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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245568**
2.STATE VENDOR OR MEDICAID NO.
(L2) **060743600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MARY JANE BROWN**
(L4) **110 SOUTH WALNUT AVENUE**
(L5) **LUVERNE, MN** (L6) **56156**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/14/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jodi Johnson, HFE NE II 11/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/19/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/22/2014
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA MDH DEPARTMENT OF HEALTH

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.

Sincerely,

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 of November 3, 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))

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,

Kamala 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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245568	A. Building B. Wing	11/14/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0329** Reg. # **483.25(l)** LSC	**11/03/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	**11/03/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KFD	11/18/2014	33564	11/14/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/21/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: U683

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00575

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245568**
2.STATE VENDOR OR MEDICAID NO.
(L2) **060743600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MARY JANE BROWN**
(L4) **110 SOUTH WALNUT AVENUE**
(L5) **LUVERNE, MN** (L6) **56156**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/16/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mary Whitlock, HFE NE II 11/03/20144 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/14/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/22/2014
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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
Kathryn.serie@state.mn.us
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,

Kamala 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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245568	A. Building B. Wing	10/16/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **10/16/2014**	ID Prefix **F0221** Reg. # **483.13(a)** LSC	Correction Completed **10/16/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **10/16/2014**
ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **10/16/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **10/16/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **10/16/2014**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **10/16/2014**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **10/16/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KFD	10/21/2014	28588	10/16/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/21/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245568	A. Building B. Wing **01 - MAIN BUILDING 01**	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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **09/30/2014**	ID Prefix	Correction Completed **09/30/2014**	ID Prefix	Correction Completed **09/30/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0011		LSC K0029		LSC K0052	
ID Prefix	Correction Completed **09/30/2014**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0062		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KFD	10/21/2014	34764	10/07/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/20/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245568	02 - 2011 ADDITION	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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0011	Correction Completed **09/30/2014**	ID Prefix Reg. # **NFPA 101** LSC K0029	Correction Completed **09/30/2014**	ID Prefix Reg. # **NFPA 101** LSC K0052	Correction Completed **09/30/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KFD	10/21/2014	34764	10/07/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/20/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **10/07/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS Based on review of the facility's plan of correction, the facility is in compliance with the Federal requirements identified as deficient at the time of their recertification survey.	{K 000}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **02 - 2011 ADDITION** B. WING _____	R **10/07/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**110 SOUTH WALNUT AVENUE** **LUVERNE, MN 56156**

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	R 10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**110 SOUTH WALNUT AVENUE LUVERNE, MN 56156**

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F 000	INITIAL COMMENTS 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 000		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329		10/28/14

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

Electronically Signed | 10/28/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	R 10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**110 SOUTH WALNUT AVENUE LUVERNE, MN 56156**

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F 329	Continued From page 1 by: Based on interview and document review the facility failed to monitor and assess the effectiveness of an antidepressant medication used for insomnia after a dose reduction for 1 of 3 residents (R9) reviewed for unnecessary medications. Findings include: Document review of R9's physician orders dated 9/12/14, identified diagnosis of but not limited to insomnia and an order to decrease Trazodone from 50 mg (milligrams) to 25 mg p.o. (by mouth) every HS (bedtime). Document review of R9's medication record dated 9/14 and 10/14, revealed R9 had been receiving Trazodone 25 mg by mouth at bedtime related to insomnia, start date of 9/12/14 and last monitoring of sleep pattern had been from 9/5/14 through 9/8/14. No documentation of monitoring sleep pattern had been done after the ordered dose reduction for the Trazodone on 9/12/14. R9's care plan date initiated 8/07/14, identified on antidepressant medication therapy related to insomnia with interventions of monitor for increased falls and observe for side effects. R9's care plan lacked any further documentation regarding insomnia. Review of R9's medical record identified last sleep assessment had been completed on 9/8/14. R9's medical record lacked monitoring of sleep pattern, a sleep assessment and any documentation related to the effectiveness of the Trazodone after the ordered dose reduction on 9/12/14.	F 329	Sleep monitoring and Sleep Assessment for R9 were initiated on 10/16/14 with Sleep assessment completion on 10/20/14. All residents prescribed medication to aide sleep were reviewed for sleep assessment completion by the DNS. Mediation Review process for medications used for sleep was reviewed with the Consultant Pharmacist, Health Information Management (HIM) director, and all Licensed Nurses through a memo dated 10/28/14. The RN will complete Sleep Assessments prior to initiating a medication for insomnia, on admission if resident is taking this type of medication on admission, any time a medication for insomnia is changed, a resident is observed to have signs of insomnia or the resident complains of new onset insomnia, and annually if taking medication for insomnia. The RN Case Manager will be notified of medication initiation or changes by the charge nurse and the HIM director. The consulting Pharmacist will verify that Sleep Assessments have been completed monthly. All physician orders received will be reviewed weekly for 4 weeks then monthly for 2 months by the DNS or designee and medications that require sleep assessment follow-up will be audited for sleep assessment completion. Results of the audits will be reported to the QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	R 10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 2 Document review of the facility sleep assessment audits dated 9/18/14, 9/24/14, 10/3/14 and 10/10/14, identified response of " NO " to any sleep medication dose changes even though a doese reduction had occurred. During interview on 10/16/14, at 9:30 a.m., director of nursing had stated, " I do not have a sleep assessment for R9 following the decrease in Trazodone. I started the 72 hour monitoring for sleep pattern today (10/16/14). It was missed being followed up on after the dose change. " Policy for sleep assessment had been requested and the director of nursing had stated the facility had no policy for sleep assessment.	F 329	committee for review and recommendation.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility consultant pharmacist failed to identify lack of monitoring and effectiveness of an antidepressant medication used for insomnia after a dose reduction for 1 of 3 residents (R9)	F 428	F 428 Sleep monitoring and Sleep assessment for R9 were initiated on 10/16/14 with Sleep assessment completion on 10/20/14.	11/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	R 10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

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F 428	Continued From page 3 reviewed for unnecessary medications. Findings include: Document review of R9's physician orders dated 9/12/14, identified diagnosis of but not limited to insomnia and an order to decrease Trazodone from 50 mg (milligrams) to 25 mg p.o. (by mouth) every HS (bedtime). Document review of R9's medication record dated 9/14 and 10/14, revealed R9 had been receiving Trazodone 25 mg by mouth at bedtime related to insomnia, start date of 9/12/14 and last monitoring of sleep pattern had been from 9/5/14 through 9/8/14. No documentation of monitoring sleep pattern had been done after the ordered dose reduction for the Trazodone on 9/12/14. Review of R9's medical record identified last sleep assessment had been completed on 9/8/14. R9's medical record lacked monitoring of sleep pattern, a sleep assessment and any documentation related to the effectiveness of the Trazodone after the ordered dose reduction on 9/12/14. Document review of pharmacy consultant progress note dated 10/10/14, revealed Trazodone dose decreased, resident refused Trazodone every HS dose times one in October so far but received each night in September. R9's pharmacy review dated 10/10/14 lacked any documentation related to the monitoring/sleep assessment related to the effectiveness of the Trazodone after the ordered dose reduction on 9/12/14. During interview on 10/16/14, at 9:30 a.m. the	F 428	All residents prescribed medication to aide sleep will be reviewed for sleep assessment completion by the DNS and Consulting Pharmacist by November 7, 2014. Medication Review process for medications used for sleep was reviewed with the Consultant Pharmacist, HIM director, and all Licensed Nurses through a memo dated 10/28/14. The RN will complete Sleep Assessments prior to initiating a medication for insomnia, on admission if resident is taking this type of medication on admission, any time a medication for insomnia is changed, a resident is observed to have signs of insomnia or the resident complains of new onset insomnia, and annually if taking medication for insomnia. The RN Case Manger will be notified of medication initiation or changes by the charge nurse and the HIM director. The consulting Pharmacist will verify that Sleep Assessments have been completed monthly. All physicians orders received for sleep aides will be audited to ensure required sleep assessments have been completed weekly for 4 weeks then monthly for 2 months by the DNS or designee. Results of the audits will be reported to the QAPI committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	R 10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**110 SOUTH WALNUT AVENUE LUVERNE, MN 56156**

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F 428	Continued From page 4 director of nursing had stated, " I do not have a sleep assessment for R9 following the decrease in Trazodone. I started the 72 hour monitoring for sleep pattern today (10/16/14). It was missed being followed up on after the dose change. " During interview on 10/16/14, at 9:44 a.m., consultant pharmacist (CP)-B had stated. " I would assume they would monitor and do a sleep assessment after a dose reduction for the Trazodone. " Document review of the facility ADDENDUM C - CONSULTANT PHARMACIST AGREEMENT FOR SKILLED NURSING FACILITY (SNF) dated 6/18/12, read " 2. Lewis Drug agrees to: a. Review the drug regimen of each resident in the Center at the time of Lewis Drug's visit at least once each month and report in writing any irregularity to the Center's Administrator, Director of Nursing Services and, where appropriate, the individual resident's physician. "	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	R 10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	R 10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

