	Date
		Correction			Correc	tion					Correction
ID Prefix		Completed 09/30/2014	ID Prefix		Compl 09/30/2			ID Prefix			Completed 09/30/2014
	NFPA 101		•	NFPA 101				0	NFPA 101		
LSC	K0011		LSC	K0029				LSC	K0052		
		Correction			Correc	tion					Correction
		Completed			Compl	leted					Completed
								ID Prefix			
Reg. #			Reg. #					Reg. #			
LSC			LSC					LSC			
		Correction			Correc	tion					Correction
		Completed			Compl	leted					Completed
ID Prefix											
Reg. #			Reg. #					Reg. #			
			LSC					LOU			
		Correction			Correc	tion					Correction
		Completed			Compl	leted					Completed
Reg. #			Reg. #					Reg. #			
							-	200			
		Correction			Correc	tion					Correction
		Completed			Compl	leted					Completed
Reg. #			Reg. #					Reg. #			
			200					200			
Reviewed E	By Revi	ewed By	Date:	Signature o	of Surveyor:					Date:	
State Agen		S/KFD	10/21/20	14		342	764			10/0	7/2014
Reviewed E	By Revi	ewed By	Date:	Signature o	of Surveyor:					Date:	
CMS RO											
Followup t	o Survey Complet			Check for any	Uncorrected			s. Was a	Summary of		
	8/20/201	4		Uncorrected	Denciencies	5 (UNS	5-230/) Sent to	the Facility?	YES	NO

		AND HUMAN SERVICES			FORM	APPROVED	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DA	0. 0938-0391 TE SURVEY	
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING 01 - MAIN BUILDING 01	CO	MPLETED	
		245568	B. WING		R — 10/07/2014		
NAME OF F	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5) COMPLETION	
PRÉFIX TAG	(EACH DEFICIENC) REGULATORY OR L	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI> TAG			COMPLETION DATE	
{K 000}	INITIAL COMMEN	rs	{K 00	00}			
	correction, the facil	f the facility's plan of ity is in compliance with the nts identified as deficient at the fication survey.					
LABORATOR	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	VATURE	TITLE		(X6) DATE	

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

PRINTED: 10/21/2014

		AND HUMAN SERVICES			FORM APPROVED
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		245568	B. WING		R 10/07/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
600D S		- MARY JANE BROWN		110 SOUTH WALNUT AVENUE	
0000 3				LUVERNE, MN 56156	
(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 X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
{K 000}	INITIAL COMMEN	TS	{K 00	00}	
	correction, the facil	f the facility's plan of ity is in compliance with the nts identified as deficient at the fication survey.			
LABORATOR	Y DIRECTOR'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

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

PRINTED: 10/21/2014

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			'		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	` ´CO№	E SURVEY IPLETED
		245568	B. WING	;			R 1 6/2014
NAME OF F	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE	10/	10/2014
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN			110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F	000)		
F 329 SS=D	of this department, to determine compl deficiencies issued exited on August 21 following regulation being corrected: F- 483.25(I) DRUG RE UNNECESSARY D Each resident's dru	during a recertification survey I, 2014. During this visit the s were determined as not -329 and F-428. EGIMEN IS FREE FROM RUGS g regimen must be free from	F	329)		10/28/14
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer	. An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of neces which indicate the dose or discontinued; or any					
	resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and o record; and residen drugs receive gradu behavioral intervent	chensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical its who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these					
LABORATORY		NT is not met as evidenced	NATURE		TITLE		(X6) DATE
Electron	ically Signed						10/28/2014

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.

PRINTED: 11/04/2014

TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED		
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _					
		245568	B. WING			F 10/1	۲ 6/2014		
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>		TREET ADDRESS, CITY, STATE, ZIP CODE	10/1	10/2014		
		- MARY JANE BROWN		11	110 SOUTH WALNUT AVENUE				
				L	UVERNE, MN 56156				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE		
F 329	Continued From pa	ige 1	F 3	329					
	by:	0	-						
		and document review the			Sleep monitoring and Sleep Asses				
	facility failed to mor	nitor and assess the			for R9 were initiated on 10/16/14 w	ith			
		antidepressant medication after a dose reduction for 1 of			Sleep assessment completion on 10/20/14.				
		viewed for unnecessary			10/20/14.				
	medications.				All residents prescribed medication	to			
					aide sleep were reviewed for sleep				
	Findings include:				assessment completion by the DNS	5.			
	Document review o	f R9's physician orders dated			Mediation Review process for medi	cations			
		diagnosis of but not limited to			used for sleep was reviewed with th				
		der to decrease Trazodone			Consultant Pharmacist, Health				
		ams) to 25 mg p.o. (by mouth)			Information Management (HIM) dire				
	every HS (bedtime)).			and all Licensed Nurses through a				
	Document review o	f R9's medication record			dated 10/28/14. The RN will comple Sleep Assessments prior to initiatin				
		14, revealed R9 had been			medication for insomnia, on admiss				
	receiving Trazodon	e 25 mg by mouth at bedtime			resident is taking this type of medic				
		, start date of 9/12/14 and last			on admission, any time a medication	on for			
		pattern had been from 9/5/14			insomnia is changed, a resident is				
		documentation of monitoring een done after the ordered			observed to have signs of insomnia resident complains of new onset	a or the			
		the Trazodone on 9/12/14.			insomnia, and annually if taking				
					medication for insomnia. The RN C	ase			
		initiated 8/07/14, identified on			Manager will be notified of medicat				
		dication therapy related to			initiation or changes by the charge				
		ventions of monitor for observe for side effects. R9's			and the HIM director. The consultin	g			
		by further documentation			Pharmacist will verify that Sleep Assessments have been completed				
	regarding insomnia				monthly.				
	Review of R9's me	dical record identified last			All physician orders received will be	9			
		had been completed on			reviewed weekly for 4 weeks then r				
	9/8/14. R9's medica	al record lacked monitoring of			for 2 months by the DNS or designed				
		ep assessment and any			medications that require sleep				
		ted to the effectiveness of the			assessment follow-up will be audite				
	i razodone atter the	e ordered dose reduction on			sleep assessment completion. Res	uits of			

Facility ID: 00575

If continuation sheet Page 2 of 5

		AND HUMAN SERVICES			FORM	11/04/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
		245568	B. WING		R 10/16/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	-	
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 329	Continued From pa	ige 2	F 32	9		
	audits dated 9/18/1 10/10/14, identified	of the facility sleep assessment 4, 9/24/14, 10/3/14 and response of "NO" to any ose changes even though a d occurred.		committee for review and recommendation.		
	director of nursing l sleep assessment in Trazodone. I star sleep pattern today being followed up of Policy for sleep ass and the director of had no policy for sleep	EGIMEN REVIEW, REPORT	F 42	8		11/7/14
	0 0	of each resident must be nce a month by a licensed				
	the attending physi	ist report any irregularities to cian, and the director of reports must be acted upon.				
	by: Based on interview facility consultant p of monitoring and e antidepressant mee	NT is not met as evidenced v and document review the harmacist failed to identify lack effectiveness of an dication used for insomnia ion for 1 of 3 residents (R9)		F 428 Sleep monitoring and Sleep a for R9 were initiated on 10/16 Sleep assessment completion 10/20/14.	/14 with	

Facility ID: 00575

If continuation sheet Page 3 of 5

		AND HUMAN SERVICES			FORM	11/04/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED R	
		245568	B. WING			ĸ 16/2014
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	Continued From pa	age 3	F 428	8		
	reviewed for unnec	essary medications.				
	9/12/14, identified of	of R9's physician orders dated diagnosis of but not limited to		All residents prescribed medicat aide sleep will be reviewed for sl assessment completion by the D Consulting Pharmacist by Nover 2014.	eep NS and	
	from 50 mg (milligr every HS (bedtime)	medications used f with the Consultant		Medication Review process for medications used for sleep was with the Consultant Pharmacist,	sleep was reviewed armacist, HIM	
	dated 9/14 and 10/ receiving Trazodon related to insomnia monitoring of sleep through 9/8/14. No sleep pattern had b	of R9's medication record 14, revealed R9 had been the 25 mg by mouth at bedtime a, start date of 9/12/14 and last to pattern had been from 9/5/14 documentation of monitoring been done after the ordered the Trazodone on 9/12/14.		director, and all Licensed Nurses a memo dated 10/28/14. The RM complete Sleep Assessments pr initiating a medication for insomn admission if resident is taking th medication on admission, any tir medication for insomnia is chang resident is observed to have sign insomnia or the resident compla	l will ior to nia, on is type of ne a ged, a ns of	
	sleep assessment 9/8/14. R9's medica sleep pattern, a sle documentation rela	dical record identified last had been completed on al record lacked monitoring of ep assessment and any ited to the effectiveness of the e ordered dose reduction on		onset insomnia, and annually if t medication for insomnia. The RN Manger will be notified of medica initiation or changes by the charg and the HIM director. The consu Pharmacist will verify that Sleep Assessments have been complet monthly.	aking I Case ation ge nurse Iting	
	progress note date Trazodone dose de Trazodone every H so far but received R9's pharmacy rev documentation rela assessment related	of pharmacy consultant d 10/10/14, revealed ecreased, resident refused S dose times one in October each night in September. iew dated 10/10/14 lacked any ated to the monitoring/sleep d to the effectiveness of the e ordered dose reduction on		All physicians orders received for aides will be audited to ensure re- sleep assessments have been of weekly for 4 weeks then monthly months by the DNS or designee of the audits will be reported to to committee for review and recommendation.	equired ompleted v for 2 Results	
	During interview on	n 10/16/14, at 9:30 a.m. the				

Facility ID: 00575

If continuation sheet Page 4 of 5

		AND HUMAN SERVICES				FORM	11/04/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245568	B. WING				२ 16/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- MARY JANE BROWN			10 SOUTH WALNUT AVENUE UVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	sleep assessment f in Trazodone. I star sleep pattern today being followed up o During interview on consultant pharmad would assume they assessment after a Trazodone. " Document review o CONSULTANT PH/ FOR SKILLED NUF 6/18/12, read " 2. L Review the drug reg Center at the time o once each month a irregularity to the Co	had stated, " I do not have a for R9 following the decrease red the 72 hour monitoring for (10/16/14). It was missed on after the dose change. " 10/16/14, at 9:44 a.m., cist (CP)-B had stated. " I would monitor and do a sleep dose reduction for the of the facility ADDENDUM C - ARMACIST AGREEMENT RSING FACILITY (SNF) dated Lewis Drug agrees to: a. gimen of each resident in the of Lewis Drug's visit at least and report in writing any enter's Administrator, Director s and, where appropriate, the	F	428			