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GOOD SAMARITAN SOCIETY - MARY JANE BROWN	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 2 Document review of the facility sleep assessment audits dated 9/18/14, 9/24/14, 10/3/14 and 10/10/14, identified response of " NO " to any sleep medication dose changes even though a doese reduction had occurred. During interview on 10/16/14, at 9:30 a.m., director of nursing had stated, " I do not have a sleep assessment for R9 following the decrease in Trazodone. I started the 72 hour monitoring for sleep pattern today (10/16/14). It was missed being followed up on after the dose change. " Policy for sleep assessment had been requested and the director of nursing had stated the facility had no policy for sleep assessment.	F 329	committee for review and recommendation.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility consultant pharmacist failed to identify lack of monitoring and effectiveness of an antidepressant medication used for insomnia after a dose reduction for 1 of 3 residents (R9)	F 428	F 428 Sleep monitoring and Sleep assessment for R9 were initiated on 10/16/14 with Sleep assessment completion on 10/20/14.	11/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	R 10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 3 reviewed for unnecessary medications. Findings include: Document review of R9's physician orders dated 9/12/14, identified diagnosis of but not limited to insomnia and an order to decrease Trazodone from 50 mg (milligrams) to 25 mg p.o. (by mouth) every HS (bedtime). Document review of R9's medication record dated 9/14 and 10/14, revealed R9 had been receiving Trazodone 25 mg by mouth at bedtime related to insomnia, start date of 9/12/14 and last monitoring of sleep pattern had been from 9/5/14 through 9/8/14. No documentation of monitoring sleep pattern had been done after the ordered dose reduction for the Trazodone on 9/12/14. Review of R9's medical record identified last sleep assessment had been completed on 9/8/14. R9's medical record lacked monitoring of sleep pattern, a sleep assessment and any documentation related to the effectiveness of the Trazodone after the ordered dose reduction on 9/12/14. Document review of pharmacy consultant progress note dated 10/10/14, revealed Trazodone dose decreased, resident refused Trazodone every HS dose times one in October so far but received each night in September. R9's pharmacy review dated 10/10/14 lacked any documentation related to the monitoring/sleep assessment related to the effectiveness of the Trazodone after the ordered dose reduction on 9/12/14. During interview on 10/16/14, at 9:30 a.m. the	F 428	All residents prescribed medication to aide sleep will be reviewed for sleep assessment completion by the DNS and Consulting Pharmacist by November 7, 2014. Medication Review process for medications used for sleep was reviewed with the Consultant Pharmacist, HIM director, and all Licensed Nurses through a memo dated 10/28/14. The RN will complete Sleep Assessments prior to initiating a medication for insomnia, on admission if resident is taking this type of medication on admission, any time a medication for insomnia is changed, a resident is observed to have signs of insomnia or the resident complains of new onset insomnia, and annually if taking medication for insomnia. The RN Case Manger will be notified of medication initiation or changes by the charge nurse and the HIM director. The consulting Pharmacist will verify that Sleep Assessments have been completed monthly. All physicians orders received for sleep aides will be audited to ensure required sleep assessments have been completed weekly for 4 weeks then monthly for 2 months by the DNS or designee. Results of the audits will be reported to the QAPI committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 4 director of nursing had stated, " I do not have a sleep assessment for R9 following the decrease in Trazodone. I started the 72 hour monitoring for sleep pattern today (10/16/14). It was missed being followed up on after the dose change. " During interview on 10/16/14, at 9:44 a.m., consultant pharmacist (CP)-B had stated. " I would assume they would monitor and do a sleep assessment after a dose reduction for the Trazodone. " Document review of the facility ADDENDUM C - CONSULTANT PHARMACIST AGREEMENT FOR SKILLED NURSING FACILITY (SNF) dated 6/18/12, read " 2. Lewis Drug agrees to: a. Review the drug regimen of each resident in the Center at the time of Lewis Drug's visit at least once each month and report in writing any irregularity to the Center's Administrator, Director of Nursing Services and, where appropriate, the individual resident's physician. "	F 428		

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245568**

2.STATE VENDOR OR MEDICAID NO.
(L2) **060743600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MARY JANE BROWN**
(L4) **110 SOUTH WALNUT AVENUE**
(L5) **LUVERNE, MN** (L6) **56156**

4. TYPE OF ACTION: **2** (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/21/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NE II 09/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/22/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 09/22/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
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.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to actively seek a resolution to voiced grievances for 4 of 4 residents (R68, R25, R51 & R18) in the sample who identified that staff call light response was not timely and for 6 of 6 (R16, R33, R48, R42, R43 & R25) residents who identified slow meal service and had informed facility staff of these complaints. Findings include: During initial interview with R68 on 8/18/14, at	F 166	Suggestion/Concern forms were initiated for R25, R51, and R18 related to concern of untimely call light response times and for R16, R33, R48, R42, R43, and R25 related to concern of slow meal service. R68 has discharged from Facility. Staff was educated on the importance of answering call lights while they are working to decrease the call light response time at an All-Staff In-service on 8-28-14. A new procedure was developed for passing trays at meal times. The	9/30/14

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

Electronically Signed | 09/09/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 166	Continued From page 1 12:46 p.m. R68 stated that she did not feel there were enough staff available at the facility to meet her needs. R68 stated it took staff a long time to answer her call light. During interview with R68 on 8/20/14, at 1:20 p.m. R68 stated she had to frequently wait over fifteen minutes when she alerted staff she needed assistance and had activated the call light. R68's family member (FM)-A, who was in the room at the time of the interview, verified it took a long time to get the lights answered. FM-A indicated R68 required assistance with toileting as she was not to walk alone. FM-A stated that when staff did not respond in a timely manner, R68 would transfer self into the bathroom to void. R68 stated that at sometimes, during the night shift, she would wait one half hour for staff to respond to the call-light. R68 stated she wore an incontinent brief product because she did not want to have an accident while waiting for staff to arrive, and stated she did not like to "have to wear that dumb Depends." R68's admission Minimum Data Set (MDS) assessment, dated 8/5/15 identified her with a brief interview for mental status (BIMs) score of 15 which indicated her decision making and cognition were intact. The MDS further identified R68 as continent of bladder and required extensive assist of one staff with toileting. During initial interview with R25 on 8/19/14, at 1:03 p.m. R25 stated she did not think there was enough staff available to meet her needs. R25 stated, "You sit there a long time and you don't get help." During a follow-up interview on 8/20/14, at 12:57	F 166	procedure includes nursing staff assisting dietary to pass trays to the assisted residents as they are ready to assist them, a new serving rotation that would formalize rotating the order in which tables are served at each meal, and included notifying the residents by adding the rotation to a monthly resident calendar and announcing it at devotions. Nursing and Dietary staff were educated to the new procedure through a Memo posted 9/3/14. Call light response times will be audited at random times 3 times per week for one month and then once a week for one month to ensure timely call light response times by LSW or designee. Meal service wait times will be audited 3 times per week at random meals for one month and then once weekly for one month by the DDS or designee. Results of the audits will be shared with Resident Council and Quality Assurance Performance Improvement (QAPI) committee for review and recommendations.	

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F 166	Continued From page 2 p.m. R25 indicated she required assistance with transfers to the bathroom and getting in and out of bed. R25 stated she often had to wait over one half hour for the call light to be answered after she alerted staff when she required assistance with transfer to the bathroom. R25 stated, "I really don't ever have accidents but when I have to wait sometimes I dribble and it makes me feel like a kid. If I sneeze or cough when I'm trying to hold it, I dribble. It makes me disappointed." R25 indicated she experienced long waits for staff assistance on a daily basis. R25 indicated she does not feel wanted when she waits a long time. R25's quarterly MDS dated 6/24/14, identified her with a BIMs of 14, indicating intact cognition, and identified her as always continent of urine. The MDS further identified she required extensive assistance of one staff with transferring and toileting. During initial interview with R51 on 8/19/14, at 2:29 p.m., R51 stated she did not feel there was enough staff available to help her. R51 stated,"With the kids returning to school the facility is short of staff and you have to wait a long time to get your light answered. I push the button and have had to wait over one half hour for help." During a follow-up interview on 8/20/14, at 1:35 p.m. R51 indicated she had to wait twenty to thirty minutes to get staff response when she activated the call light. R51 identified the worst times of the day were before and after meals. R51 stated, "I have to go in my pad because they take too long. I can hold it until I stand up to walk to the bathroom and then it's too late." R51 stated she did not want to be incontinent but she could not get up by herself.	F 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 3 R51's quarterly MDS dated 6/25/14 identified her with a BIMs of 15, as occasionally incontinent, and requiring extensive assistance of one staff with transfers and toileting. During initial interview with R18 on 8/18/14, at 2:48 p.m. R18 stated she did not feel there was 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." 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. During an observation on 8/18/14, continuously	F 166		

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	245568	A. BUILDING _____ B. WING _____	08/21/2014

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from 11:45 a.m. to 1:00 p.m. it was noted that residents who were independent with eating were being served their meal subsequent to residents who required assistance. Residents who did not require assistance with eating expressed complaints and dissatisfaction related to a long wait time prior to their meal service. It was noted that residents who were independent with eating waited over 30 minutes from the start of meal time, which was posted as being served at 12:00 noon. The last resident who was independent was served food 35 minutes after the posted time of the meal (noon). Cook-A was interviewed on 8/18/14, at 12:30 p.m. verified that residents who required assistance were served first and when they were finished with their meal the independent residents were served.