Facility ID: 00575

If continuation sheet Page 5 of 5

TAG REQULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REPERENCE TO THE APPROPRIATE DME F 000 INITIAL COMMENTS F 000 An onsite resurvey was conducted by surveyors of this department, on October 15 and 16 2014, to determine compliance with Federal deficiencies issued during a recertification survey exited on August 21, 2014. During this visit the following regulations were determined as not being corrected. F-329 and F-428. F 329 433.25(1) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS F 329 10/28/14 SS=0 UNNECESSARY DRUGS F 329 ads.25(1) or for excessive dose (including duplicate therapy); or for excessive dose (including duplicate therapy); or for excessive dose (including duplicate therapy); or for excessive duration, or without adequate monitoring; or without adequate monitoring; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drug are not given these drugs unless antipsychotic drug are not given these drugs unless antipsychotic drug therapy is necessary drug unless antipsychotic drug therapy is necessary drug the aspecific condition as diagnosed and documented in the clinical record; and resident in the dose reductions, and behavioral interventions, unless clinically contrained; in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced			AND HUMAN SERVICES				FORM	: 11/03/2014 APPROVED
245568 B. WING R MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10/16/2014 GOOD SAMARITAN SOCIETY - MARY JANE BROWN STREET ADDRESS, CITY, STATE, ZIP CODE 100 SOUTH WALNUT AVENUE COOD SAMARITAN SOCIETY - MARY JANE BROWN Interview of the second state second counce state the sec	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE SURVEY	
245568 E. WING 10/16/2014 NAME OF PROMDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE CODE GOOD SAMARITAN SOCIETY - MARY JANE BROWN STREET ADDRESS, CITY, STATE, ZIP CODE COMPARIANE	741010410	o connection	DENTIFICATION NONDER.	A. BUILD	ING			
10 200TH WALNUT AVENUE 10 200TH WALNUT AVENUE 10 200TH WALNUT AVENUE 10 200TH WALNUT AVENUE 200 INITIAL COMMENT OF DEFICIENCIES TAG PREFIX PREFIX 10 PROTECTION (EACH CONNECTIVAL TO ISC DENTIFICING INFORMATION) F 000 INITIAL COMMENTS An onsite resurvey was conducted by surveyors of flis department, on October 15 and 18 2014, to determine compliance with Federal deficiencies issued during a recertification survey exited on August 21, 2014. During flis visit the following regulations were determined as not being corrected: F-329 and F-428. F 329 F 329 Additions were determined as not being corrected: F-329 and F-428. F 329 Each resident's drug regimen must be free from unnecessary drug. An unnecessary drug is any drug when used in excessive dorse (including duplicate therapy); or for excessive dorse (including duplicate therapy); or for excessive dorse (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indictions of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsycholic drugs ecvice gradual dose reductions, and behavioral intervotions, unless enlineally contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced			245568	B. WING				
GODD SAMARTIAN SOCIETY - MARY JANE BROWN LUVERNE, MN 58156 (%) ID PRETK TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CERCINCH MIST BE HARDOF MIST BE HARDOF MIST BE ANOLD BE CROSS-REFERENCES AT ONLY A DURING THE AT ONLY AT ONLY AT A DURING AT AN ONLY AND AN ONLY AND AN ONLY AT ONLY AT A DURING AT AN ONLY AND AN ONLY AND AN ONLY AND AN ONLY AT A DURING AT AN ONLY AND AN ONLY AND AN ONLY AND AN ONLY AT A DURING AT AN ONLY AND AN ONLY AND AN ONLY AND AN ONLY AT A DURING AT AN ONLY AND AN ONLY AND AN ONLY AND AN ONLY AND AN ONLY AND ANY	NAME OF I	PROVIDER OR SUPPLIER						
Précix TAG RECULTORY OR LSC DENTIFYING INFORMATION) PRÉLX TAG CEACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY COMPARING CROSS-REFERENCE TO THE DEFICIENCY COMPARING CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY COMPARING CROSS-REFERENCE TO THE APPROPRIATE DEFICI	GOOD SAMARITAN SOCIETY - MARY JANE BROWN							
An onsile resurvey was conducted by surveyors of this department, on October 15 and 16 2014, to determine compliance with Federal deficiencies issued during a recertification survey exited on August 21, 2014. During this visit the following regulations were determined as not being corrected: F-329 and F-428. F 329 F 329 483.26(i) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS F 329 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contriandicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
of this department, on October 15 and 16 2014, to determine compliance with Federal deficiencies issued during a recertification survey exited on August 21, 2014. During this visit the following regulations were determined as not being corrected: F-329 and F-428. F 322 483.25(1) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy): or for excessive dose (including duplicate therapy): or for excessive dose (including duplicate therapy): or for excessive dose of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drugs therapy is necessary drugs and behavioral interventions, unless clinically contraindicated, in an effort to discontlinue these drugs. This REQUIREMENT is not met as evidenced	F 000	INITIAL COMMENT	ſS	FC	000			
unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.		of this department, to determine compl deficiencies issued exited on August 21 following regulation being corrected: F- 483.25(I) DRUG RE	on October 15 and 16 2014, iance with Federal during a recertification survey 1, 2014. During this visit the s were determined as not 329 and F-428. EGIMEN IS FREE FROM	F 3	329			10/28/14
resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.		unnecessary drugs. drug when used in a duplicate therapy); a without adequate m indications for its us adverse consequen should be reduced	An unnecessary drug is any excessive dose (including or for excessive duration; or ionitoring; or without adequate se; or in the presence of icces which indicate the dose or discontinued; or any					
		resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and d record; and residen drugs receive gradu behavioral intervent contraindicated, in a	must ensure that residents antipsychotic drugs are not inless antipsychotic drug y to treat a specific condition ocumented in the clinical ts who use antipsychotic ial dose reductions, and ions, unless clinically					
A DOMAIONE MEDICIONO ON HOMBERICO I LETINE ALCOMATINE O DIONATONE ALCE MEDICIONO DALE	LABORATORY			NATURE		TITLE		(X6) DATE

Electronically Signed

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 provide. 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	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATI	0938-039 SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		PLETED
		245568	B WING			2
	PROVIDER OR SUPPLIER	243300		STREET ADDRESS, CITY, STATE, ZIP C		6/2014
	NOWDER OR SOLA ELER			110 SOUTH WALNUT AVENUE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		LUVERNE, MN 56156		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) Completion Date
F 329	Continued From pa	ige 1	F 32	9		
	by: Based on interview facility failed to mor effectiveness of an used for insomnia a 3 residents (R9) rev medications. Findings include: Document review of 9/12/14, identified of insomnia and an or from 50 mg (milligra every HS (bedtime) Document review of dated 9/14 and 10/ receiving Trazodon related to insomnia monitoring of sleep through 9/8/14. No sleep pattern had b dose reduction for the R9's care plan date antidepressant median	v and document review the nitor and assess the antidepressant medication after a dose reduction for 1 of viewed for unnecessary of R9's physician orders dated diagnosis of but not limited to der to decrease Trazodone ams) to 25 mg p.o. (by mouth)		Sleep monitoring and Sleep for R9 were initiated on 10/ Sleep assessment complete 10/20/14. All residents prescribed me aide sleep were reviewed for assessment completion by Mediation Review process for used for sleep was reviewe Consultant Pharmacist, Hea Information Management (H and all Licensed Nurses thr dated 10/28/14. The RN will Sleep Assessments prior to medication for insomnia, or resident is taking this type of on admission, any time a m insomnia is changed, a resident complains of new of insomnia, and annually if ta medication for insomnia. Th Manager will be notified of m initiation or changes by the and the HIM director. The of Pharmacist will verify that S	16/14 with ion on dication to or sleep the DNS. for medications d with the alth HIM) director, rough a memo I complete o initiating a n admission if of medication nedication for ident is nsomnia or the onset king ne RN Case medication charge nurse consulting	
	regarding insomnia Review of R9's med sleep assessment I 9/8/14. R9's medica sleep pattern, a sle documentation rela	hy further documentation dical record identified last had been completed on al record lacked monitoring of ep assessment and any ted to the effectiveness of the e ordered dose reduction on		Assessments have been comonthly. All physician orders receive reviewed weekly for 4 week for 2 months by the DNS or medications that require sle assessment follow-up will b sleep assessment completi	d will be ts then monthly designee and eep le audited for	

Event ID: U68312

Facility ID: 00575

If continuation sheet Page 2 of 5

TATEMENT	OF DEFICIENCIES	KANDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IB NO. 0938-039 X3) DATE SURVEY COMPLETED
		245568	B. WING		R 10/16/2014
	PROVIDER OR SUPPLIER	- MARY JANE BROWN		STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE LUVERNE, MN 56156	
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 329	Continued From pa	age 2	F 329		
	audits dated 9/18/1 10/10/14, identified	of the facility sleep assessment 4, 9/24/14, 10/3/14 and I response of "NO" to any ose changes even though a ad occurred.		committee for review and recommendation.	
F 428 SS=D	director of nursing sleep assessment in Trazodone. I star sleep pattern today being followed up of Policy for sleep ass and the director of had no policy for sl	EGIMEN REVIEW, REPORT	F 428		11/7/14
		of each resident must be nce a month by a licensed			
	the attending physi	ist report any irregularities to cian, and the director of reports must be acted upon.			
	by: Based on interview facility consultant p of monitoring and e antidepressant med	NT is not met as evidenced v and document review the harmacist failed to identify lack offectiveness of an dication used for insomnia ion for 1 of 3 residents (R9)		F 428 Sleep monitoring and Sleep assessr for R9 were initiated on 10/16/14 with Sleep assessment completion on 10/20/14.	

Event ID: U68312

Facility ID: 00575

If continuation sheet Page 3 of 5

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	IPLE CONSTRUCTION		E SURVEY PLETED	
		245568				R 16/2014	
NAME OF I	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP C		10/16/2014	
		- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 428	Findings include: Document review o 9/12/14, identified d insomnia and an or from 50 mg (milligra every HS (bedtime) Document review o dated 9/14 and 10/7 receiving Trazodone related to insomnia, monitoring of sleep through 9/8/14. No sleep pattern had b dose reduction for t Review of R9's medica sleep pattern, a sleet documentation relat Trazodone after the 9/12/14. Document review o progress note dated Trazodone dose de Trazodone dose de Trazodone every HS so far but received R9's pharmacy revie documentation relation	f R9's physician orders dated liagnosis of but not limited to der to decrease Trazodone ams) to 25 mg p.o. (by mouth)	F 42	All residents prescribed med aide sleep will be reviewed f assessment completion by 6 Consulting Pharmacist by N 2014. Medication Review process medications used for sleep with the Consultant Pharma director, and all Licensed Ne a memo dated 10/28/14. Th complete Sleep Assessmen initiating a medication for ins admission if resident is takin medication on admission, an medication for insomnia is of resident is observed to have insomnia or the resident cor onset insomnia, and annual medication for insomnia. Th Manger will be notified of me initiation or changes by the of and the HIM director. The cor Pharmacist will verify that SI Assessments have been co monthly. All physicians orders receiver aides will be audited to ensu- sleep assessments have be weekly for 4 weeks then mo months by the DNS or desig of the audits will be reported committee for review and	for sleep the DNS and ovember 7, for was reviewed cist, HIM urses through e RN will ts prior to somnia, on ng this type of ny time a thanged, a e signs of mplains of new ly if taking e RN Case edication charge nurse onsulting teep mpleted ed for sleep ire required en completed nthly for 2 inee. Results		

Facility ID: 00575

If continuation sheet Page 4 of 5

		AND HUMAN SERVICES				FORM	: 11/03/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245568	B. WING	i			R 16/2014
NAME OF	PROVIDER OR SUPPLIER	1 <u></u>		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN			10 SOUTH WALNUT AVENUE UVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y 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 428	director of nursing I sleep assessment I in Trazodone. I star sleep pattern today being followed up o During interview on consultant pharmad would assume they assessment after a Trazodone. " Document review o CONSULTANT PH/ FOR SKILLED NUF 6/18/12, read " 2. L Review the drug reg Center at the time o once each month a irregularity to the Co	had stated, "I do not have a for R9 following the decrease ted the 72 hour monitoring for (10/16/14). It was missed on after the dose change." 10/16/14, at 9:44 a.m., cist (CP)-B had stated. "I would monitor and do a sleep dose reduction for the f the facility ADDENDUM C - ARMACIST AGREEMENT RSING FACILITY (SNF) dated lewis Drug agrees to: a. gimen of each resident in the of Lewis Drug's visit at least nd report in writing any enter's Administrator, Director and, where appropriate, the	F 4	428			

Facility ID: 00575

If continuation sheet Page 5 of 5

DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES		
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: U683		
	PART I -	TO BE COMPI	LETED BY T	THE STAT	FE SURVEY AGENCY	Facility ID: 00575		
1. MEDICARE/MEDICAID PROVID (L1) 245568 2.STATE VENDOR OR MEDICAID ID (L2) 060743600		 NAME AND AI (L3) GOOD SAM (L4) 110 SOUTH (L5) LUVERNE, 	IARITAN SOC WALNUT AV	CIETY - M	IARY JANE BROWN (L6) 56156	4. TYPE OF ACTION: 2(L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
 5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 08/2 	OWNERSHIP 21/2014 (L34)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual	IPPLIER CATEG 05 HHA 06 PRTF	ORY 09 ESRD 10 NF	<u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/III 12 RHC		FISCAL YEAR ENDING DATE: (L35) 12/31		
 11LTC PERIOD OF CERTIFICATIO From (a): To (b): 12.Total Facility Beds 	N 51 (L18)	Complianc		AS:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director		
13.Total Certified Beds	51 (L17)	X B. Not in Com Requireme	pliance with Prog ents and/or Appli		* Code: B *	(L12)		
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS			
18 SNF 18/19 SNF 51	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	YAPPROVAL Date:		
Connie Brady,	HFE NE II	0	9/09/2014	(L19)	Kamala Fiske-Downing, Enforcement Specialist 09/22/2014 (L20)			
PA	RT II - TO BE	COMPLETED H	BY HCFA RE	GIONAI	L OFFICE OR SINGLE S	TATE AGENCY		
 DETERMINATION OF ELIGIBII 1. Facility is Eligible to l 2. Facility is not Eligible 	Participate		IPLIANCE WITH ITS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :		
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	1ENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION 07/01/1991	BEGINNINC	5 DATE	ENDING DA	ГЕ	VOLUNTARY 00	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	of Full to Meet Fightement		
25. LTC EXTENSION DATE: (L27)	VE SANCTIONS	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	n <u>OTHER</u> 07-Provider Status Change 00-Active			
()	B. Rescind Si	spension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS			
		00140						
	(L28)			(L31)	Posted 09/22/2014 C	co.		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE				
	(L32)			(L33)	DETERMINATION APPI	ROVAL		



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered September 2, 2014

Mr. Philip Samuelson, Administrator Good Samaritan Society - Mary Jane Brown 110 South Walnut Avenue Luverne, Minnesota 56156

RE: Project Number S5568024

Dear Mr. Samuelson:

On August 21, 2014, 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.

Good Samaritan Society - Mary Jane Brown September 2, 2014 Page 2

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:

Kathryn Serie, Unit Supervisor Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 <u>Kathryn.serie@state.mn.us</u> Office: (507) 476-4233 Fax: (507) 537-7194

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 September 30, 2014, 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 September 30, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Good Samaritan Society - Mary Jane Brown September 2, 2014 Page 4

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 November 21, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 21, 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 Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900 Good Samaritan Society - Mary Jane Brown September 2, 2014 Page 5

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	<u> //B NO.</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245568	B. WING _		08/:	21/2014
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE		
				LUVERNE, MN 56156		
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	F 00	0		
F 166 SS=E	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an a on-site revisit of you validate that substa regulations has beet your verification. 483.10(f)(2) RIGHT RESOLVE GRIEVA A resident has the r facility to resolve gr	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with TO PROMPT EFFORTS TO	F 16	6		9/30/14
	by: Based on observat review the facility fa resolution to voiced residents (R68, R25 who identified that s not timely and for 6 R43 & R25) resider service and had info complaints. Findings include:	NT is not met as evidenced ion, interview and document iled to actively seek a grievances for 4 of 4 5, R51 & R18) in the sample staff call light response was of 6 (R16, R33, R48, R42, hts who identified slow meal prmed facility staff of these		Suggestion/Concern forms were in for R25, R51, and R18 related to co of untimely call light response times for R16, R33, R48, R42, R43, and R related to concern of slow meal ser R68 has discharged from Facility. Staff was educated on the importan answering call lights while they are working to decrease the call light response time at an All-Staff In-serv 8-28-14. A new procedure was deve for passing trays at meal times. The	oncern s and R25 vice. nce of vice on eloped	
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically Signed					09/09/2014

Electronically Signed

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.

PRINTED: 09/09/2014

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	SURVEY
ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:		B		PLETED
		245568	B. WING		08/2	21/2014
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(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) COMPLETIC DATE
F 166	Continued From pa	ge 1	F 166	5		
	12:46 p.m. R68 stat were enough staff a her needs. R68 stat answer her call ligh During interview wit p.m. R68 stated sho fifteen minutes whe needed assistance light. R68's family n the room at the time took a long time to indicated R68 requi as she was not to w when staff did not r R68 would transfer R68 stated that at s shift, she would wai respond to the call- incontinent brief pro- want to have an acc arrive, and stated s wear that dumb De R68's admission Mi assessment, dated brief interview for m 15 which indicated cognition were intac R68 as continent of extensive assist of During initial intervie 1:03 p.m. R25 state enough staff availal	ted that she did not feel there available at the facility to meet ted it took staff a long time to t. th R68 on 8/20/14, at 1:20 e had to frequently wait over en she alerted staff she and had activated the call nember (FM)-A, who was in e of the interview, verified it get the lights answered. FM-A ired assistance with toileting valk alone. FM-A stated that espond in a timely manner, self into the bathroom to void. cometimes, during the night it one half hour for staff to light. R68 stated she wore an oduct because she did not cident while waiting for staff to he did not like to "have to		 procedure includes nursing staff a dietary to pass trays to the assister residents as they are ready to ass a new serving rotation that would formalize rotating the order in whi are served at each meal, and inclustion to a monthly resident cale and announcing it at devotions. N and Dietary staff were educated to new procedure through a Memo p 9/3/14. Call light response times will be a random times 3 times per week for month and then once a week for or month to ensure timely call light retimes by LSW or designee. Meal wait times will be audited 3 times week at random meals for one month to DDS or designee. Results of the a will be shared with Resident Cour Quality Assurance Performance Improvement (QAPI) committee for and recommendations. 	ed isst them, ch tables uded he endar ursing to the posted udited at or one one esponse service per onth and by the audits icil and	

If continuation sheet Page 2 of 42

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION	OMB NC (X3) DA	TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
		245568	B. WING _		08	/21/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 166		-	F 10	66		
	transfers to the bat of bed. R25 stated half hour for the ca she alerted staff wh with transfer to the really don't ever ha to wait sometimes	d she required assistance with hroom and getting in and out she often had to wait over one Il light to be answered after hen she required assistance bathroom. R25 stated, "I ve accidents but when I have I dribble and it makes me feel te or cough when I'm trying to				
	hold it, I dribble. It r indicated she expe assistance on a da	nakes me disappointed." R25 rienced long waits for staff ily basis. R25 indicated she ed when she waits a long time.				
	with a BIMs of 14, i identified her as alv MDS further identif	S dated 6/24/14, identified her ndicating intact cognition, and ways continent of urine. The ied she required extensive staff with transferring and				
	2:29 p.m., R51 stat enough staff availa stated,"With the kic facility is short of st time to get your ligh	ew with R51 on 8/19/14, at ed she did not feel there was ble to help her. R51 Is returning to school the aff and you have to wait a long ht answered. I push the button ait over one half hour for help."				
	p.m. R51 indicated minutes to get staff the call light. R51 id day were before an have to go in my pa I can hold it until I s bathroom and then	interview on 8/20/14, at 1:35 she had to wait twenty to thirty response when she activated dentified the worst times of the d after meals. R51 stated, "I ad because they take too long. tand up to walk to the it's too late." R51 stated she ncontinent but she could not				

		AND HUMAN SERVICES				FORM	09/09/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245568	B. WING			08/:	21/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN			10 SOUTH WALNUT AVENUE UVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166	Continued From pa	ige 3	F 1	66			
	with a BIMs of 15, a	S dated 6/25/14 identified her as occasionally incontinent, sive assistance of one staff oileting.					
	2:48 p.m. R18 state enough staff availal stated, "I had to wa putting my call light bathroom." R18 sta toileting, it was urge surgeries related to she was tempted to herself but didn't da supposed to. R18 in	ew with R18 on 8/18/14, at ed she did not feel there was ble to meet her needs. R18 it 25 minutes for help after on this morning to get to the ated that when she required ent due to a history of bladder issues. R18 stated o walk to the bathroom by are because she was not indicated she was "soaked" ceived assistance to the					
	p.m. R18 stated sho receive assistance realize its busy. Sor they walk past the r to take care of first,	interview on 8/21/14, at 12:45 e had to wait a long time to with toileting. R18 stated, "I metimes my light is on and room; I guess they have others or they're not assigned to me. the bathroom. I don't like					
	a BIMS score of 14	ission MDS identified her with , occasionally incontinent, and ive assistance of one staff with ng.					
	(DON) on 8/21/14, a had been aware of light response times	th the director of nursing at 9:20 a.m. she stated she resident complaints about call s. ion on 8/18/14, continuously					

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	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION		0. 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,	NG		MPLETED
		245568	B. WING _		30	8/21/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
GOOD S	AMARITAN SOCIET	(- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE
F 166	Continued From pa	age 4	F 16	66		
		1:00 p.m. it was noted that				
	residents who were independent with eating were					
		meal subsequent to residents				
		stance. Residents who did not with eating expressed				
		satisfaction related to a long				
		heir meal service. It was noted				
		were independent with eating				
		nutes from the start of meal				
		osted as being served at 12:00				
		sident who was independent 5 minutes after the posted time				
		. Cook-A was interviewed on				
		o.m. verified that residents who				
	required assistanc	e were served first and when				
		with their meal the				
	independent reside					
		tion and interview on 8/18/14,				
		verified she arrived in the				
		00 noon and added that it was to perform the second structure to 30-35 minutes to be				
		neal. R48 verified that				
		been expressed to the dietary				
		ccasions and was also aware				
		n discussed at the resident				
		R48 had a Brief Interview of //S) score on 8/15/14, of 15/15				
	which indicated co					
		erview was conducted with R33				
		4, at approximately 12:20 p.m.				
		expressed complaints related ne for meals to be served. R33				
		well, what else do I have to do				
		3 and R42 were aware that				
	issues were broug	ht up at the resident council				
	meetings but nothi	ing had changed. R33 had a				
		5/30/14, of 15/15 indicating no				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 09/09/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245568	B. WING		08/	21/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(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	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 166	dated 7/18/14, of 14 cognitive impairment R16 and R25 were 8/18/14, at 12:27 p. time to be served th R16 had a BIMS score which indicated no had a BIMS score of indicating no cognit During an observati 12:30 p.m. R43 exp long wait for meal s dated 6/13/14, of 9 cognitive impairment An interview was co at 8:37 a.m. verified good half hour or lo at lunch and supper go down there (dini because of how lon food. I even got up Review of the Resid dated 4/24/14, iden department. One re don't get our meals Director responded We will start serving meals". The facility policy for	ht. R42 had a BIMS score 4/15 which also indicated no nt. observed/interviewed on m. and also verified the wait he noon meal was too long. ore dated 7/18/14, of 15/15 cognition impairment. R25 dated 6/2/14, of 14/15 ive impairment. ion/interview on 8/18/14, at pressed dissatisfaction with the pervice. R43 had a BIMS score 1/15 which indicated moderate nt. onducted with R43 on 8/21/14, d that she had to wait for a inger to have her meal served r. She added, "I just hate to ng room) at lunch and supper ig I have to wait to get my	F 166			
	grievance procedur					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	09/09/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245568	B. WING		08/	21/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 166	 will be given with a procedure. 2. When a resident, staff member expret to a staff member expret to a staff member reservices, it will be renonjudgmental marror reprisal. 3. If the problem cat the staff member winformation and prot the problem. The gradocumented on the submitted to the cell 4. If the complaint of services department services will complet form upon receipt of 5. The social servic Suggestion or Concord department head as The policy continue investigate the grievinvestigation and id grievance to the ap Even when the facili support staff were a complaints about slow of the social service investigate form and it of the grieven when the facili support staff were a complaints about slow of the social service in the facili support staff were a complaints about slow of the social service in the staff were a complaints about slow of the social service in the social service integration and id grieven when the facili support staff were a complaints about slow of the social service integration and id grieven when the facili support staff were a complaints about slow of the social service integration and id grieven when the facili support staff were a complaints about slow of the social service integration and id grieven when the facili support staff were a complaints about slow of the social service integration and id grieven when the facili support staff were a complex of the social service integration and id grieven were show of the social service integration and id grieven were service were service and the service integration and id grieven were service were service	esolving the Issues" brochure review of the grievance a family member, visitor or esses a concern or grievance elated to resident care or eceived in an open, friendly, aner and without discrimination n be resolved immediately, ill thank the individual for the ceed to take action regarding rievance then will be Suggestion or Concern and neter social service director. comes directly to the social at, then the director of social ete a Suggestion or Concern of the complaint. es director will route the cern form to the appropriate s soon as possible. d to identify the facility will vance, document the entify their response to the plicable party. ity administrative and direct aware of the residents ow call light responses and here were no interventions put	F 166	5		
F 221 SS=D	483.13(a) RIGHT T PHYSICAL RESTR	O BE FREE FROM	F 22′			9/30/14

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION		E SURVEY PLETED
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		
		245568	B. WING _		08/	21/2014
	PROVIDER OR SUPPLIER	- MARY JANE BROWN		STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE LUVERNE, MN 56156	θE	
(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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 221	Continued From pa	age 7	F 22	21		
	discipline or convert treat the resident's This REQUIREMEN by: Based on observar review the facility fa assess the appropri 1 resident (R61) ref Findings include: On 8/19/14, at 5:42 seated in her whee with a lap buddy (a resident's lap and is the w/c, which can remove themselves 5:45 p.m. dietary st meal to the table. A	 imposed for purposes of nience, and not required to medical symptoms. NT is not met as evidenced tion, interview, and document ailed to comprehensively riate use of a lap buddy for 1 of viewed for physical restraints. 2 p.m. R61 was observed lchair (w/c) in the dining room thick cushion that fits over a secured to the armrests of restrict the resident's ability to s from the w/c.) in place. At taff delivered R61's supper At 5:47 p.m., R61 was e the flat top portion of the lap een previously velcroed in 		A Physical Restraint assessmer was completed 9-3-14, and the u restraint was discontinued. All residents were reviewed for th completion of physical restraint assessments if indicated. Education was provided to all Lia Nurses on the Physical Restrain and Procedure at a Licensed Nu Meeting on 9-4-14. Any use of p restraints will be reviewed by the Interdisciplinary team initially and quarterly. Random audits will be done wee	use of the ne t Policy rses hysical	
	place, and turned h The main portion or remain across the f from rising. The de split down the midd place. At 5:48 p.m approached R61, re the lap buddy, turne asked her if she wa clothing protector for then walked away f residents; R61 mad	herself away from the table. f the lap buddy continued to front of the w/c restricting R61 evice was observed to have a lle and was velcroed into ., nursing assistant (NA)-N eplaced the flat top portion of ed R61 towards the table and anted to eat. NA-N applied a or R61, encouraged her to eat, from the table to assist other de no attempt to eat her meal ndependently. At 5:51 p.m.,		one month and then monthly for month to monitor completion of r assessments by DNS or designe Results of the audits will be repo the QAPI committee for review a recommendations.	one restraint ee. rted to	