During an observation and interview on 8/18/14, at 12:25 p.m. R48 verified she arrived in the dining room at 12:00 noon and added that it was not unusual to wait up to 30-35 minutes to be served the noon meal. R48 verified that dissatisfaction had been expressed to the dietary staff on multiple occasions and was also aware the issue had been discussed at the resident council meetings. R48 had a Brief Interview of Mental Status (BIMS) score on 8/15/14, of 15/15 which indicated cognitively intact.

An observation/interview was conducted with R33 and R42 on 8/18/14, at approximately 12:20 p.m. Both R33 and R42 expressed complaints related to the long wait time for meals to be served. R33 further added "Oh well, what else do I have to do but wait." Both R33 and R42 were aware that issues were brought up at the resident council meetings but nothing had changed. R33 had a BIMS score dated 5/30/14, of 15/15 indicating no

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cognitive impairment. R42 had a BIMS score dated 7/18/14, of 14/15 which also indicated no cognitive impairment.

R16 and R25 were observed/interviewed on 8/18/14, at 12:27 p.m. and also verified the wait time to be served the noon meal was too long. R16 had a BIMS score dated 7/18/14, of 15/15 which indicated no cognition impairment. R25 had a BIMS score dated 6/2/14, of 14/15 indicating no cognitive impairment.

During an observation/interview on 8/18/14, at 12:30 p.m. R43 expressed dissatisfaction with the long wait for meal service. R43 had a BIMS score dated 6/13/14, of 9/15 which indicated moderate cognitive impairment.

An interview was conducted with R43 on 8/21/14, at 8:37 a.m. verified that she had to wait for a good half hour or longer to have her meal served at lunch and supper. She added, "I just hate to go down there (dining room) at lunch and supper because of how long I have to wait to get my food. I even got up and left one time."

Review of the Resident Council Meeting minutes dated 4/24/14, identified a concern for the dietary department. One resident asked, "How come we don't get our meals more quickly"? Dietary Director responded, "That system is changing. We will start serving you when you come down to meals".

The facility policy for Grievances, Complaints or Concerns, dated 2/2013, identified the following grievance procedure:

1. Upon resident admission the Suggestion or

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F 166	Continued From page 6 Concern form or "Resolving the Issues" brochure will be given with a review of the grievance procedure. 2. When a resident, family member, visitor or staff member expresses a concern or grievance to a staff member related to resident care or services, it will be received in an open, friendly, nonjudgmental manner and without discrimination or reprisal. 3. If the problem can be resolved immediately, the staff member will thank the individual for the information and proceed to take action regarding the problem. The grievance then will be documented on the Suggestion or Concern and submitted to the center social service director. 4. If the complaint comes directly to the social services department, then the director of social services will complete a Suggestion or Concern form upon receipt of the complaint. 5. The social services director will route the Suggestion or Concern form to the appropriate department head as soon as possible. The policy continued to identify the facility will investigate the grievance, document the investigation and identify their response to the grievance to the applicable party. Even when the facility administrative and direct support staff were aware of the residents complaints about slow call light responses and slow meal service there were no interventions put in place to resolve the grievances.	F 166		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS	F 221		9/30/14

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F 221	Continued From page 7 The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess the appropriate use of a lap buddy for 1 of 1 resident (R61) reviewed for physical restraints. Findings include: On 8/19/14, at 5:42 p.m. R61 was observed seated in her wheelchair (w/c) in the dining room with a lap buddy (a thick cushion that fits over a resident's lap and is secured to the armrests of the w/c, which can restrict the resident's ability to remove themselves from the w/c.) in place. At 5:45 p.m. dietary staff delivered R61's supper meal to the table. At 5:47 p.m., R61 was observed to remove the flat top portion of the lap buddy which had been previously velcroed in place, and turned herself away from the table. The main portion of the lap buddy continued to remain across the front of the w/c restricting R61 from rising. The device was observed to have a split down the middle and was velcroed into place. At 5:48 p.m., nursing assistant (NA)-N approached R61, replaced the flat top portion of the lap buddy, turned R61 towards the table and asked her if she wanted to eat. NA-N applied a clothing protector for R61, encouraged her to eat, then walked away from the table to assist other residents; R61 made no attempt to eat her meal or drink her fluids independently. At 5:51 p.m.,	F 221	A Physical Restraint assessment for R61 was completed 9-3-14, and the use of the restraint was discontinued. All residents were reviewed for the completion of physical restraint assessments if indicated. Education was provided to all Licensed Nurses on the Physical Restraint Policy and Procedure at a Licensed Nurses Meeting on 9-4-14. Any use of physical restraints will be reviewed by the Interdisciplinary team initially and quarterly. Random audits will be done weekly for one month and then monthly for one month to monitor completion of restraint assessments by DNS or designee. Results of the audits will be reported to the QAPI committee for review and recommendations.	

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F 221	Continued From page 8 R61 was observed to remove her clothing protector, push herself away from the table and turn her w/c so that her back was facing the table, she then threw her clothing protector on the floor. At 5:57 p.m., R61 was observed attempting to remove the lap buddy from her w/c by grabbing the outer edge of the lap buddy and pulling upward. R61 continued to pull on the lap buddy until 6:03 p.m. when NA-S approached the resident and asked if she was hungry. R61 indicated being hungry and NA-S then turned R61 so that her w/c faced the table. NA-S attempted to assist R61 with eating but the resident refused all offered food/drink. At 6:05 p.m., NA-S exited R61's table to assist other residents. At 6:10 p.m. R61 started pulling on the lap buddy and was able to remove the rigid flat portion velcroed to the top of the device; the main portion remained restricting R61's ability to stand from the w/c. R61 continued to pull on the main portion of the lap buddy. R61 continued to pull on the lap buddy until 6:21 p.m., when she was able to successfully separate the two velcroed portions that connected the lap buddy and threw one of the halves on the floor. NA-S then approached R61, picked up the half of the lap buddy that was on the floor along with the rigid, flat top piece and asked R61 if she could put it back on the w/c. R61 indicated she wanted the lap buddy off as NA-S replaced it and NA-S stated, "No, we're gonna keep that on." NA-S attempted to assist R61 with eating; R61 took one bite of food then once again attempted to remove the lap buddy. When interviewed at 6:24 p.m., NA-S indicated that R61 utilized the lap buddy in her w/c at all times including meals. On 8/20/14, at 12:03 p.m. R61 was observed seated in her w/c with the lap buddy in place at	F 221		

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the dining room table. A family friend was present and seated at the table next to R61. At 12:11 p.m., NA-T arrived at the table and was observed to assist R61 with eating until 12:28 p.m. The lap buddy remained in place throughout the observation. R61 appeared calm throughout the observation and did not attempt to remove the lap buddy.

On 8/20/14, at 1:32 p.m. R61 was observed seated in her w/c in the common area with the lap buddy in place. R61 stated to registered nurse (RN)-R, "How do I get out of this thing? Do you know how to get me out of this thing?"and motioned to the lap buddy attached to her w/c. RN-R responded that she did know how to remove the lap buddy but then pushed R61 to her bedroom and asked for staff assistance to lay R61 down in bed.

On 8/21/14, at 10:25 a.m. R61 was observed seated in her w/c in the activity room with lap buddy in place. Activity staff and several other residents were also present and were participating in an organized activity. R61 appeared calm and was not observed trying to remove the lap buddy.

R61's 14-day Minimum Data Set (MDS) assessment dated 8/11/14, indicated R61 had severe cognitive impairment, total dependence with locomotion on/off the unit and toileting, and extensive assistance with transfer, bed mobility, personal hygiene, dressing, and eating. The assessment further indicated no restraint use.