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STATEMEN	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	TE SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		NG	ĆO	MPLETED
		245568	B. WING _	B. WING		8/21/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 221	protector, push her turn her w/c so that she then threw her At 5:57 p.m., R61 y remove the lap bud the outer edge of the upward. R61 contri- until 6:03 p.m. whe resident and asked indicated being hur so that her w/c fact to assist R61 with all offered food/drin R61's table to assist R61 started pulling able to remove the the top of the device restricting R61's at R61 continued to p lap buddy. R61 co buddy until 6:21 p.1 successfully separ- that connected the the halves on the f R61, picked up the on the floor along y asked R61 if she c R61 indicated she NA-S replaced it at	to remove her clothing rself away from the table and t her back was facing the table. clothing protector on the floor. was observed attempting to ddy from her w/c by grabbing he lap buddy and pulling inued to pull on the lap buddy en NA-S approached the d if she was hungry. R61 ngry and NA-S then turned R61 ed the table. NA-S attempted eating but the resident refused nk. At 6:05 p.m., NA-S exited st other residents. At 6:10 p.m. g on the lap buddy and was e rigid flat portion velcroed to ce; the main portion remained bility to stand from the w/c. bull on the main portion of the ontinued to pull on the lap m., when she was able to ate the two velcroed portions lap buddy and threw one of loor. NA-S then approached e half of the lap buddy that was with the rigid, flat top piece and could put it back on the w/c. wanted the lap buddy off as nd NA-S stated, "No, we're		21		
	lap buddy. R61 co buddy until 6:21 p.t successfully separ that connected the the halves on the f R61, picked up the on the floor along v asked R61 if she c R61 indicated she NA-S replaced it at gonna keep that or R61 with eating; R once again attemp When interviewed	ontinued to pull on the lap m., when she was able to ate the two velcroed portions lap buddy and threw one of loor. NA-S then approached half of the lap buddy that was with the rigid, flat top piece and could put it back on the w/c. wanted the lap buddy off as				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COM	IPLETED
		245568	B. WING			08/	21/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN			10 SOUTH WALNUT AVENUE UVERNE, MN 56156		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 221	present and seated 12:11 p.m., NA-T a observed to assist p.m. The lap budd the observation. R the observation and lap buddy. On 8/20/14, at 1:32 seated in her w/c in buddy in place. R6 (RN)-R, "How do I a know how to get m motioned to the lap RN-R responded th remove the lap bud her bedroom and a R61 down in bed. On 8/21/14, at 10:2 seated in her w/c in buddy in place. Ac residents were also participating in an of appeared calm and remove the lap bud R61's 14-day Minin assessment dated severe cognitive im with locomotion on/ extensive assistant personal hygiene, of assessment further	e. A family friend was l at the table next to R61. At rrived at the table and was R61 with eating until 12:28 y remained in place throughout 61 appeared calm throughout d did not attempt to remove the the common area with the lap of the common area with the lap of stated to registered nurse get out of this thing? Do you e out of this thing? The you buddy attached to her w/c. that she did know how to ldy but then pushed R61 to sked for staff assistance to lay to the activity room with lap tivity staff and several other opresent and were organized activity. R61 I was not observed trying to	F 2	221			
	diagnoses to includ	le: cognitive deficits due to sease, personal history of fall,					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245568 B. WING 08/21/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **110 SOUTH WALNUT AVENUE GOOD SAMARITAN SOCIETY - MARY JANE BROWN** LUVERNE, MN 56156 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 221 Continued From page 10 F 221 and aftercare for healing traumatic fracture of hip. The care plan identified R61 at risk for falls with interventions to include a tear away lap buddy if resident allows. Review of R61's incident reports revealed R61 had experienced 15 falls between 7/12/14 -8/3/14. R61 was diagnosed with a right hip fracture on 7/24/14 following a fall on 7/23/14. When interviewed on 8/21/14, at 10:46 a.m. the director of nursing (DON) verified R61's lap buddy was initiated on 7/29/14 following re-entry to the facility (on 7/28/14), after hospitalization due to a fractured hip. DON confirmed that assessment of a physical restraint was not completed for R61's lap buddy as the resident was able to remove it, therefore it was not considered a restraint or coded as such. DON further confirmed that nursing staff initiated the use of the lap buddy without a physician order. The DON could not confirm nor deny whether R61 could easily remove the lap buddy. The DON agreed that when R61 monitored closely by staff, such as during meal time or during an activity, the lap buddy could be removed. During a subsequent interview on 8/21/14, at 12:12 p.m. the DON confirmed R61's care plan indicated: tear away lap buddy if resident allows. DON stated that defined parameters had not been developed for staff to know when to apply and/or release the lap buddy as "resident allows". DON stated that staff were directed to replace the lap buddy on R61's w/c when it was removed; and if she doesn't want it on-take it off. DON further stated, "I would say most people put it back on."

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 09/09/2014

	RS FOR MEDICARE					0.0938-039
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		TE SURVEY MPLETED
		245568	B. WING _		08/21/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLETIO DATE
F 221	Continued From pa	age 11	F 22	1		
	•	on 8/21/14, at 10:31 a.m.				
		coordinator stated R61 utilized				
		times unless R61 was				
		d or laid down to rest. NA-T				
		he had witnessed that R6 had ve the lap buddy when seated				
		ng area but had never				
		mpt to remove the lap buddy				
	during meal time.					
	The procedure title	d Physical Restraints revised				
	10/13, indicated: A	Anytime a device, material or				
		hed or placed adjacent to the				
		determination will be made by a				
		o whether it is or could be a lividual resident. If the device,				
		ent cannot be removed easily				
		restricts freedom of				
		al access to one's own body,				
		aint and this procedure must be				
		vice, material or equipment is his resident, then the steps				
		decision must be documented				
		pharmacological Med/Physical				
		evice, material or equipment is				
		ust be reviewed with a				
		in condition and quarterly in				
		e care plan to ensure that it a restraint for the resident.				
		e documented as part of the				
		e PN - Care Plan Review.				
F 241		AND RESPECT OF	F 24	1		9/30/14
SS=E	INDIVIDUALITY					
	The facility must pr	omote care for residents in a				
	manner and in an e	environment that maintains or				
	enhances each res	sident's dignity and respect in				
		is or her individuality.				

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PRINTED: 09/09/2014 FORM APPROVED

ATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	0938-039	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED		
		245568			08/2	21/2014	
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 241	Continued From pa	ige 12	F 24	1			
	This REQUIREME	NT is not met as evidenced					
	Based on observative review the facility far and respond to call of 4 residents (R68 complained that cal was not timely and dining experience for R21) who were assisted that we are the factor of the table of t	tion, interview and document ailed to promote dignified care lights in a timely manner for 4 , R25, R51 & R18) who Il light response time from staff failed to provide a dignified or 3 of 48 residents (R15, R38, isted during meal time by staff he resident when assistance		Staff was educated on the importa answering call lights while they are working to decrease the call light response time at an All-Staff In-se 8/28/14. Providing a dignified dinin experience was reviewed with staf All-Staff In-Service 8/28/14. All staff will respond to call lights. S not stand while assisting residents eating.	e rvice ig f at an Staff will		
	12:46 p.m. R68 sta were enough staff a her needs. R68 sta answer her call ligh During interview wit p.m. R68 stated shi fifteen minutes whe needed assistance light. R68's family n the room at the time took a long time to indicated R68 requi as she was not to w when staff did not r R68 would transfer R68 stated that at s shift, she would wa respond to the call-	ew with R68 on 8/18/14, at ted that she did not feel there available at the facility to meet ted it took staff a long time to t. th R68 on 8/20/14, at 1:20 e had to frequently wait over en she alerted staff she and had activated the call nember (FM)-A, who was in e of the interview, verified it get the lights answered. FM-A ired assistance with toileting valk alone. FM-A stated that espond in a timely manner, self into the bathroom to void. sometimes, during the night it one half hour for staff to light. R68 stated she wore an oduct because she did not		Call light response times will be au random times 3 times per week for month and then once a week for o month to ensure timely response t the Licensed Social Worker (LSW designee. Dining experience will b audited 3 times per week for one r and then one time per week for one month to ensure feeding assistant provided in a dignified manner. Au be reported to resident council and committee for review and recommendations.	r one ne ime by) or e month ie ce is dits will		

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TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED
		245568	B. WING			08/21/2014	
	PROVIDER OR SUPPLIER	- MARY JANE BROWN	STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE LUVERNE, MN 56156				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 241	wear that dumb De R68's admission M assessment, dated brief interview for m 15 which indicated cognition were intac R68 as continent of extensive assist of During initial intervit 1:03 p.m. R25 state enough staff availal stated, "You sit ther get help." During a follow-up i p.m. R25 indicated transfers to the batt of bed. R25 stated half hour for the cal she alerted staff wh with transfer to the really don't ever hav to wait sometimes I like a kid. If I sneez hold it, I dribble. It m indicated she expen assistance on a dai does not feel wante R25's quarterly MD with a BIMs of 14, ii identified her as alw MDS further identifi	he did not like to "have to	F 2	241			

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		AND HUMAN SERVICES			FORM	09/09/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245568	B. WING		08/:	21/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(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
F 241	During initial intervi 2:29 p.m., R51 state enough staff availal stated, "With the kic facility is short of st time to get your ligh and have had to wa During a follow-up in p.m. R51 indicated minutes to get staff the call light. R51 ic day were before an have to go in my part can hold it until I s bathroom and then did not want to be in get up by herself. R51's quarterly MD with a BIMs of 15, at and requiring exten with transfers and t During initial intervi 2:48 p.m. R18 state enough staff availal stated, "I had to wa putting my call light bathroom." R18 state of supposed to. R18 in when she finally red bathroom.	ew with R51 on 8/19/14, at sed she did not feel there was ble to help her. R51 ds returning to school the saff and you have to wait a long nt answered. I push the button ait over one half hour for help." interview on 8/20/14, at 1:35 she had to wait twenty to thirty response when she activated dentified the worst times of the ad after meals. R51 stated, "I ad because they take too long. stand up to walk to the it's too late." R51 stated she ncontinent but she could not	F 24 ²			

If continuation sheet Page 15 of 42

	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		TE SURVEY	
	IDENTIFICATION NUMBER:			· · ·	MPLETED	
	245568	B. WING		08	8/21/2014	
PROVIDER OR SUPPLIER				P CODE		
AMARITAN SOCIETY	- MARY JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE	
p.m. R18 stated sh receive assistance realize its busy. So they walk past the to take care of first I still have to go to having accidents." R18's 7/24/14 adm a BIMS score of 14 as requiring extens transfers and toilet During interview wi (DON) on 8/21/14, had been aware of light response time received the reside residents frequentl issues and staff res A dignified dining e 8/20/14, during the (R15, R38, and R2 dining room. Nursi observed to be sta while she assisted utilize the the whee available to use du R38 was interview and verified that wi meal, his preference him vs. standing on	he had to wait a long time to with toileting. R18 stated, "I pretimes my light is on and room; I guess they have others , or they're not assigned to me. the bathroom. I don't like hission MDS identified her with 4, occasionally incontinent, and sive assistance of one staff with ing. ith the director of nursing at 9:20 a.m. she stated she resident complaints about call es and stated she always ent council minutes and y complained about staffing sponse time to call lights. experience was not provided on breakfast meal for 3 residents (1) who were observed in the ng assistant (NA)-A was nd over R15, R38, and R21 with the meal. NA-A did not eled stools which were ring the meal. ed on 8/20/14, at 10:03 a.m. hen staff assisted with the ce included staff seated next to		-41			
	PROVIDER OR SUPPLIER AMARITAN SOCIETY SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From pa p.m. R18 stated sh receive assistance realize its busy. So they walk past the to take care of first I still have to go to having accidents." R18's 7/24/14 adm a BIMS score of 14 as requiring extens transfers and toilet During interview wi (DON) on 8/21/14, had been aware of light response time received the reside residents frequentl issues and staff re A dignified dining e 8/20/14, during the (R15, R38, and R2 dining room. Nursii observed to be sta while she assisted utilize the the whee available to use du R38 was interview and verified that wi meal, his preferent	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245568 PROVIDER OR SUPPLIER AMARITAN SOCIETY - MARY JANE BROWN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 p.m. R18 stated she had to wait a long time to receive assistance with toileting. R18 stated, "I realize its busy. Sometimes my light is on and they walk past the room; I guess they have others to take care of first, or they're not assigned to me. I still have to go to the bathroom. I don't like having accidents." R18's 7/24/14 admission MDS identified her with a BIMS score of 14, occasionally incontinent, and as requiring extensive assistance of one staff with transfers and toileting. During interview with the director of nursing (DON) on 8/21/14, at 9:20 a.m. she stated she had been aware of resident complaints about call light response times and stated she always received the resident council minutes and residents frequently complained about staffing issues and staff response time to call lights. A dignified dining experience was not provided on 8/20/14, during the breakfast meal for 3 residents (R15, R38, and R21) who were observed in the dining room. Nursing assistant (NA)-A was observed to be stand over R15, R38, and R21 while she assisted with the meal. NA-A did not utilize the the wheeled stools which were available to use during the meal. R38 was interviewed on 8/20/14, at 10:03 a.m. and verified that when staff assisted with the meal, his preference included staff seated next to him vs. standing over him when assistance was </td <td>OF DEFICIENCIES FCORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD 245568 B. WING PROVIDER OR SUPPLIER 245568 B. WING AMARITAN SOCIETY - MARY JANE BROWN ID REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 2 Continued From page 15 p.m. R18 stated she had to wait a long time to receive assistance with toileting. R18 stated, "I realize its busy. Sometimes my light is on and they walk past the room; I guess they have others to take care of first, or they're not assigned to me. I still have to go to the bathroom. I don't like having accidents." F 2 R18'S 7/24/14 admission MDS identified her with a BIMS score of 14, occasionally incontinent, and as requiring extensive assistance of one staff with transfers and toileting. F 2000 no 8/21/14, at 9:20 a.m. she stated she had been aware of resident complaints about call light response times and stated she always received the resident council minutes and residents frequently complained about staffing issues and staff response time to call lights. A dignified dining experience was not provided on 8/20/14, during the breakfast meal for 3 residents (R15, R38, and R21) who were observed in the dining room. Nursing assistant (NA)-A was observed to be stand over R15, R38, and R21 while she assisted with the meal. R38 was interviewed on 8/20/14, at 10:03 a.m. and verified that when staff assisted with the meal, his preference included staff seated next to him vs. standing over him when assistance was<td>OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 245568 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZII 10 SOUTH WALNUT AVENUE LUVERNE, MN 56156 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S CITY, STATE, ZII 10 SOUTH WALNUT AVENUE LUVERNE, MN 56156 Continued From page 15 p.m. R18 stated she had to wait a long time to reacive assistance with toileiting. R18 stated, "I realize its busy. Sometimes my light is on and they walk past the room; I guess they have others to take care of first, or they're not assigned to me. I still have to go to the bathroom. I don't like having accidents." F 241 R18'S 7/24/14 admission MDS identified her with a S requiring extensive assistance of one staff with transfers and toileiting. 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WING AMARITAN SOCIETY - MARY JANE BROWN ID REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 2 Continued From page 15 p.m. R18 stated she had to wait a long time to receive assistance with toileting. R18 stated, "I realize its busy. Sometimes my light is on and they walk past the room; I guess they have others to take care of first, or they're not assigned to me. I still have to go to the bathroom. I don't like having accidents." F 2 R18'S 7/24/14 admission MDS identified her with a BIMS score of 14, occasionally incontinent, and as requiring extensive assistance of one staff with transfers and toileting. 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WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZII 10 SOUTH WALNUT AVENUE LUVERNE, MN 56156 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S CITY, STATE, ZII 10 SOUTH WALNUT AVENUE LUVERNE, MN 56156 Continued From page 15 p.m. R18 stated she had to wait a long time to reacive assistance with toileiting. R18 stated, "I realize its busy. Sometimes my light is on and they walk past the room; I guess they have others to take care of first, or they're not assigned to me. I still have to go to the bathroom. I don't like having accidents." F 241 R18'S 7/24/14 admission MDS identified her with a S requiring extensive assistance of one staff with transfers and toileiting. 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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY	
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COMPLETED		
		245568	B. WING		08/21/2014		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156				
(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) COMPLETIO DATE	
F 241	Continued From pa	age 16	F 2	41			
	•	5 was not interviewable and					
	and stated that she R38 and R21 durin 8/20/14. NA-A furt	ved on 8/20/14, at 9:15 a.m. e stood while she assisted R15, g the breakfast meal on her added that she had been d next to residents who e with eating.					
	Dining last revision #7: "Residents will staff in a dignified r than stand, allowing	edure titled, Resident Choice dated 8/12, identified under Receive assistance from nanner, e.g., staff to sit rather g resident adequate time od and sips of water."					
F 244 SS=E	8/20/14, at 12:06 p expectation was that the resident whom and not stand over added that rolling s that staff could rem meal.	sing (DON) was interviewed on .m. and verified the at staff remain seated next to they assist during the meal the resident. The DON further tools were available for use so hain seated throughout the EN/ACT ON GROUP OMMENDATION	F 2	44		9/30/14	
	must listen to the v grievances and rec and families conce	r family group exists, the facility iews and act upon the commendations of residents rning proposed policy and ns affecting resident care and					
	This REQUIREME	NT is not met as evidenced					

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	COF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	IPLE CONSTRUCTION		0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	``'	NG		PLETED	
		245568	B. WING		08/	08/21/2014	
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 244	Based on observat review, the facility fa council concerns re response time and addressed and effo resolution. This inc 10 of 48 residents (R25, R33, R42, R4: expressed these qu Findings include: During review of the following concerns council members a lacking to indicate t concerns: (1) On 1/30/13, res times still needed s The meetin minutes nursing (DON) was (2) On 4/24/14, res identified that call lig improvement. The n DON was notified a (3) On 7/31/14, res identified, "Sometir regarding the wait t call light. Documer service director info light time-out syster decreases the inter after it had been ac alert staff. The mee DON was also notif During interview wit on 8/21/14, at 1:43	ion, interview and document ailed to ensure resident dated to slow call light slow meal service were rts were made toward duded resident interviews for R68, R25, R51, R18, R16, 3 & R48) in the facility who dality of care concerns.	F 2		hs were initiated ated to concern inse times and R43, and R25 meal service. e importance of ghts while they he call light aff In-service was developed imes. The g staff assisting e assisted ly to assist them, t would er in which tables and included adding the lent calendar tions. Nursing ucated to the Memo posted will be audited at week for one esponse times by al service wait es per week at nth and then h by the Director or designee. ed to Resident		

Facility ID: 00575

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PRINTED: 09/09/2014

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	CO	COMPLETED	
		245568	B. WING		08/21/2014		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 244	actions taken to resconcerns. SS verifivith the resident collight response time resident council metrosident council metrosident council metrosident council mitersidents frequently and call light waits. During further interview the the DON, she resident council metrosident council communicated with voiced grievances in response time. Wh had implemented a recommendations, nothing for you". A had been aware of slow call light response time. During initial intervitation council committee. During initial intervitation co	ent council meetings to explain spond to the expressed ied she had not followed up oncerns related to slow call s but only asked during the eetings whether there were th the director of nursing at 9:20 a.m. she stated she ent complaints about call light d stated she always got the nutes and was aware that y complained about staffing view on 8/21/14, at 2:14 p.m. verified she had not attended eetings and had not the group regarding the related to slow call light en questioned whether they my interventions and/or the DON replied, "I have Althought administrative staff resident complaints about onse time from staff, no follow had occurred with the resident	F 24				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DA	D. 0938-039	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	CC	MPLETED	
		245568	B. WING _		08	08/21/2014	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE	
F 244	Continued From pa	age 19	F 24	44			
		and had activated the call					
		member (FM)-A, who was in					
		e of the interview, verified it get the lights answered. FM-A					
		lired assistance with toileting					
		walk alone. FM-A stated that					
		respond in a timely manner, r self into the bathroom to void.					
		sometimes, during the night					
	shift, she would wa	ait one half hour for staff to					
		-light. R68 stated she wore an oduct because she did not					
		cident while waiting for staff to					
	arrive, and stated s	she did not like to "have to					
	wear that dumb De	epends."					
	R68's admission M	linimum Data Set (MDS)					
		8/5/15 identified her with a					
		nental status (BIMs) score of her decision making and					
		ct. The MDS further identified					
	R68 as continent o	f bladder and required					
	extensive assist of	one staff with toileting.					
	During initial interv	iew with R25 on 8/19/14, at					
		ed she did not think there was					
		ble to meet her needs. R25 re a long time and you don't					
	get help."	re a long time and you don't					
		interview on 8/20/14, at 12:57					
		d she required assistance with throom and getting in and out					
	of bed. R25 stated	she often had to wait over one					
		Il light to be answered after					
		hen she required assistance bathroom. R25 stated, "I					
		ive accidents but when I have					
		I dribble and it makes me feel					

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245568	B. WING		08/21/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 244	like a kid. If I sneez hold it, I dribble. It r indicated she expe assistance on a da does not feel wante R25's quarterly MD with a BIMs of 14, i identified her as alw MDS further identifi assistance of one s toileting. During initial intervi 2:29 p.m., R51 stat enough staff availa stated, "With the kin facility is short of st time to get your ligh and have had to wa During a follow-up p.m. R51 indicated minutes to get staff the call light. R51 in day were before an have to go in my pa I can hold it until I s bathroom and then did not want to be i get up by herself. R51's quarterly MD with a BIMs of 15, a and requiring exter with transfers and the	te or cough when I'm trying to makes me disappointed." R25 rienced long waits for staff ily basis. R25 indicated she ed when she waits a long time. S dated 6/24/14, identified her indicating intact cognition, and ways continent of urine. The ied she required extensive staff with transferring and ew with R51 on 8/19/14, at ted she did not feel there was ble to help her. R51 ds returning to school the taff and you have to wait a long nt answered. I push the button ait over one half hour for help." interview on 8/20/14, at 1:35 she had to wait twenty to thirty f response when she activated dentified the worst times of the nd after meals. R51 stated, "I ad because they take too long. stand up to walk to the it's too late." R51 stated she ncontinent but she could not	F 24			

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TATEMAEN							
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED	
		245568	B. WING _		08/21/2014		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 110 SOUTH WALNUT AVENUE		ODE	E	
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN					
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 244	Continued From pa	age 21	F 24	14			
	 Continued From page 21 enough staff available to meet her needs. R18 stated, "I had to wait 25 minutes for help after putting my call light on this morning to get to the bathroom." R18 stated that when she required toileting, it was urgent due to a history of surgeries related to bladder issues. R18 stated she was tempted to walk to the bathroom by herself but didn't dare because she was not supposed to. R18 indicated she was "soaked" when she finally received assistance to the bathroom. During a follow-up interview on 8/21/14, at 12:45 p.m. R18 stated she had to wait a long time to receive assistance with toileting. R18 stated, "I realize its busy. Sometimes my light is on and they walk past the room; I guess they have others to take care of first, or they're not assigned to me. I still have to go to the bathroom. I don't like having accidents." 						
	a BIMS score of 14 as requiring extens transfers and toileti During an observat from 11:45 a.m. to residents who were being served their r who required assis require assistance complaints and disa wait time prior to th that residents who waited 35 minutes	ission MDS identified her with a, occasionally incontinent, and ive assistance of one staff with ing. ion on 8/18/14, continuously 1:00 p.m. it was noted that a independent with eating were meal subsequent to residents tance. Residents who did not with eating expressed satisfaction related to a long eir meal service. It was noted were independent with eating from the start of meal time, as being served at 12:00 noon.					

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DA	<mark>). 0938-039</mark> TE SURVEY MPLETED	
				ING			
	PROVIDER OR SUPPLIER	245568	B. WING	STREET ADDRESS, CITY, STATE, ZIP		/21/2014	
		- MARY JANE BROWN		CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE	
F 244	dining room at 12:0 not unusual to wait served the noon me dissatisfaction had staff on multiple oc the issue had been council meetings. Mental Status (BIM which indicated cog An observation/inte and R42 on 8/18/14 Both R33 and R42 to the long wait time further added "Oh w but wait." Both R33 issues were brough meetings but nothin BIMS score dated 3 cognitive impairme dated 7/18/14, of 14 cognitive impairme R16 and R25 were 8/18/14, at 12:27 p time to be served th R16 had a BIMS score of indicating no cognit During an observat 12:30 p.m. R43 exp long wait for meal s dated 6/13/14, of 9 cognitive impairme	00 noon and added that it was up to 30-35 minutes to be eal. R48 verified that been expressed to the dietary casions and was also aware discussed at the resident R48 had a Brief Interview of S) score on 8/15/14, of 15/15 gnitively intact. rview was conducted with R33 4, at approximately 12:20 p.m. expressed complaints related e for meals to be served. R33 well, what else do I have to do 8 and R42 were aware that at up at the resident council ng had changed. R33 had a 5/30/14, of 15/15 indicating no nt. R42 had a BIMS score 4/15 which also indicated no nt. observed/interviewed on .m. and also verified the wait he noon meal was too long. core dated 7/18/14, of 15/15 cognition impairment. R25 dated 6/2/14, of 14/15 tive impairment. ion/interview on 8/18/14, at pressed dissatisfaction with the service. R43 had a BIMS score 1/15 which indicated moderate nt.	F 2	244			

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		AND HUMAN SERVICES			FORM	09/09/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245568	B. WING		08/2	21/2014
NAME OF F	PROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		10 SOUTH WALNUT AVENUE .UVERNE, MN 56156		
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 244	Continued From pa good half hour or lo at lunch and suppe go down there (dini because of how lon food. I even got up Review of the resid dated 12/26/13, ide dietary department: for our food". Three One resident said s while the others sai Some say the food it. One resident up with family member before residents wh Review of the resid dated 4/24/14, iden department: one re don't get our meals Director responded We will start serving meals". The director of dieta interviewed on 8/21 the resident council dietary service grief A review of the facil "Open Dining" read first-come, first-serving wait more than 10- Batch cooking is re food with nutrient re	age 23 onger to have her meal served r. She added, "I just hate to ng room) at lunch and supper og I have to wait to get my o and left one time." ent council meeting minutes ontified concerns related to the "We have to wait to [sik] long e residents agreed with this. she had waited 45 minutes id they waited but not that long. is barely warm when they get set that on holidays residents rs present get served meals no have no family visiting. ent council meeting minutes tified a concern for the dietary sident asked, "How come we more quickly?" Dietary , "That system is changing. g you when you come down to ary services (DSS) was /14, at 2:01 p.m. verified that I meetings which identified vances had not been resolved. lity policy dated 8/12, titled, ; Residents are served on a ved basis. Residents do not 15 minutes to be served. quired to ensure high-quality etention. Food should be kept	F 244			
		ninutes on the steam table. or Grievances, Complaints or				

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		& MEDICAID SERVICES	1			0. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
		245568	B. WING		08/21/2014	
NAME OF I	PROVIDER OR SUPPLIER	-	-	STREET ADDRESS, CITY, STATE, ZIP COI	DE	
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(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 S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 244	Continued From pa	age 24	F 24	14		
	-	20/13, identified the following				
	1. Upon resident admission the Suggestion or Concern form or "Resolving the Issues" brochure will be given with a review of the grievance procedure.					
	staff member expre to a staff member r services, it will be r	t, family member, visitor or esses a concern or grievance related to resident care or eceived in an open, friendly, nner and without discrimination				
	the staff member w information and pro the problem. The g documented on the	an be resolved immediately, vill thank the individual for the boceed to take action regarding rievance then will be a Suggestion or Concern and enter social service director.				
	services department	comes directly to the social nt, then the director of social ete a Suggestion or Concern of the complaint.				
	Suggestion or Con	ces director will route the cern form to the appropriate s soon as possible.				
	support staff were a complaints about s	lity administrative and direct aware of the residents low call light responses and there were no interventions put the grievances.				
F 278 SS=D	483.20(g) - (j) ASS	-	F 27	78		9/30/14