R61's care plan revised 8/11/14, revealed diagnoses to include: cognitive deficits due to cerebrovascular disease, personal history of fall,

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F 221	Continued From page 10 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."	F 221		

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F 221	Continued From page 11 When interviewed on 8/21/14, at 10:31 a.m. NA-T/nursing staff coordinator stated R61 utilized the lap buddy at all times unless R61 was toileted/repositioned or laid down to rest. NA-T further confirmed she had witnessed that R6 had attempted to remove the lap buddy when seated in the common living area but had never observed R61 attempt to remove the lap buddy during meal time. The procedure titled Physical Restraints revised 10/13, indicated: Anytime a device, material or equipment is attached or placed adjacent to the resident's body, a determination will be made by a licensed nurse as to whether it is or could be a restraint for the individual resident. If the device, material or equipment cannot be removed easily by the resident and restricts freedom of movement or normal access to one's own body, then this is a restraint and this procedure must be followed. If the device, material or equipment is not a restraint for this resident, then the steps taken to make this decision must be documented in the PN - Psychopharmacological Med/Physical Restraint. If the device, material or equipment is not a restraint, it must be reviewed with a significant change in condition and quarterly in conjunction with the care plan to ensure that it continues to not be a restraint for the resident. This review may be documented as part of the quarterly note in the PN - Care Plan Review.	F 221		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		9/30/14

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F 241	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to promote dignified care and respond to call lights in a timely manner for 4 of 4 residents (R68, R25, R51 & R18) who complained that call light response time from staff was not timely and failed to provide a dignified dining experience for 3 of 48 residents (R15, R38, R21) who were assisted during meal time by staff who stood next to the resident when assistance was offered. Findings include: During initial interview with R68 on 8/18/14, at 12:46 p.m. R68 stated that she did not feel there were enough staff available at the facility to meet her needs. R68 stated it took staff a long time to answer her call light. During interview with R68 on 8/20/14, at 1:20 p.m. R68 stated she had to frequently wait over fifteen minutes when she alerted staff she needed assistance and had activated the call light. R68's family member (FM)-A, who was in the room at the time of the interview, verified it took a long time to get the lights answered. FM-A indicated R68 required assistance with toileting as she was not to walk alone. FM-A stated that when staff did not respond in a timely manner, R68 would transfer self into the bathroom to void. R68 stated that at sometimes, during the night shift, she would wait one half hour for staff to respond to the call-light. R68 stated she wore an incontinent brief product because she did not want to have an accident while waiting for staff to	F 241	Staff was educated on the importance of answering call lights while they are working to decrease the call light response time at an All-Staff In-service 8/28/14. Providing a dignified dining experience was reviewed with staff at an All-Staff In-Service 8/28/14. All staff will respond to call lights. Staff will not stand while assisting residents with eating. Call light response times will be audited at random times 3 times per week for one month and then once a week for one month to ensure timely response time by the Licensed Social Worker (LSW) or designee. Dining experience will be audited 3 times per week for one month and then one time per week for one month to ensure feeding assistance is provided in a dignified manner. Audits will be reported to resident council and QAPI committee for review and recommendations.	

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F 241	Continued From page 13 arrive, and stated she did not like to "have to wear that dumb Depends." R68's admission Minimum Data Set (MDS) assessment, dated 8/5/15 identified her with a brief interview for mental status (BIMs) score of 15 which indicated her decision making and cognition were intact. The MDS further identified R68 as continent of bladder and required extensive assist of one staff with toileting. During initial interview with R25 on 8/19/14, at 1:03 p.m. R25 stated she did not think there was enough staff available to meet her needs. R25 stated, "You sit there a long time and you don't get help." During a follow-up interview on 8/20/14, at 12:57 p.m. R25 indicated she required assistance with transfers to the bathroom and getting in and out of bed. R25 stated she often had to wait over one half hour for the call light to be answered after she alerted staff when she required assistance with transfer to the bathroom. R25 stated, "I really don't ever have accidents but when I have to wait sometimes I dribble and it makes me feel like a kid. If I sneeze or cough when I'm trying to hold it, I dribble. It makes me disappointed." R25 indicated she experienced long waits for staff assistance on a daily basis. R25 indicated she does not feel wanted when she waits a long time. R25's quarterly MDS dated 6/24/14, identified her with a BIMs of 14, indicating intact cognition, and identified her as always continent of urine. The MDS further identified she required extensive assistance of one staff with transferring and toileting.	F 241		

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F 241	Continued From page 14 During initial interview with R51 on 8/19/14, at 2:29 p.m., R51 stated she did not feel there was enough staff available to help her. R51 stated,"With the kids returning to school the facility is short of staff and you have to wait a long time to get your light answered. I push the button and have had to wait over one half hour for help." During a follow-up interview on 8/20/14, at 1:35 p.m. R51 indicated she had to wait twenty to thirty minutes to get staff response when she activated the call light. R51 identified the worst times of the day were before and after meals. R51 stated, "I have to go in my pad because they take too long. I can hold it until I stand up to walk to the bathroom and then it's too late." R51 stated she did not want to be incontinent but she could not get up by herself. R51's quarterly MDS dated 6/25/14 identified her with a BIMs of 15, as occasionally incontinent, and requiring extensive assistance of one staff with transfers and toileting. During initial interview with R18 on 8/18/14, at 2:48 p.m. R18 stated she did not feel there was 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	F 241		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	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 provided. During an interview on 8/20/14, at 10:08 a.m. R21 verified her preference with meal assistance was that staff remain seated next to her rather than	F 241		

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F 241	Continued From page 16 stand over her. R15 was not interviewable and unable to verbalize a preference. NA-A was interviewed on 8/20/14, at 9:15 a.m. and stated that she stood while she assisted R15, R38 and R21 during the breakfast meal on 8/20/14. NA-A further added that she had been taught to be seated next to residents who required assistance with eating. Review of the procedure titled, Resident Choice Dining last revision dated 8/12, identified under #7: "Residents will...Receive assistance from staff in a dignified manner, e.g., staff to sit rather than stand, allowing resident adequate time between bites of food and sips of water." The director of nursing (DON) was interviewed on 8/20/14, at 12:06 p.m. and verified the expectation was that staff remain seated next to the resident whom they assist during the meal and not stand over the resident. The DON further added that rolling stools were available for use so that staff could remain seated throughout the meal.	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by:	F 244		9/30/14

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F 244	Continued From page 17 Based on observation, interview and document review, the facility failed to ensure resident council concerns related to slow call light response time and slow meal service were addressed and efforts were made toward resolution. This included resident interviews for 10 of 48 residents (R68, R25, R51, R18, R16, R25, R33, R42, R43 & R48) in the facility who expressed these quality of care concerns. Findings include: During review of the resident council minutes the following concerns were voiced by the resident council members and documentation was lacking to indicate the facility had acted upon the concerns: (1) On 1/30/13, residents identified call light times still needed some work on being shortened. The meetin minutes identified the director of nursing (DON) was notified about the concern. (2) On 4/24/14, resident council members identified that call light response times needed improvement. The meeting minutes identified the DON was notified about the concern. (3) On 7/31/14, resident council members identified, "Sometimes it takes forever," regarding the wait time for staff to respond to the call light. Documentation indicated the social service director informed residents about the call light time-out system. The time out system decreases the interval between call light chimes after it had been activated for fifteen minutes to alert staff. The meeting minutes identified the DON was also notified of the concern. During interview with social service director (SS) on 8/21/14, at 1:43 p.m. it was confirmed that nursing staff never acted upon the grievances	F 244	Suggestion/Concern forms were initiated for R25, R51, and R18 related to concern of untimely call light response times and for R16, R33, R48, R42, R43, and R25 related to concern of slow meal service. R68 has discharged. Staff was educated on the importance of everyone answering call lights while they are working to decrease the call light response time at an All-Staff In-service 9/28/14. A new procedure was developed for passing trays at meal times. The procedure includes nursing staff assisting dietary to pass trays to the assisted residents as they are ready to assist them, a new serving rotation that would formalize rotating the order in which tables are served at each meal, and included notifying the residents by adding the rotation to a monthly resident calendar and announcing it at devotions. Nursing and Dietary staff were educated to the new procedure through a Memo posted 9/3/14. Call light response times will be audited at random times 3 times per week for one month and then once a week for one month to ensure timely response times by the LSW or designee. Meal service wait times will be audited 3 times per week at random meals for one month and then once weekly for one month by the Director of Dietary Services (DDS) or designee. Audit results will be reported to Resident Council and QAPI committee for review and recommendations.	

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F 244	Continued From page 18 discussed at resident council meetings to explain actions taken to respond to the expressed concerns. SS verified she had not followed up with the resident concerns related to slow call light response times but only asked during the resident council meetings whether there were concerns. During interview with the director of nursing (DON) on 8/21/14, at 9:20 a.m. she stated she was aware of resident complaints about call light response times and stated she always got the resident council minutes and was aware that residents frequently complained about staffing and call light waits. During further interview on 8/21/14, at 2:14 p.m. with the DON, she verified she had not attended resident council meetings and had not communicated with the group regarding the voiced grievances related to slow call light response time. When questioned whether they had implemented any interventions and/or recommendations, the DON replied, "I have nothing for you" . Althought administrative staff had been aware of resident complaints about slow call light response time from staff, no follow up communication had occurred with the resident council committee. During initial interview with R68 on 8/18/14, at 12:46 p.m. R68 stated that she did not feel there were enough staff available at the facility to meet her needs. R68 stated it took staff a long time to answer her call light. During interview with R68 on 8/20/14, at 1:20 p.m. R68 stated she had to frequently wait over fifteen minutes when she alerted staff she	F 244		

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needed assistance and had activated the call light. R68's family member (FM)-A, who was in the room at the time of the interview, verified it took a long time to get the lights answered. FM-A indicated R68 required assistance with toileting as she was not to walk alone. FM-A stated that when staff did not respond in a timely manner, R68 would transfer self into the bathroom to void. R68 stated that at sometimes, during the night shift, she would wait one half hour for staff to respond to the call-light. R68 stated she wore an incontinent brief product because she did not want to have an accident while waiting for staff to arrive, and stated she did not like to "have to wear that dumb Depends."

R68's admission Minimum Data Set (MDS) assessment, dated 8/5/15 identified her with a brief interview for mental status (BIMs) score of 15 which indicated her decision making and cognition were intact. The MDS further identified R68 as continent of bladder and required extensive assist of one staff with toileting.

During initial interview with R25 on 8/19/14, at 1:03 p.m. R25 stated she did not think there was enough staff available to meet her needs. R25 stated, "You sit there a long time and you don't get help."

During a follow-up interview on 8/20/14, at 12:57 p.m. R25 indicated she required assistance with transfers to the bathroom and getting in and out of bed. R25 stated she often had to wait over one half hour for the call light to be answered after she alerted staff when she required assistance with transfer to the bathroom. R25 stated, "I really don't ever have accidents but when I have to wait sometimes I dribble and it makes me feel

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like a kid. If I sneeze or cough when I'm trying to hold it, I dribble. It makes me disappointed." R25 indicated she experienced long waits for staff assistance on a daily basis. R25 indicated she does not feel wanted when she waits a long time.

R25's quarterly MDS dated 6/24/14, identified her with a BIMs of 14, indicating intact cognition, and identified her as always continent of urine. The MDS further identified she required extensive assistance of one staff with transferring and toileting.

During initial interview with R51 on 8/19/14, at 2:29 p.m., R51 stated she did not feel there was enough staff available to help her. R51 stated,"With the kids returning to school the facility is short of staff and you have to wait a long time to get your light answered. I push the button and have had to wait over one half hour for help."

During a follow-up interview on 8/20/14, at 1:35 p.m. R51 indicated she had to wait twenty to thirty minutes to get staff response when she activated the call light. R51 identified the worst times of the day were before and after meals. R51 stated, "I have to go in my pad because they take too long. I can hold it until I stand up to walk to the bathroom and then it's too late." R51 stated she did not want to be incontinent but she could not get up by herself.

R51's quarterly MDS dated 6/25/14 identified her with a BIMs of 15, as occasionally incontinent, and requiring extensive assistance of one staff with transfers and toileting.

During initial interview with R18 on 8/18/14, at 2:48 p.m. R18 stated she did not feel there was

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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."

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 an observation on 8/18/14, continuously from 11:45 a.m. to 1:00 p.m. it was noted that residents who were independent with eating were being served their meal subsequent to residents who required assistance. Residents who did not require assistance with eating expressed complaints and dissatisfaction related to a long wait time prior to their meal service. It was noted that residents who were independent with eating waited 35 minutes from the start of meal time, which was posted as being served at 12:00 noon.

During an observation and interview on 8/18/14, at 12:25 p.m. R48 verified she arrived in the

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dining room at 12:00 noon and added that it was not unusual to wait up to 30-35 minutes to be served the noon meal. R48 verified that dissatisfaction had been expressed to the dietary staff on multiple occasions and was also aware the issue had been discussed at the resident council meetings. R48 had a Brief Interview of Mental Status (BIMS) score on 8/15/14, of 15/15 which indicated cognitively intact.

An observation/interview was conducted with R33 and R42 on 8/18/14, at approximately 12:20 p.m. Both R33 and R42 expressed complaints related to the long wait time for meals to be served. R33 further added "Oh well, what else do I have to do but wait." Both R33 and R42 were aware that issues were brought up at the resident council meetings but nothing had changed. R33 had a BIMS score dated 5/30/14, of 15/15 indicating no cognitive impairment. R42 had a BIMS score dated 7/18/14, of 14/15 which also indicated no cognitive impairment.

R16 and R25 were observed/interviewed on 8/18/14, at 12:27 p.m. and also verified the wait time to be served the noon meal was too long. R16 had a BIMS score dated 7/18/14, of 15/15 which indicated no cognition impairment. R25 had a BIMS score dated 6/2/14, of 14/15 indicating no cognitive impairment.

During an observation/interview on 8/18/14, at 12:30 p.m. R43 expressed dissatisfaction with the long wait for meal service. R43 had a BIMS score dated 6/13/14, of 9/15 which indicated moderate cognitive impairment.

An interview was conducted with R43 on 8/21/14, at 8:37 a.m. verified that she had to wait for a

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good half hour or longer to have her meal served at lunch and supper. She added, "I just hate to go down there (dining room) at lunch and supper because of how long I have to wait to get my food. I even got up and left one time."

Review of the resident council meeting minutes dated 12/26/13, identified concerns related to the dietary department: "We have to wait to [sik] long for our food". Three residents agreed with this. One resident said she had waited 45 minutes while the others said they waited but not that long. Some say the food is barely warm when they get it. One resident upset that on holidays residents with family members present get served meals before residents who have no family visiting.

Review of the resident council meeting minutes dated 4/24/14, identified a concern for the dietary department: one resident asked, "How come we don't get our meals more quickly?" Dietary Director responded, "That system is changing. We will start serving you when you come down to meals".

The director of dietary services (DSS) was interviewed on 8/21/14, at 2:01 p.m. verified that the resident council meetings which identified dietary service grievances had not been resolved.

A review of the facility policy dated 8/12, titled, "Open Dining" read; Residents are served on a first-come, first-served basis. Residents do not wait more than 10-15 minutes to be served. Batch cooking is required to ensure high-quality food with nutrient retention. Food should be kept no longer than 30 minutes on the steam table.

The facility policy for Grievances, Complaints or

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F 244	Continued From page 24 Concerns, dated 2/20/13, identified the following grievance procedure: 1. Upon resident admission the Suggestion or Concern form or "Resolving the Issues" brochure will be given with a review of the grievance procedure. 2. When a resident, family member, visitor or staff member expresses a concern or grievance to a staff member related to resident care or services, it will be received in an open, friendly, nonjudgmental manner and without discrimination or reprisal. 3. If the problem can be resolved immediately, the staff member will thank the individual for the information and proceed to take action regarding the problem. The grievance then will be documented on the Suggestion or Concern and submitted to the center social service director. 4. If the complaint comes directly to the social services department, then the director of social services will complete a Suggestion or Concern form upon receipt of the complaint. 5. The social services director will route the Suggestion or Concern form to the appropriate department head as soon as possible. Even when the facility administrative and direct support staff were aware of the residents complaints about slow call light responses and slow meal service there were no interventions put in place to resolve the grievances.	F 244		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		9/30/14

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F 278	Continued From page 25 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to accurately code the minimum data set (MDS) related to the use of a lap buddy for 1 of 1 resident (R61) reviewed for a physical restraint. Findings include:	F 278	The 14-day MDS assessment for R61 was modified on 9/8/14 to reflect that a physical restraint was in use. All residents were reviewed for use of physical restraints.	