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245568	B. WING			08/2	21/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN			10 SOUTH WALNUT AVENUE UVERNE, MN 56156		
(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 SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	Continued From pa	ge 25	F 2	78			
	The assessment m resident's status.	ust accurately reflect the					
	A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.						
	A registered nurse assessment is com	must sign and certify that the pleted.					
	Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment in a resident assessment is subject to a civil money penalty of not more penalty of not more than \$1,000 for each assessment is subject to a civil money penalty of not more than \$2,000 for each assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.						
	Clinical disagreeme material and false s	ent does not constitute a statement.					
	by: Based on interview facility failed to acc set (MDS) related t	NT is not met as evidenced and document review the urately code the minimum data the use of a lap buddy for 1 reviewed for a physical			The 14-day MDS assessment for I was modified on 9/8/14 to reflect th physical restraint was in use. All residents were reviewed for use physical restraints.	at a	

Facility ID: 00575

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PRINTED: 09/09/2014

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED	
			A. BUILDIN	G			
		245568	B. WING _			21/2014	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156			
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE	
F 278	assessment dated severe cognitive im with locomotion on/ extensive assistance personal hygiene, of MDS assessment f restraint had not be the lap buddy utilize resident to remove standing ability move wheelchair. On 8/19/14, at 5:42 seated in her whee with a lap buddy (a resident's lap and is the w/c, which can remove themselves 5:45 p.m. dietary st meal to the table. A observed to remove buddy which had be place, and turned h The main portion of remain across the f from rising. The de split down the mido place. At 5:48 p.m approached R61, re the lap buddy. At 5 attempting to remove by grabbing the out	num Data Set (MDS) 8/11/14, indicated R61 had pairment, total dependence /off the unit and toileting, and ce with transfer, bed mobility, dressing, and eating. The further indicated that a physical een utilized for R61. However, ed for R61 was difficult for the and restricted transfer and vement when applied to the 2 p.m. R61 was observed lchair (w/c) in the dining room thick cushion that fits over a s secured to the armrests of restrict the resident's ability to s from the w/c.) in place. At taff delivered R61's supper At 5:47 p.m., R61 was e the flat top portion of the lap een previously velcroed in herself away from the table. f the lap buddy continued to front of the w/c restricting R61 evice was observed to have a alle and was velcroed into ., nursing assistant (NA)-N eplaced the flat top portion of 5:57 p.m., R61 was observed ve the lap buddy from her w/c ter edge of the lap buddy and a continued to pull on the lap	F 27	Education was provided to Nurses on the Physical Re and Procedure on 9-4-14. provided to the Case Man appropriate coding of phy the MDS on 9/4/14. Any u restraints will be reviewed Interdisciplinary Team incl Manager initially and quar Audits will be completed f physical restraint coding f identified as using a physi monthly for 2 months by D designee. Results of audir reported to the QAPI com and recommendations.	estraint Policy Education was ager on sical restraints in se of physical by the luding the Case terly. or accurate or all residents cal restraint DNS or ts will be		

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		AND HUMAN SERVICES			FORM	09/09/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245568	B. WING		08/2	21/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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
F 278	velcroed to the top remained restricting the w/c. R61 contin portion of the lap but the lap buddy until 6 to successfully sepa that connected the the halves on the fle R61, picked up the on the floor along w asked R61 if she co R61 indicated she w NA-Samantha repl gonna keep that on then once again att buddy. When interviewed a that R61 utilized the times including mea On 8/20/14, at 1:32 seated in her w/c in buddy in place. R6 (RN)-R, "How do I g know how to get me motioned to the lap When interviewed of director of nursing (was initiated on 7/2 facility (on 7/28/14), fractured hip. DON restraint as the resi DON could not continent.	of the device; the main portion g R61's ability to stand from nued to pull on the main uddy. R61 continued to pull on 6:21 p.m., when she was able arate the two velcroed portions lap buddy and threw one of oor. NA-S then approached half of the lap buddy that was with the rigid, flat top piece and ould put it back on the w/c. wanted the lap buddy off as laced it and stated, "No, we're n." R61 took one bite of food tempted to remove the lap	F 27			

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	RS FOR MEDICARE			OMB NO. 0938-0 (X3) DATE SURVE		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	E SURVEY IPLETED
		245568	B. WING		08/	/21/2014
NAME OF	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN	1 L			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 278	Continued From pa	age 28	F 278			
F 279 SS=D	10/13, indicated: A equipment is attack resident's body, a c licensed nurse as t restraint for the ind material or equipm by the resident and movement or norm then this is a restra followed. If the dev not a restraint for th taken to make this in the PN - Psycho Restraint. If the de not a restraint, it m significant change conjunction with the continues to not be This review may be quarterly note in the 483.20(d), 483.20(f COMPREHENSIVE A facility must use to develop, review comprehensive pla The facility must de plan for each reside objectives and time medical, nursing, a needs that are ider assessment. The care plan must	E CARE PLANS the results of the assessment and revise the resident's	F 279			9/30/14

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STATEMEN	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245568		G	00/04/0044	
NAME OF	PROVIDER OR SUPPLIER	245500	D. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	08/2	21/2014
		- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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)	ILD BE	(X5) COMPLETIC DATE
F 279	psychosocial well-b §483.25; and any s be required under § due to the resident' §483.10, including t under §483.10(b)(4 This REQUIREMEN by: Based on interview failed to develop a d infections for 1 of 1 who had a long hist infections (UTI's). Findings include: R12, admitted on 2 included: hypertent depression, anxiety R12's hospital disclidentified that R12 I UTI's. The record a prophylactic antibio and upon admissio Cipro 500 milligram prophylactic for UT R12's urinary care p R12's urinary care p	 veing as required under ervices that would otherwise \$483.25 but are not provided s exercise of rights under the right to refuse treatment the right to refuse treatment of the right to refuse the reatment of the right to refuse the reaction of the record review the facility care plan related to urinary resident (R12) in the sample tory of frequent urinary tract /7/14, had diagnoses that sion, hypothyroidism, of the requent urinary tract /7/14, had diagnoses that sion, hypothyroidism, of the requent urinary tract /7/14, had diagnoses that sion, hypothyroidism, of the requent urinary tract /7/14, had diagnoses that sion, hypothyroidism, of the requent urinary tract /7/14, had diagnoses that sion, hypothyroidism, of the requent urinary tract /7/14, had a long history of frequent urinary tract /7/14, had a long history of frequent urinary tract /7/14, had a long history of frequent urinary tract 	F 27	 A comprehensive care plan was developed for R12 related to hist urinary tract infections on 8/28/14 All residents with history of UTIs reviewed for comprehensive care completion on 9/8/14 and care plupdated as necessary. The policy for comprehensive card development was reviewed with nurses and Case Manager at a L Nurses Meeting on 9/4/14. Audits will be conducted on all neresidents admitted with a history and current residents who develop for comprehensive care plan dev weekly for one month and month month by the DNS or designee. If audits will be reported to QAPI care for review and recommendations 	ory of 4. were e plan lans re plan charge icensed of UTIs op a UTI relopment ly for one Results of ommittee	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	· · /	. 0938-039 E SURVEY IPLETED
		245568	B. WING _		08/	21/2014
	PROVIDER OR SUPPLIER	- MARY JANE BROWN		STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 279	During interview on registered nurse (R	vent or minimize UTI's. 8/21/14, at 10:16 a.m. N)-B confirmed that R12 had	F 27	7 9		
	of frequent UTI's. R lacked any identific	tic treatment due to a history RN-B verified R12's care plan ation of risk factors, goals or e prevention, monitoring and 's.				
	(DON) on 8/21/14, care plan lacked int verified the care pla developed to includ interventions.	th the director of nursing at 11:30 a.m. she verified the terventions for UTI's and an should have been le infection risks, goals and				
F 329 SS=D	483.25(I) DRUG RE UNNECESSARY D	EGIMEN IS FREE FROM RUGS	F 32	29		9/30/14
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer	g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any e reasons above.				
	resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and o record; and residen drugs receive gradu	whensive assessment of a r must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical the who use antipsychotic ual dose reductions, and tions, unless clinically				

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		AND HUMAN SERVICES & MEDICAID SERVICES	1			FORM	09/09/2014 APPROVED 0938-0391
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245568	B. WING			08/21/2014	
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	GOOD SAMARITAN SOCIETY - MARY JANE BROWN				0 SOUTH WALNUT AVENUE UVERNE, MN 56156		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page 31 contraindicated, in an effort to discontinue these drugs.		, F :	329			
	by: Based on interview facility failed to mor effectiveness of me 2 of 5 residents (RS unnecessary medic Findings include: R9 received the me antidepressant med to sleep). R9 was n the effectiveness of Review of the medi indicated that R9 ha Review of the signe that R9 received Tr every day at bedtim identified that R9 w medication therapy pharmacist consult recommended a do 75 mg to 50 mg. S on 7/3/14 to 50 mg assessment dated for assessment as disturbance". The f	edication Trazodone (an dication) for insomnia (inability ot monitored or assessed for			Sleep assessments were complete R9 and R5 on 9/8/14. All residents with an insomnia diagr were reviewed and sleep assessme were completed if needed. Mediation Review process for medi used for sleep was reviewed with th consultant pharmacist on 9/8/14 an Licensed Nurses at a Licensed Nur meeting on 9/4/14. The RN will com Sleep Assessments prior to initiatin medication for insomnia, on admiss resident is taking this type of medic on admission, any time a medication insomnia is changed, a resident is observed to have signs of insomnia resident complains of new onset insomnia, and annually if taking medication for insomnia. The consu- Pharmacist will verify that Sleep Assessments have been completed All new insomnia diagnosis will be a for assessment completion weekly month and monthly for one month b DNS or designee. Results of audits reported to the QAPI committee for and recommendation.	cations cations d se plete g a sion if ation on for a or the ulting d. audited for one y the will be	

Facility ID: 00575

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STATEMEN	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		TE SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		245568	B. WING _		08/21/2014		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE	
F 329	assessment. Docu indicate that sleep monitoring had bee effectiveness of the reduction had been During an interview director of nursing assessment had no dose reduction and been no sleep mor stated that a sleep been done since 2 assessment dated verified that R9's s been monitored an assessment should R5 received the mo- strength (an over the containing diphenthe sleep) for insomnia patterns monitored whether the medic Review of a fax se (MD)-A on 4/2/14, if following: Could w schedule for Tylend 4/3/14, MD-A wrote Tylenol PM 25-500 (hour of sleep) PR Review of the form Home Physician N identified the conce [R5] asks for Tylend	umentation was unavailable to patterns and/or any sleep en conducted to determine e medication after the dose	F 32				

Facility ID: 00575

If continuation sheet Page 33 of 42

		AND HUMAN SERVICES			FORM	09/09/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245568	B. WING		08/	21/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		10 SOUTH WALNUT AVENUE .UVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329 F 329 F 371 SS=F	Continued From pa tabs HS 500/25 mg Review of the care following: resident i (related to) sleeples was defined as: R5 adverse side effects review date of 9/30, interventions specif possible side effect day time drowsines in the morning, incr fractures, dizziness Documentation in th assessment as wel to the effectiveness RN-A was interview and verified that a s been conducted to medication used for 483.35(i) FOOD PF STORE/PREPARE, The facility must - (1) Procure food fro considered satisfac authorities; and	age 33 dx insomnia. plan dated 8/7/14, verified the s on hypnotic therapy R/T ssness. The care plan goal would be free from any s of hypnotic use through the /14. The care plan fied for staff to observe for ts every shift that may cause as, confusion, loss of appetite reased risk of falls and s. he record lacked a sleep I as any documentation related s of the hypnotic medication. wed on 8/21/14, at 8:20 a.m. sleep assessment had never monitor the efficacy of the r insomnia. ROCURE, /SERVE - SANITARY	F 329			9/30/14
	This REQUIREMEN	NT is not met as evidenced				

If continuation sheet Page 34 of 42

		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (· /	E SURVEY PLETED
		245568	B. WING _			08/21/2014	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN			10 SOUTH WALNUT AVENUE UVERNE, MN 56156		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
F 371	review the facility fa manner, failed to e equipment was pro adequately monitor the dishwasher. Th 48 residents who w kitchen. Findings include: The noon meal dish from 11:45 a.m12 observed to wear g resident's laminated under the plate and baked potato and re observation on 8/18 laminated diet card spilled liquid on the 8/18/14, at 12:35 p. cards were not san it would take too lor cards to air dry betw that staff attempted cards thru the dishw During another obs p.m. cook-B was w each laminated dief	tion, interview and document ailed to serve food in a sanitary ensure food preparation perly cleaned and failed to the final rinse temperature of his had the potential to affect rere served food out of the h-up was observed on 8/18/14, :45 p.m. Cook-A was loves and then touched each d diet card, hold the diet card then touched each half of the oll/bun. It was noted during the 3/14, at 12:15 p.m. that the s had dried food debris and m. Cook-A verified on .m. that the laminated diet itized prior to meal service as ng to allow the laminated diet ween meals. Cook-A added to send the laminated diet washer 2-3 times per week. thervation on 8/19/14, at 12:01 earing gloves and touched t card. Cook-B then the chicken fritter and small	F 37	71	Diet cards are cleaned after each m The mixers and refrigerator floor were cleaned on August 18, 2014. Staff h been educated on the proper storage labeling of food items. A cleaning schedule has been implemented for the kitchen. Staff h been and will be further educated on September 24, 2014 on the cleaning schedule, food storage and labeling, cleaning of the diet cards, proper use gloves and recording the final rinse temperature on the dish washer. Random audits will be done 3x per w for one month and then weekly for o month to monitor the temperatures, cleanliness of the kitchen and storage areas, cleanliness of the diet cards, the cleanliness of the kitchen equipm glove usage, and proper food storage labeling by the Director of Dietary Services or designee. Results of the audits will be reported to the QAPI committee for review and recommendations.	re nas e and nave n e of week ne ge and nent, ge and	
	interviewed on 8/19 the laminated diet of to dietary staff hand the above noted pra	ary services (DDS) was 0/14, at 12:15 p.m. and verified cards were to be cleaned prior dling them. The DDS verified actice was not in accordance on control guidelines.					

If continuation sheet Page 35 of 42

		AND HUMAN SERVICES				FORM	09/09/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245568	B. WING			08/;	21/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN			IO SOUTH WALNUT AVENUE UVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From pa	ige 35	F 3	71			
	3/2009, read: Glov	y titled, Gloves revised es are to be changed before eat" foods and when coming in omething that is					
	(DA)-A on 8/20/14, was not aware that had ever been clea past three years. S laminated dietary ca and hand dried on 8	onducted with dietary aid at 9:15 a.m. and stated she the laminated dietary cards ned via the dishwasher in the She further added the ards had just been sanitized 8/20/14, prior to the noon to the noted observations on					
	a.m. a portion of from walk in freezer. The or labeled and appending the outer edges. The discarded this item refrigerator was observed substance. A large food debris on the re bowl was observed which was verified l	e kitchen on 8/18/14, at 11:35 bzen ham was noted in the e ham was not covered, dated eared to have freezer burn on he DDS immediately after observed. The walk in served to have a spilled sticky mixer was observed to have mixing blades. A small mixer to have unidentified contents, by the DDS. Both mixers were and ready for use by the DDS.					
	Temperature record 8/1-8/19/14, the fina documented 14 out breakfast, 13 out of meal and 7 out of 1 DDS indicated the o water rinse and the	mal Sanitizing Dishwasher d identified that from al rinse temperature was not t of 19 times following f 19 times following the noon 9 times following supper. The dishwasher sanitized by hot lack of documentation was 5 on 8/20/14, at 11:45 a.m.					

Facility ID: 00575

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	OF DEFICIENCIES					0938-039 E SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	COMPLETED	
		245568			08/	21/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN				
(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 SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 371	Continued From pa	ge 36	F 37	1		
F 428 SS=D	on 8/19/14, at 11:30 the dietary departm schedules available department. 483.60(c) DRUG R IRREGULAR, ACT		F 42	8		9/30/14
		of each resident must be nce a month by a licensed				
	the attending physic	st report any irregularities to cian, and the director of reports must be acted upon.				
	This REQUIREMEI	NT is not met as evidenced				
	Based on interview consulting pharmad effectiveness of me monitored for 2 of 5	and document review the sist failed to ensure the dications used for sleep were (R5 and R9) residents essary medications.		Sleep assessments were complet R9 and R5 on 9/8/14. Pharmacist consultant reviewed the effectiven the medications on 9/8/14.		
	Findings include:			All residents with an insomnia diag were reviewed and sleep assessm were completed if needed. Mediat	ients ion	
	antidepressant meet to sleep). The cons reviews failed to rep	edication Trazodone (an dication) for insomnia (inability sulting pharmacist monthly port that the effectiveness of not been monitored.		Review process for medications us sleep was reviewed with the consu- pharmacist on 9/8/14 and License Nurses at a Licensed Nurse meeti 9-4-14. The RN will complete Slee	ultant d ng on	
	Review of the medi	cal record diagnosis sheet		assessments prior to initiating a medication for insomnia, on admis	sion if	

Facility ID: 00575

If continuation sheet Page 37 of 42

IAIEWENI	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		IG		COMPLETED	
		245568	B. WING _		08/2	21/2014	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 428	Review of the signed that R9 received Tr every day at bedtim identified that R9 w medication therapy pharmacist consult recommended a do 75 mg to 50 mg. S on 7/3/14 to 50 mg assessment dated for assessment as disturbance". The under "other comm antidepressant Tra night". No sleep pa effects were identif Documentation wa sleep patterns and been conducted to medication after the implemented. During an interview consulting pharmace identify the lack of and also concurred medication should R5 received the m strength (an over the containing diphenh sleep) for insomnia patterns monitored whether the medication and consulting pharmace	ad a diagnosis of insomnia. ed physician orders identified razodone 50 mg (milligrams) ne. The care plan dated 8/7/14 vas on antidepressant v related to insomnia. The tant report dated 6/16/14, ose reduction from Trazodone Subsequently, it was reduced every bedtime. A sleep 8/19/14 identified the reason "experiencing sleep following statement was noted	F 42		edication for dent is comnia or the inset king will verify that een completed ew. All new udited for weekly for one month by the f audits will be		

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	OF DEFICIENCIES F CORRECTION	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
NU PLAN U		IDENTIFICATION NUMBER:	A. BUILDIN	NG	0		
		245568	B. WING _			8/21/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156			
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE	
F 428	Continued From pa	ige 38	F 42	28			
	(MD)-A on 4/2/14, a following: Could w schedule for Tylend 4/3/14, MD-A wrote Tylenol PM 25-500	at 2355 (11:55 p.m.) noted the e have a diagnosis, dose and ol PM? The following day, e the following prescription: mg. (milligrams), 2 tabs H.S. N (as needed) insomnia.					
	Home Physician Ne identified the conce [R5] asks for Tylend Might we please has instead of PRN. De	sent to R5's provider, Nursing otification dated 5/21/14, ern/incident: resident name of PM 2 tabs every night. ave an order to schedule this, ocumentation by MD-A on he following: Tylenol PM 2 g dx insomnia.					
	following: resident i (related to) sleeples was defined as: R5 adverse side effect review date of 9/30 interventions specif possible side effect day time drowsines	fied for staff to observe for as every shift that may cause as, confusion, loss of appetite reased risk of falls and					
	assessment as well	he record lacked any sleep I as any documentation related s of the hypnotic medication.					
	and verified that the a sleep assessmen of unwanted hypno	ved on 8/21/14, at 8:20 a.m. e facility had never completed at on R5 to monitor for the use tic side effects or to assess nedication used for insomnia.					

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COM	IPLETED
		245568	B. WING		08/	21/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 428	Continued From pa	ige 39	F 428	3		
		cist on 8/21/14, at 2:00 p.m. recommendation had not been				
	made to conduct a	sleep assessment to				
	Tylenol PM, used f	tiveness of the medication, or insomnia.				
	483.75(o)(1) QAA COMMITTEE-MEM	IBERS/MEET	F 520)		9/30/14
00-L	QUARTERLY/PLAI					
	assurance committ	tain a quality assessment and ee consisting of the director of				
		physician designated by the 3 other members of the				
	committee meets a issues with respect and assurance acti	ment and assurance t least quarterly to identify to which quality assessment vities are necessary; and ements appropriate plans of				
		entified quality deficiencies.				
	disclosure of the re except insofar as s	retary may not require cords of such committee uch disclosure is related to the committee with the s section.				
		s by the committee to identify deficiencies will not be used as is.				
	by:	NT is not met as evidenced		Suggestion/Concern forms war	nitiotod	
		tion, interview and document Quality Assessment and		Suggestion/Concern forms were for R25, R51, and R18 related to o		

If continuation sheet Page 40 of 42

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPI F	CONSTRUCTION	MB NO.	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245568	B. WING			08/21/2014	
NAME OF	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 LU			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 520	Continued From pa	ge 40	F 52	20			
	 520 Continued From page 40 Assurance (QA&A) committee failed to develop and implement appropriate action plans for previously identified areas of concern related to call light response time for 4 of 48 residents (R68, R25, R51 & R18) and timely meal service for 6 of 48 residents (R16, R33, R48, R42, R43 & R25) who reside in the facility and had communicated these quality of care concerns to staff. This had the potential to affect all 48 residents who resided in the facility. Findings include: During interview on 8/21/14, at 2:14 p.m. the director of nursing (DON) confirmed the slow staff response time to resident call lights had been discussed at QA&A but this issue had never been communicated to the direct care staff. The DON confirmed she had not communicated with the residents during resident council meetings to follow up on the voiced concerns so that quality of care issues could be resolved. On 8/21/14, at 2:20 p.m. the social worker stated the facility had been aware of the complaints related to call light response times and the issue had been discussed at QA&A meetings. The SSD indicated that call light audits had been conducted and the data indicated that staff response time was over 30 minutes. However, 				of untimely call light response time for R16, R33, R48, R42, R43, and related to concern of slow meal se R68 has discharged. Staff was educated on the importa everyone answering call lights whi are working to decrease the call lig response time at an All-Staff In-se 8/28/14. The QAPI committee will educated on 9/11/14 on the implementation of action plans and follow-up. A Memo was posted for and nursing staff on 9/4/14 educat the new procedure for passing me Call light response times will be au random times 3 times per week for month and then once a week for o month by the LSW or designee. M service wait times will be audited 3 per week at random meals for one and then once weekly for one mor the DDS or designee. Monthly aud be completed for 3 months by the Coordinator or designee to ensure implementation and follow-up has occurred. Audit results will be repor Resident Council and QAPI comm review and recommendations.	R25 rvice. nce of le they ght rvice be dietary ing on al trays. dited at r one ne eal s times e month th by lits will QAPI proper	
	developed and imp complaints related to call lights nor had the meal service been a had not been imple identified resident of quality of care issue	action plan had been lemented to address these to slow response to resident ne complaints related to slow addressed. Follow-up audits mented to determine whether concerns related to these es had been resolved and/or e DNS and SW were					

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		AND HUMAN SERVICES				FORM	09/09/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245568	B. WING			08/	21/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN			10 SOUTH WALNUT AVENUE UVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 520	collected but there	wrified the information was was no process implemented care outcomes and resolve cerns.	F	520			

Facility ID: 00575

		AND HUMAN SERVICES	F	55	568073 0		APPROVED 0938-0391
and the second se		& MEDICAID SERVICES	· · · ·			1	E SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		01 - MAIN BUILDING 01		IPLETED
	•						
		245568	B. WING	-		08/	20/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH WALNUT AVENUE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN			UVERNE, MN 56156		
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE RIATE	COMPLETION DATE
TAG	REGULATORY OR L	SCIDENTIFTING INFORMATION)	IAG		DEFICIENCY)		
K 000	INITIAL COMMENT	TS	KC	000			
	FIRE SAFETY						
		OC WILL SERVE AS YOUR					
		COMPLIANCE UPON THE					
		CCEPTANCE. YOUR					
		S-2567 FORM WILL BE					
	USED AS VERIFIC	ATION OF COMPLIANCE.					
	UPON RECEIPT O	F AN ACCEPTABLE POC, AN					
		OF YOUR FACILITY MAY BE					
	CONDUCTED TO						
		MPLIANCE WITH THE AS BEEN ATTAINED IN					
		ITH YOUR VERIFICATION.					
	A Life Safety Code	Survey was conducted by the nent of Public Safety, State					
	Fire Marshal Divisio	on, on August 20,2014. At the					
	time of this survey,	Building 01 of Good					
		Mary J. Brown was found not					
	requirements for pa	compliance with the articipation in					
	Medicare/Medicaid	at 42 CFR, Subpart					
	483.70(a), Life Safe	ety from Fire, and the 2000					9
		Fire Protection Association afety Code (LSC), Chapter 19					
	Existing Health Car				and the second se	٦	
	PLEASE RETURN	THE PLAN OF R THE FIRE SAFETY					
	DEFICIENCIES (K				EPOC		
	Health Care Fire In State Fire Marshal						
	445 Minnesota St.,						
	St. Paul, MN 55107						
	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
	nically Signed						09/09/2014

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.