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F 278	Continued From page 26 R61's 14-day Minimum Data Set (MDS) assessment dated 8/11/14, indicated R61 had severe cognitive impairment, total dependence with locomotion on/off the unit and toileting, and extensive assistance with transfer, bed mobility, personal hygiene, dressing, and eating. The MDS assessment further indicated that a physical restraint had not been utilized for R61. However, the lap buddy utilized for R61 was difficult for the resident to remove and restricted transfer and standing ability movement when applied to the wheelchair. On 8/19/14, at 5:42 p.m. R61 was observed seated in her wheelchair (w/c) in the dining room with a lap buddy (a thick cushion that fits over a resident's lap and is secured to the armrests of the w/c, which can restrict the resident's ability to remove themselves from the w/c.) in place. At 5:45 p.m. dietary staff delivered R61's supper meal to the table. At 5:47 p.m., R61 was observed to remove the flat top portion of the lap buddy which had been previously velcroed in place, and turned herself away from the table. The main portion of the lap buddy continued to remain across the front of the w/c restricting R61 from rising. The device was observed to have a split down the middle and was velcroed into place. At 5:48 p.m., nursing assistant (NA)-N approached R61, replaced the flat top portion of the lap buddy. At 5:57 p.m., R61 was observed attempting to remove the lap buddy from her w/c by grabbing the outer edge of the lap buddy and pulling upward. R61 continued to pull on the lap buddy until 6:03 p.m. At 6:10 p.m. R61 started pulling on the lap buddy and was able to remove the rigid flat portion	F 278	Education was provided to all Licensed Nurses on the Physical Restraint Policy and Procedure on 9-4-14. Education was provided to the Case Manager on appropriate coding of physical restraints in the MDS on 9/4/14. Any use of physical restraints will be reviewed by the Interdisciplinary Team including the Case Manager initially and quarterly. Audits will be completed for accurate physical restraint coding for all residents identified as using a physical restraint monthly for 2 months by DNS or designee. Results of audits will be reported to the QAPI committee for review and recommendations.	

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velcroed to the top of the device; the main portion remained restricting R61's ability to stand from the w/c. R61 continued to pull on the main portion of the lap buddy. R61 continued to pull on the lap buddy until 6:21 p.m., when she was able to successfully separate the two velcroed portions that connected the lap buddy and threw one of the halves on the floor. NA-S then approached R61, picked up the half of the lap buddy that was on the floor along with the rigid, flat top piece and asked R61 if she could put it back on the w/c. R61 indicated she wanted the lap buddy off as NA-Samantha replaced it and stated, "No, we're gonna keep that on." R61 took one bite of food then once again attempted to remove the lap buddy.

When interviewed at 6:24 p.m., NA-S indicated that R61 utilized the lap buddy in her w/c at all times including meals.

On 8/20/14, at 1:32 p.m. R61 was observed seated in her w/c in the common area with the lap buddy in place. R61 stated to registered nurse (RN)-R, "How do I get out of this thing? Do you know how to get me out of this thing?", and motioned to the lap buddy attached to her w/c.

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 a physical restraint assessment had not been completed for R61's lap buddy and had not considered it a restraint as the resident could remove it. The DON could not confirm or deny whether R61 could remove the the lap buddy easily.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

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F 278	Continued From page 28 The procedure titled Physical Restraints revised 10/13, indicated: Anytime a device, material or equipment is attached or placed adjacent to the resident's body, a determination will be made by a licensed nurse as to whether it is or could be a restraint for the individual resident. If the device, material or equipment cannot be removed easily by the resident and restricts freedom of movement or normal access to one's own body, then this is a restraint and this procedure must be followed. If the device, material or equipment is not a restraint for this resident, then the steps taken to make this decision must be documented in the PN - Psychopharmacological Med/Physical Restraint. If the device, material or equipment is not a restraint, it must be reviewed with a significant change in condition and quarterly in conjunction with the care plan to ensure that it continues to not be a restraint for the resident. This review may be documented as part of the quarterly note in the PN - Care Plan Review.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279		9/30/14

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F 279	Continued From page 29 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop a care plan related to urinary infections for 1 of 1 resident (R12) in the sample who had a long history of frequent urinary tract infections (UTI's). Findings include: R12, admitted on 2/7/14, had diagnoses that included: hypertension, hypothyroidism, depression, anxiety and history of frequent UTI's. R12's hospital discharge record dated 2/7/14, identified that R12 had a long history of frequent UTI's. The record also identified that R12 had prophylactic antibiotic therapy to suppress UTI's and upon admission, R12 a physician order for Cipro 500 milligrams (mg) twice a day prophylactic for UTI's. R12's urinary care plan dated 8/11/14, identified R12 with bladder incontinence related to dementia evidenced by occasional incontinence. The care plan goal was identified as: R12 would remain continent during wake hours. The care plans interventions included: staff will encourage fluids to promote voiding responses and the use of urinary briefs. The care plan lacked any measures related to the UTI's or non-medicinal	F 279	A comprehensive care plan was developed for R12 related to history of urinary tract infections on 8/28/14. All residents with history of UTIs were reviewed for comprehensive care plan completion on 9/8/14 and care plans updated as necessary. The policy for comprehensive care plan development was reviewed with charge nurses and Case Manager at a Licensed Nurses Meeting on 9/4/14. Audits will be conducted on all new residents admitted with a history of UTIs and current residents who develop a UTI for comprehensive care plan development weekly for one month and monthly for one month by the DNS or designee. Results of audits will be reported to QAPI committee for review and recommendations.	

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F 279	Continued From page 30 interventions to prevent or minimize UTI's. During interview on 8/21/14, at 10:16 a.m. registered nurse (RN)-B confirmed that R12 had prophylactic antibiotic treatment due to a history of frequent UTI's. RN-B verified R12's care plan lacked any identification of risk factors, goals or interventions for the prevention, monitoring and intervention for UTI's. During interview with the director of nursing (DON) on 8/21/14, at 11:30 a.m. she verified the care plan lacked interventions for UTI's and verified the care plan should have been developed to include infection risks, goals and interventions.	F 279		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329		9/30/14

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F 329	Continued From page 31 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to monitor and assess the effectiveness of medication used for insomnia for 2 of 5 residents (R9 & R5) who were reviewed for unnecessary medications. Findings include: R9 received the medication Trazodone (an antidepressant medication) for insomnia (inability to sleep). R9 was not monitored or assessed for the effectiveness of the medication. Review of the medical record diagnosis sheet indicated that R9 had a diagnosis of insomnia. Review of the signed physician orders identified that R9 received Trazodone 50 mg (milligrams) every day at bedtime. The care plan dated 8/7/14 identified that R9 was on antidepressant medication therapy related to insomnia. The pharmacist consultant report dated 6/16/14, recommended a dose reduction from Trazodone 75 mg to 50 mg. Subsequently, it was reduced on 7/3/14 to 50 mg every bedtime. A sleep assessment dated 8/19/14 identified the reason for assessment as "experiencing sleep disturbance". The following statement was noted -"receiving antidepressant Trazodone for insomnia every night." No sleep patterns or possible causes and effects were identified in the	F 329	Sleep assessments were completed on R9 and R5 on 9/8/14. All residents with an insomnia diagnosis were reviewed and sleep assessments were completed if needed. Mediation Review process for medications used for sleep was reviewed with the consultant pharmacist on 9/8/14 and Licensed Nurses at a Licensed Nurse meeting on 9/4/14. The RN will complete Sleep Assessments prior to initiating a medication for insomnia, on admission if resident is taking this type of medication on admission, any time a medication for insomnia is changed, a resident is observed to have signs of insomnia or the resident complains of new onset insomnia, and annually if taking medication for insomnia. The consulting Pharmacist will verify that Sleep Assessments have been completed. All new insomnia diagnosis will be audited for assessment completion weekly for one month and monthly for one month by the DNS or designee. Results of audits will be reported to the QAPI committee for review and recommendation.	

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assessment. Documentation was unavailable to indicate that sleep patterns and/or any sleep monitoring had been conducted to determine effectiveness of the medication after the dose reduction had been implemented.

During an interview on 8/21/14, at 9:15 a.m. the director of nursing (DON) verified a sleep assessment had not been completed after the dose reduction and also confirmed there had been no sleep monitoring completed. The DON stated that a sleep assessment for R9 had not been done since 2010 and the current assessment dated 8/19/14, was incomplete. She verified that R9's sleep patterns should have been monitored and a complete sleep assessment should have been conducted.
R5 received the medication Tylenol PM extra strength (an over the counter medication containing diphenhydramine, used to assist with sleep) for insomnia and did not have sleep patterns monitored nor assessed to determine whether the medication was effective.

Review of a fax sent to R5's medical doctor (MD)-A on 4/2/14, at 2355 (11:55 p.m.) noted the following: Could we have a diagnosis, dose and schedule for Tylenol PM? The following day, 4/3/14, MD-A wrote the following prescription: Tylenol PM 25-500 mg. (milligrams), 2 tabs H.S. (hour of sleep) PRN (as needed) insomnia.