PRINTED: 09/10/2014

		AND HUMAN SERVICES					M APPROVE D. 0938-039	
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245568	B. WING	_		0	8/20/2014	
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, Z	IP CODE		
		- MARY JANE BROWN			SOUTH WALNUT AVENUE			
GOOD 3/				LU	/ERNE, MN 56156			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y 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 THE APPROPRIATE	(X5) COMPLETIOI DATE	
K 000	Continued From pa	nne 1	ко					
1000	Facsimile: 651-215	-					1	
		n.Whitney@state.mn.us						
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:						
	1. A description of v to correct the defici	what has been, or will be, done ency.						
	2. The actual, or pr	oposed, completion date.						
		r title of the person rection and monitoring to ence of the deficiency.						
	Brown was constru The original buildin one-story, has a pa	g was constructed in 1959, is Irtial basement, is fully fire						
	construction; The 1st Addition wa one-story, has no b	and is of Type II(111) as constructed in 1965, is basement, is fully fire sprinkler Type II(111) construction;						
	The 2nd Addition w one-story, has no b protected and is of The 3rd Addition wa	Type II(000) construction; assement, is fully fire sprinkler Type II(000) construction; as constructed in 1995, is assement, is fully fire sprinkler			ana in'ny taonana			
		Type II(111) construction.						
	detection in the cor corridors, which is department notifica	fire alarm system with smoke ridors and spaces open to the monitored for automatic fire ition. The facility has a and had a census of 50 at						

PRINTED: 09/10/2014

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COM	E SURVEY PLETED
		245568	B. WING		08/2	20/2014
NAME OF F	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
			1	10 SOUTH WALNUT AVENUE		
GOOD S	AMARITAN SOCIET	(- MARY JANE BROWN	L	UVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE
K 000	Continued From p	age 2	K 000			
K 011	NOT MET as evid	at 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD	K 011			9/30/14
SS=F	If the building has nonconforming bu barrier having at le rating constructed addition. Commun corridors and are	a common wall with a ilding, the common wall is a fire east a two-hour fire resistance of materials as required for the nicating openings occur only in protected by approved ors. 19.1.1.4.1, 19.1.1.4.2				
	Based on observa facility failed to pro at the building sep with 2000 - NFPA	is not met as evidenced by: ation and staff interview, the ovide 2-hour rated construction paration walls in accordance 101, sections 19.1.1.4.1 and ient practice could affect 50 out		The penetrations in the separations in the separations building 1 and building sealed on September 3, 2014. A smoke barriers where inspected sealed as needed. The Maintenance Director or destinations of the sector of the secto	2 where All other and	
	observation revea wall separating Bu open penetrations conduit ends. The above the drop-ce doors. NOTE: The entire	tween 1:00 PM and 4:00 PM, led, that the 2-hour fire rated ilding 1 and Building 2, has around cable wires and open ese penetration were located iling, over the horizontal exit e 2-hour fire rated wall g 1 and Building 2, needs to be		be responsible to conduct biwee to ensure penetrations are proper throughout the facility for one mo then monthly for two months to e compliance. He will bring the re the Quality Assurance Performan Improvement Committee (QAPI) review and recommendations. Completion Date: September 30	kly audits erly sealed onth and ensure sults to nce) for	

Facility ID: 00575

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PRINTED: 09/10/2014

PRINTED:	09/10/2014
FORM	APPROVED
OMB NO	0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONS ⁻ ING 01 - MAI	TRUCTION In Building 01		E SURVEY PLETED	
		245568	B. WING			08/2	20/2014	
	PROVIDER OR SUPPLIER	- MARY JANE BROWN	STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE LUVERNE, MN 56156					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X CF	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K 011	Continued From pa	ige 3	ĸ)11				
K 029	facility Maintenance discovery.	ice was confirmed by the e Director (DW) at the time of FETY CODE STANDARD	кс	29			9/30/14	
SS=F	fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved autor option is used, the other spaces by sm doors. Doors are s field-applied protect	construction (with ³ / ₄ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or tive plates that do not exceed bottom of the door are 2.1			·			
	Based on observa facility failed to mai partitions and door following requirement	s not met as evidenced by: tion and staff interview, the intain smoke-resisting s in accordance with the ents of 2000 NFPA 101, Fhe deficient practice could residents.		for ro haza exan	-closing devices have bee ooms #139, 140, 141, 142. Irdous area enclosures wh nined to ensure proper clo ces where installed and op erly.	All ere sing		
	08/20/2014, observ to storage rooms #	ween 1:00 PM and 4:00 PM on vation revealed, that the doors : 139, 140, 141, 142 (over 50 self-closing devices.		be re to en prop room self- then	Maintenance Director or d esponsible to conduct biwe sure self-closing devices a erly throughout the facility ns being used for storage h closing devices for one mo monthly for two months to pliance. He will bring the r	ekly audits are working and that nave onth and ensure		

FORM CMS-2567(02-99) Previous Versions Obsolete

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
ND PLAN C	OF CORRECTION	IDENTIFICATION NOMBER.	A BUILDING	3 01 - MAIN BUILDING 01		
		245568	B. WING		08/	20/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(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) COMPLETIO DATE
 K 029 Continued From page 4 Facility Maintenance Director (DW) at the t discovery. K 052 NFPA 101 LIFE SAFETY CODE STANDAF SS=F A fire alarm system required for life safety i installed, tested, and maintained in accorda with NFPA 70 National Electrical Code and 72. The system has an approved maintena and testing program complying with applica requirements of NFPA 70 and 72. 9.6.1.4 		e Director (DW) at the time of FETY CODE STANDARD required for life safety is d maintained in accordance nal Electrical Code and NFPA s an approved maintenance n complying with applicable	K 029	Improvement Committee (QAPI) f review and recommendations.	ör	9/30/14
	Based on observat facility failed to test accordance with the 101, Sections 19.3. NFPA 72 - 5-5.3.2.1 This could effect all Findings include: On facility tour betw 08/20/2014, observ following was found 1. The phone(s) fo Communicator Tran be tested to verify t system and monitor			The facility does have two phone the D.A.C.T. The battery backup properly operating by September as we continue to work with the fir system and monitoring company. The Maintenance Director or desi be responsible to conduct monthly for two months to ensure fire alart system is properly operating. He the results to the Quality Assurance Performance Improvement Comm (QAPI) for review and recomment	will be 30, 2014 re alarm gnee will y audits ms will bring ce nittee	

Facility ID: 00575

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If continuation sheet Page 5 of 7

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION (X3) D/	TE SURVEY
D PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING	01 - MAIN BUILDING 01	
		245568	B. WING	0	3/20/2014
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
K 052	batteries for the D./ no trouble signal wa	ge 5 A.C.T. were disconnected and as received by the premises nd monitoring company with-in	K 052		
	2. It could not be c two phone lines for	onfirmed that the facility has the D.A.C.T.			
K 062	These deficient practices were confirmed by the Facility Maintenance Director (DW) at the time of discovery. NFPA 101 LIFE SAFETY CODE STANDARD		K 062	2	9/30/14
SS=D	continuously mainta condition and are in	sprinkler systems are ained in reliable operating spected and tested .6, 4.6.12, NFPA 13, NFPA 25,			
	Based on observation facility failed to main accordance with NFPA 101, Section	s not met as evidenced by: tion and staff interview, the ntain the fire sprinkler system the requirements of 2000 s 19.3.4.1 and 9.6, as well as tions 2-2.1.1 This deficient of all 50 residents		All sprinkler heads where reviewed and new sprinkler heads where ordered on September 3, 2014 for those showing corrosion. The sprinkler heads will be installed by September 30, 2014.	
	08/20/2014, observ	veen 1:00 PM and 4:00 PM on ration revealed that several ler heads are corroded.		The Maintenance Director or designee w be responsible to conduct monthly audits for two months to ensure sprinkler heads are in good working order. He will bring the results to the Quality Assurance Performance Improvement Committee (QAPI) for review and recommendations	5

Facility ID: 00575

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ATEMENT D PLAN C	OF DEFICIENCIES	K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION Ng 01 - Main Building 01	(X3) DA COI	TE SURVEY
		245568	B. WING_		08	/20/2014
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		
		- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(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 S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
K 062		age 6 ce Director (DW) at the time of	K 06	62		
	TEAM COMPOSI Kimberly Swenson	TION , Life Safety Code Spc.				
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				a.		

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PRINTED: 09/10/2014

		AND HUMAN SERVICES & MEDICAID SERVICES	F55	68023	FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 02 - 2011 ADDITION	(X3) DATE SURVEY COMPLETED
		245568	B. WING		08/20/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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 COMPLÉTION
K 000	INITIAL COMMENT	S	K 000		
	FIRE SAFETY				
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O ONSITE REVISIT C CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE. F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.			
	Minnesota Departm Fire Marshal Divisio the time of this surv Samaritan Society I in substantial comp for participation in M Subpart 483.70(a), 2000 edition of Nati Association (NFPA) Chapter 18 New He PLEASE RETURN	R THE FIRE SAFETY TAGS) TO: spections Division Suite 145 -5145		EPOC]
		ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE
	ically Signed				09/09/2014

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.

TEMENT	OF DEFICIENCIES	& MEDICAID SERVICES		PLE CONSTRUCTION		TE SURVEY
D PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG 02 - 2011 ADDITION		
		245568	B. WING _			/20/2014
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 110 SOUTH WALNUT AVENUE	CODE	
OOD S	AMARITAN SOCIETY	- MARY JANE BROWN		LUVERNE, MN 56156		
(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 ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
K 000	Continued From pa	ge 1	K 00	00		
	By e-mail to: Mariar	n.Whitney@state.mn.us				
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:				
	1. A description of v to correct the defici	vhat has been, or will be, done ency.				
	2. The actual, or pro	oposed, completion date.				
		r title of the person rection and monitoring to ence of the deficiency.				
	Brown consists of the which includes a new conference room at one-story in height,	d Samaritan Society Mary J. he 2011 building addition, w main entrance, offices, nd beauty shop. Building 02 is has no basement, is fully fire and was determined to be of uction.				
	detection in the cor corridors, which is r department notifica	fire alarm system with smoke ridors and spaces open to the monitored for automatic fire tion. The facility has a and had a census of 50 at				
K 011	NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD	K 0'	11		9/30/14
SS=F	If the building has a nonconforming buil	a common wall with a ding, the common wall is a fire				

Facility ID: 00575

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		02 - 2011 ADDITION		LETED
		245568	B. WING		08/2	0/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		110 SOUTH WALNUT AVENUE LUVERNE, MN 56156		
(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 SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 011	barrier having at lea rating constructed of addition. Commun corridors and are p	ge 2 ast a two-hour fire resistance of materials as required for the icating openings occur only in rotected by approved ors. 18.1.1.4.1, 18.1.1.4.2	K 011			
	This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour rated construction at the building separation walls in accordance with 2000 - NFPA 101, sections 18.1.1.4.1 and 8.2.3.2. The deficient practice could affect 50 out of 51 residents.			The penetrations in the separating between building 1 and building 2 w sealed on September 3, 2014. All of smoke barriers where inspected an sealed as needed. The Maintenance Director or design be responsible to conduct biweekly	vhere other d nee will	
	observation revealed wall separating Bui open penetrations a conduit ends. The	ween 1:00 PM and 4:00 PM, ed, that the 2-hour fire rated lding 1 and Building 2, has around cable wires and open se penetration were located ling, over the horizontal exit		to ensure penetrations are properly throughout the facility for one month then monthly for two months to ens compliance. He will bring the result the Quality Assurance Performance Improvement Committee (QAPI) fo review and recommendations.	sealed h and ure ts to	
		2-hour fire rated wall 1 and Building 2, needs to be ficiency.				
	facility Maintenance discovery.	ice was confirmed by the e Director (DW) at the time of				0/20/44
K 029 SS=F	NFPA 101 LIFE SA Hazardous areas a	FETY CODE STANDARD	K 029	9		9/30/14

Facility ID: 00575

If continuation sheet Page 3 of 5

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2011 ADDITION B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		(X3) DATE SURVEY COMPLETED 08/20/2014	
		245568				
		243366				
GOOD SAMARITAN SOCIETY - MARY JANE BROWN			110 SOUTH WALNUT AVENUE LUVERNE, MN 56156			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIC DATE	
K 029	fire-rated barrier, w without windows (ir	ith a 3/4 hour fire-rated door, accordance with 8.4). Doors automatic closing in	K 029			
K 052 SS=F	Based on observat facility has a hazard was not constructed 101 (2000 edition) of and Chapter 7, Sec this deficient practic 50 residents, visitor FINDINGS INCLUE On facility tour betw 08/20/2014, observ Room in Building 00 feet and no 45 minu located on door. This deficient pract Facility Maintenanc discovery. NFPA 101 LIFE SA A fire alarm system installed, tested, an with NFPA 70 Natio 72. The system has	DE: ween 1:00 PM and 4:00 PM on vation revealed the Mechanical 2 was greater than 100 square ute fire rated label could be ice was confirmed by the e Director (DW) at the time of FETY CODE STANDARD required for life safety is id maintained in accordance onal Electrical Code and NFPA s an approved maintenance in complying with applicable	K 052	A new door with a fire rating of at leas minutes was ordered. All hazardous areas were examined to ensure prope door fire rating. The Maintenance Director or designed be responsible to ensure compliance w any physical change that would chang fire rated door or need for a fire rated door. The Maintenance Director or designee will be responsible to conduc monthly audits for two months to ensu all rooms have the proper fire rating or the door per the use of the room. He bring the results to the Quality Assurar Performance Improvement Committee (QAPI) for review and recommendatio	will vith e a t re vill ce	

Facility ID: 00575

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ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
ID PLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	3 02 - 2011 ADDITION		
		245568	B. WING		08/2	20/2014
IAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE			
GOOD S	AMARITAN SOCIETY	- MARY JANE BROWN		LUVERNE, MN 56156		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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)	ULD BE	(X5) COMPLETIC DATE
K 052	Continued From pa	ge 4	K 052	2		
	Based on observat facility failed to test accordance with the 101, Sections 19.3. NFPA 72 - 5-5.3.2.7 This could effect all Findings include: On facility tour betw 08/20/2014, observ following was found 1. The phone(s) fo Communicator Tran be tested to verify t system and monito trouble signal with- batteries for the D./ no trouble signal wa fire alarm system a 4 minutes.			The facility does have two phor the D.A.C.T. The battery backup properly operating by September as we continue to work with the system and monitoring company. The Maintenance Director or de be responsible to conduct mont for two months to ensure fire all system is properly operating. H the results to the Quality Assura Performance Improvement Com (QAPI) for review and recomment	p will be ir 30, 2014 fire alarm y. signee will nly audits arms e will bring nce mittee	
	two phone lines for These deficient pra	the D.A.C.T.				
	Facility Maintenanc discovery.	e Director (DW) at the time of				
	*TEAM COMPOSI Kimberly Swenson,					

Facility ID: 00575

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