Review of the form sent to R5's provider, Nursing Home Physician Notification dated 5/21/14, identified the concern/incident: resident name [R5] asks for Tylenol PM 2 tabs every night. Might we please have an order to schedule this, instead of PRN. Documentation by MD-A on 5/22/14, included the following: Tylenol PM 2

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F 329	Continued From page 33 tabs HS 500/25 mg dx insomnia. Review of the care plan dated 8/7/14, verified the following: resident is on hypnotic therapy R/T (related to) sleeplessness. The care plan goal was defined as: R5 would be free from any adverse side effects of hypnotic use through the review date of 9/30/14. The care plan interventions specified for staff to observe for possible side effects every shift that may cause day time drowsiness, confusion, loss of appetite in the morning, increased risk of falls and fractures, dizziness. Documentation in the record lacked a sleep assessment as well as any documentation related to the effectiveness of the hypnotic medication. RN-A was interviewed on 8/21/14, at 8:20 a.m. and verified that a sleep assessment had never been conducted to monitor the efficacy of the medication used for insomnia.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		9/30/14

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F 371	Continued From page 34 Based on observation, interview and document review the facility failed to serve food in a sanitary manner, failed to ensure food preparation equipment was properly cleaned and failed to adequately monitor the final rinse temperature of the dishwasher. This had the potential to affect 48 residents who were served food out of the kitchen. Findings include: The noon meal dish-up was observed on 8/18/14, from 11:45 a.m.-12:45 p.m. Cook-A was observed to wear gloves and then touched each resident's laminated diet card, hold the diet card under the plate and then touched each half of the baked potato and roll/bun. It was noted during the observation on 8/18/14, at 12:15 p.m. that the laminated diet cards had dried food debris and spilled liquid on them. Cook-A verified on 8/18/14, at 12:35 p.m. that the laminated diet cards were not sanitized prior to meal service as it would take too long to allow the laminated diet cards to air dry between meals. Cook-A added that staff attempted to send the laminated diet cards thru the dishwasher 2-3 times per week. During another observation on 8/19/14, at 12:01 p.m. cook-B was wearing gloves and touched each laminated diet card. Cook-B then proceeded to touch the chicken fritter and small buns with the same gloved hands. The director of dietary services (DDS) was interviewed on 8/19/14, at 12:15 p.m. and verified the laminated diet cards were to be cleaned prior to dietary staff handling them. The DDS verified the above noted practice was not in accordance with current infection control guidelines.	F 371	Diet cards are cleaned after each meal. The mixers and refrigerator floor were cleaned on August 18, 2014. Staff has been educated on the proper storage and labeling of food items. A cleaning schedule has been implemented for the kitchen. Staff have 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 of gloves and recording the final rinse temperature on the dish washer. Random audits will be done 3x per week for one month and then weekly for one month to monitor the temperatures, cleanliness of the kitchen and storage areas, cleanliness of the diet cards, and the cleanliness of the kitchen equipment, glove usage, and proper food storage and labeling by the Director of Dietary Services or designee. Results of the audits will be reported to the QAPI committee for review and recommendations.	

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F 371	Continued From page 35 Review of the policy titled, Gloves revised 3/2009, read: Gloves are to be changed before handling "ready to eat" foods and when coming in contact that with something that is contaminated..... An interview was conducted with dietary aid (DA)-A on 8/20/14, at 9:15 a.m. and stated she was not aware that the laminated dietary cards had ever been cleaned via the dishwasher in the past three years. She further added the laminated dietary cards had just been sanitized and hand dried on 8/20/14, prior to the noon meal, subsequent to the noted observations on 8/18 abd 8/19. During a tour of the kitchen on 8/18/14, at 11:35 a.m. a portion of frozen ham was noted in the walk in freezer. The ham was not covered, dated or labeled and appeared to have freezer burn on the outer edges. The DDS immediately discarded this item after observed. The walk in refrigerator was observed to have a spilled sticky substance. A large mixer was observed to have food debris on the mixing blades. A small mixer bowl was observed to have unidentified contents, which was verified by the DDS. Both mixers were identified as clean and ready for use by the DDS. Review of the Thermal Sanitizing Dishwasher Temperature record identified that from 8/1-8/19/14, the final rinse temperature was not documented 14 out of 19 times following breakfast, 13 out of 19 times following the noon meal and 7 out of 19 times following supper. The DDS indicated the dishwasher sanitized by hot water rinse and the lack of documentation was verified by the DSS on 8/20/14, at 11:45 a.m.	F 371		

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F 371	Continued From page 36 A cleaning schedule was requested from the DSS on 8/19/14, at 11:30 a.m. and the DSS verified the dietary department did not have any cleaning schedules available/utilized in the dietary department.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the consulting pharmacist failed to ensure the effectiveness of medications used for sleep were monitored for 2 of 5 (R5 and R9) residents reviewed for unnecessary medications. Findings include: R9 received the medication Trazodone (an antidepressant medication) for insomnia (inability to sleep). The consulting pharmacist monthly reviews failed to report that the effectiveness of the medication had not been monitored. Review of the medical record diagnosis sheet	F 428	Sleep assessments were completed on R9 and R5 on 9/8/14. Pharmacist consultant reviewed the effectiveness of the medications on 9/8/14. All residents with an insomnia diagnosis were reviewed and sleep assessments were completed if needed. Mediation Review process for medications used for sleep was reviewed with the consultant pharmacist on 9/8/14 and Licensed Nurses at a Licensed Nurse meeting on 9-4-14. The RN will complete Sleep assessments prior to initiating a medication for insomnia, on admission if	9/30/14

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F 428	Continued From page 37 indicated that R9 had a diagnosis of insomnia. Review of the signed physician orders identified that R9 received Trazodone 50 mg (milligrams) every day at bedtime. The care plan dated 8/7/14 identified that R9 was on antidepressant medication therapy related to insomnia. The pharmacist consultant report dated 6/16/14, recommended a dose reduction from Trazodone 75 mg to 50 mg. Subsequently, it was reduced on 7/3/14 to 50 mg every bedtime. A sleep assessment dated 8/19/14 identified the reason for assessment as "experiencing sleep disturbance". The following statement was noted under "other comments"-"receiving antidepressant Trazodone for insomnia every night". No sleep patterns or possible causes and effects were identified in the assessment. Documentation was unavailable to indicate that sleep patterns and/or any sleep monitoring had been conducted to determine effectiveness of the medication after the dose reduction had been implemented. During an interview on 8/21/14, at 2:10 p.m. the consulting pharmacist concurred she had failed to identify the lack of a sleep assessment for R9 and also concurred the effectiveness of the medication should have been monitored. R5 received the medication Tylenol PM extra strength (an over the counter medication containing diphenhydramine, used to assist with sleep) for insomnia and did not have sleep patterns monitored nor assessed to determine whether the medication was effective. The consulting pharmacist monthly reviews failed to identify that the medication, Tylenol PM, had not been monitored for effectiveness of insomnia. Review of a fax sent to R5's medical doctor	F 428	resident is taking this type of medication on admission, any time a medication for insomnia is changed, a resident is observed to have sign of insomnia or the resident complains of new onset insomnia, and annually if taking medication for insomnia. The consulting Pharmacist will verify that Sleep Assessments have been completed as part of their monthly review. All new insomnia diagnosis will be audited for assessment completion for weekly for one month and monthly for one month by the DNS or designee. Results of audits will be reported to the QAPI committee for review and recommendation.	

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(MD)-A on 4/2/14, at 2355 (11:55 p.m.) noted the following: Could we have a diagnosis, dose and schedule for Tylenol PM? The following day, 4/3/14, MD-A wrote the following prescription: Tylenol PM 25-500 mg. (milligrams), 2 tabs H.S. (hour of sleep) PRN (as needed) insomnia.

Review of the form sent to R5's provider, Nursing Home Physician Notification dated 5/21/14, identified the concern/incident: resident name [R5] asks for Tylenol PM 2 tabs every night. Might we please have an order to schedule this, instead of PRN. Documentation by MD-A on 5/22/14, included the following: Tylenol PM 2 tabs HS 500/25 mg dx insomnia.

Review of the care plan dated 8/7/14, verified the following: resident is on hypnotic therapy R/T (related to) sleeplessness. The care plan goal was defined as: R5 would be free from any adverse side effects of hypnotic use through the review date of 9/30/14. The care plan interventions specified for staff to observe for possible side effects every shift that may cause day time drowsiness, confusion, loss of appetite in the morning, increased risk of falls and fractures, dizziness.

Documentation in the record lacked any sleep assessment as well as any documentation related to the effectiveness of the hypnotic medication.

RN-A was interviewed on 8/21/14, at 8:20 a.m. and verified that the facility had never completed a sleep assessment on R5 to monitor for the use of unwanted hypnotic side effects or to assess the efficacy of the medication used for insomnia.

A telephone interview was conducted with the

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F 428	Continued From page 39 consulting pharmacist on 8/21/14, at 2:00 p.m. and verified that a recommendation had not been made to conduct a sleep assessment to determine the effectiveness of the medication, Tylenol PM, used for insomnia.	F 428		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility's Quality Assessment and	F 520	Suggestion/Concern forms were initiated for R25, R51, and R18 related to concern	9/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

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F 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, she verified that no action plan had been developed and implemented to address these complaints related to slow response to resident call lights nor had the complaints related to slow meal service been addressed. Follow-up audits had not been implemented to determine whether identified resident concerns related to these quality of care issues had been resolved and/or improved. When the DNS and SW were	F 520	of untimely call light response times and for R16, R33, R48, R42, R43, and R25 related to concern of slow meal service. R68 has discharged. Staff was educated on the importance of everyone answering call lights while they are working to decrease the call light response time at an All-Staff In-service 8/28/14. The QAPI committee will be educated on 9/11/14 on the implementation of action plans and follow-up. A Memo was posted for dietary and nursing staff on 9/4/14 educating on the new procedure for passing meal trays. Call light response times will be audited at random times 3 times per week for one month and then once a week for one month by the LSW or designee. Meal service wait times will be audited 3 times per week at random meals for one month and then once weekly for one month by the DDS or designee. Monthly audits will be completed for 3 months by the QAPI Coordinator or designee to ensure proper implementation and follow-up has occurred. Audit results will be reported to Resident Council and QAPI committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	08/21/2014

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F 520	Continued From page 41 interviewed both verified the information was collected but there was no process implemented to improve resident care outcomes and resolve the expressed concerns. Refer to tags: F166, F241 and F244.	F 520		

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	245568	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/20/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 20,2014. At the time of this survey, Building 01 of Good Samaritan Society Mary J. Brown was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145	K 000	EPOC	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/20/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Facsimile: 651-215-0525, or By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Good Samaritan Society Mary J. Brown was constructed as follows: The original building was constructed in 1959, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1965, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1987, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 3rd Addition was constructed in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 51 beds and had a census of 50 at time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/20/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**110 SOUTH WALNUT AVENUE LUVERNE, MN 56156**

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 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 19.1.1.4.1 and 8.2.3.2. The deficient practice could affect 50 out of 51 residents. Findings include: On 08/20/2014 between 1:00 PM and 4:00 PM, observation revealed, that the 2-hour fire rated wall separating Building 1 and Building 2, has open penetrations around cable wires and open conduit ends. These penetration were located above the drop-ceiling, over the horizontal exit doors. NOTE: The entire 2-hour fire rated wall separating Building 1 and Building 2, needs to be checked for this deficiency.	K 011	The penetrations in the separating wall between building 1 and building 2 where sealed on September 3, 2014. All other smoke barriers where inspected and sealed as needed. The Maintenance Director or designee will be responsible to conduct biweekly audits to ensure penetrations are properly sealed throughout the facility for one month and then monthly for two months to ensure compliance. He will bring the results to the Quality Assurance Performance Improvement Committee (QAPI) for review and recommendations. Completion Date: September 30, 2014	9/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/20/2014**

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K 011	Continued From page 3 This deficient practice was confirmed by the facility Maintenance Director (DW) at the time of discovery.	K 011		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 50 out of 51 residents. Findings include: On facility tour between 1:00 PM and 4:00 PM on 08/20/2014, observation revealed, that the doors to storage rooms # 139, 140, 141, 142 (over 50 sq. ft.) do not have self-closing devices. This deficient practice was confirmed by the	K 029	Self-closing devices have been ordered for rooms #139, 140, 141, 142. All hazardous area enclosures where examined to ensure proper closing devices where installed and operating properly. The Maintenance Director or designee will be responsible to conduct biweekly audits to ensure self-closing devices are working properly throughout the facility and that rooms being used for storage have self-closing devices for one month and then monthly for two months to ensure compliance. He will bring the results to the Quality Assurance Performance	9/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 029	Continued From page 4 Facility Maintenance Director (DW) at the time of discovery.	K 029	Improvement Committee (QAPI) for review and recommendations.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to test the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72 - 5-5.3.2.1.6.1 and Table 7-2.2 (16) (b). This could effect all 50 of 51 residents. Findings include: On facility tour between 1:00 PM and 4:00 PM on 08/20/2014, observation revealed that the following was found: 1. The phone(s) for the Digital Alarm Communicator Transmitter (D.A.C.T.), could not be tested to verify that the premises fire alarm system and monitoring company received the trouble signal with-in 4 minutes. The back up	K 052	The facility does have two phone lines for the D.A.C.T. The battery backup will be properly operating by September 30, 2014 as we continue to work with the fire alarm system and monitoring company. The Maintenance Director or designee will be responsible to conduct monthly audits for two months to ensure fire alarms system is properly operating. He will bring the results to the Quality Assurance Performance Improvement Committee (QAPI) for review and recommendations	9/30/14

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	245568	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/20/2014**

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K 052	Continued From page 5 batteries for the D.A.C.T. were disconnected and no trouble signal was received by the premises fire alarm system and monitoring company with-in 4 minutes. 2. It could not be confirmed that the facility has two phone lines for the D.A.C.T. These deficient practices were confirmed by the Facility Maintenance Director (DW) at the time of discovery.	K 052		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, sections 2-2.1.1 This deficient practice could affect all 50 residents Findings include: On facility tour between 1:00 PM and 4:00 PM on 08/20/2014, observation revealed that several kitchen area sprinkler heads are corroded. This deficient practice was confirmed by the	K 062	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. The Maintenance Director or designee will 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.	9/30/14

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K 062	Continued From page 6 Facility Maintenance Director (DW) at the time of discovery. *TEAM COMPOSITION* Kimberly Swenson, Life Safety Code Spc.	K 062		

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	245568	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**08/20/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August, 20, 2014. At the time of this survey, Building 02 of Good Samaritan Society Mary J. Brown was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145 Facsimile: 651-215-0525, or	K 000	EPOC	

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

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 02 of Good Samaritan Society Mary J. Brown consists of the 2011 building addition, which includes a new main entrance, offices, conference room and beauty shop. Building 02 is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II (111) construction. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 51 beds and had a census of 50 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire	K 011		9/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 011	Continued From page 2 barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2 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. Findings include: On 08/20/2014 between 1:00 PM and 4:00 PM, observation revealed, that the 2-hour fire rated wall separating Building 1 and Building 2, has open penetrations around cable wires and open conduit ends. These penetration were located above the drop-ceiling, over the horizontal exit doors. NOTE: The entire 2-hour fire rated wall separating Building 1 and Building 2, needs to be checked for this deficiency. This deficient practice was confirmed by the facility Maintenance Director (DW) at the time of discovery.	K 011	The penetrations in the separating wall between building 1 and building 2 where sealed on September 3, 2014. All other smoke barriers where inspected and sealed as needed. The Maintenance Director or designee will be responsible to conduct biweekly audits to ensure penetrations are properly sealed throughout the facility for one month and then monthly for two months to ensure compliance. He will bring the results to the Quality Assurance Performance Improvement Committee (QAPI) for review and recommendations.	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour	K 029		9/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**08/20/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has a hazardous area enclosure which was not constructed in accordance with NFPA 101 (2000 edition) Chapter 18, Section 18.3.2.1 and Chapter 7, Section 7.2. In a fire emergency, this deficient practice could adversely affect 2 of 50 residents, visitors and staff. FINDINGS INCLUDE: On facility tour between 1:00 PM and 4:00 PM on 08/20/2014, observation revealed the Mechanical Room in Building 02 was greater than 100 square feet and no 45 minute fire rated label could be located on door. This deficient practice was confirmed by the Facility Maintenance Director (DW) at the time of discovery.	K 029	A new door with a fire rating of at least 45 minutes was ordered. All hazardous areas were examined to ensure proper door fire rating. The Maintenance Director or designee will be responsible to ensure compliance with any physical change that would change a fire rated door or need for a fire rated door. The Maintenance Director or designee will be responsible to conduct monthly audits for two months to ensure all rooms have the proper fire rating on the door per the use of the room. He will bring the results to the Quality Assurance Performance Improvement Committee (QAPI) for review and recommendations	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		9/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**08/20/2014**

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K 052	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to test the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72 - 5-5.3.2.1.6.1 and Table 7-2.2 (16) (b). This could effect all 50 of 51 residents. Findings include: On facility tour between 1:00 PM and 4:00 PM on 08/20/2014, observation revealed that the following was found: 1. The phone(s) for the Digital Alarm Communicator Transmitter (D.A.C.T.), could not be tested to verify that the premises fire alarm system and monitoring company received the trouble signal with-in 4 minutes. The back up batteries for the D.A.C.T. were disconnected and no trouble signal was received by the premises fire alarm system and monitoring company with-in 4 minutes. 2. It could not be confirmed that the facility has two phone lines for the D.A.C.T. These deficient practices were confirmed by the Facility Maintenance Director (DW) at the time of discovery. *TEAM COMPOSITION* Kimberly Swenson, Life Safety Code Spc.	K 052	The facility does have two phone lines for the D.A.C.T. The battery backup will be properly operating by September 30, 2014 as we continue to work with the fire alarm system and monitoring company. The Maintenance Director or designee will be responsible to conduct monthly audits for two months to ensure fire alarms system is properly operating. He will bring the results to the Quality Assurance Performance Improvement Committee (QAPI) for review and recommendations.	