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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: UGPG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00022

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245285**

2.STATE VENDOR OR MEDICAID NO.
(L2) **659561800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS**
(L4) **1301 50TH STREET EAST**
(L5) **INVER GROVE HEIGHTS, MN** (L6) **55077**

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 **09/12/2016** (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 **46** (L18)

13.Total Certified Beds **46** (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:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	46			
(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 :
Susanne Reuss, Unit Supervisor 09/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 09/13/2016 (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
08/01/1985
(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 09/22/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/06/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245285
September 13, 2016

Ms. Pamela Schultz, Administrator
Good Samaritan Society - Inver Grove Heights
1301 50th Street East
Inver Grove Heights, MN 55077

Dear Ms. Schultz:

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 August 29, 2016 the above facility is certified for or recommended for:

46 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 46 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 13, 2016

Ms. Pamela Schultz, Administrator
Good Samaritan Society - Inver Grove Heights
1301 50th Street East
Inver Grove Heights, MN 55077

RE: Project Number S5285025

Dear Ms. Schultz:

On August 9, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 28, 2016. This survey found the most serious deficiencies 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 September 12, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 29, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 28, 2016, effective August 29, 2016 and therefore remedies outlined in our letter to you dated August 9, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245285	A. Building B. Wing	9/12/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 08/29/2016	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 08/29/2016	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	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 09/13/2016	SIGNATURE OF SURVEYOR 16022	DATE 09/12/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/28/2016	☐ 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: UGPG

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(L1) **245285**

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(L3) **GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS**
(L4) **1301 50TH STREET EAST**
(L5) **INVER GROVE HEIGHTS, MN** (L6) **55077**

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 **07/28/2016** (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 **46** (L18)

13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	46			
(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 Beth Lacina HFE NE II — 08/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 08/29/2016 (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)

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21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
08/01/1985
(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 09/06/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 9, 2016

Ms. Pamela Schultz, Administrator
Good Samaritan Society - Inver Grove Heights
1301 50th Street East
Inver Grove Heights, MN 55077

RE: Project Number S5285025

Dear Ms. Schultz:

On July 28, 2016, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

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 6, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 October 28, 2016 (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 January 28, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. BUILDING _____ B. WING _____	07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. On 7/25/16 through 7/28/16, surveyors of this Department's staff visited the above provider.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		8/29/16

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

Electronically Signed | 08/17/2016

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
	245285	A. BUILDING _____ B. WING _____	07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(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 279	Continued From page 1 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 document review, the facility failed to develop a plan of care to include a system to monitor for side effects of psychotropic medications for 1 of 6 residents (R17) reviewed for unnecessary medications. Findings include: R17's admission Minimum Data Set (MDS), dated 6/25/16, revealed R17 received antidepressant medications on 7 of 7 days and 5 of 7 days in the assessment reference period. R17's physician progress notes, dated 6/21/16, revealed medication prescriptions for mirtazapine (anti-depressant) and lorazepam (antianxiety). R17's Order summary report, dated 7/28/16, revealed R17 was prescribed the following medications: citalopram (antidepressant), lorazepam and mirtazapine. R17's care plan, dated 7/6/16 to 7/28/16, did not include directions to monitor for side effects of psychotropics, until amended after surveyor notification on 7/28/16. The care plan did not indicate R17 was also using an as needed antianxiety medication. Review of the July 2016 medication and treatment administration record (MAR/TAR) and order summary, dated 7/28/16, did not direct staff to monitor R17 for side effects of psychotropic medications.	F 279	R: 17 The Medical record (care plan and MAR) was revised on 7/28/16 to include monitoring of side effects related to the use of the antidepressants and anti-anxiety medications. The DNS, MDS Nurse and Social Worker will review Care Plans and MARs for all residents receiving psychoactive medications for inclusion of monitoring of side effects and revise as appropriate. The DNS or designee will provide re-education for the nurses on the facility policy and procedure for monitoring for side effects of psychoactive medications and ensuring this information is in the Medical Record (MAR and Care Plan). R 17 and random other residents receiving psychoactive medications will be audited weekly X 4, then monthly X 3 by DNS or designee to ensure the MAR and care plans reflect appropriate monitoring of potential side effects of psychoactive medications. These results will be taken to QAPI Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. BUILDING _____ B. WING _____	07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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F 279	Continued From page 2 On 7/28/16, at 10:03 a.m. the social service director (LSW)-B and a registered nurse (RN)-D confirmed the side effect monitoring was not included in the care plan and there was no evidence in R17's record staff were monitoring R17 for side effects of psychotropic medications. The Unnecessary Medication policy, dated 9/2012, directed staff to ensure "Monitoring for efficacy and adverse consequences through areas such as vital signs as appropriate."	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 contraindicated, in an effort to discontinue these drugs.	F 329		8/29/16

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 - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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F 329	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately identify, assess, and monitor clinical indicators for the continual use of psychopharmacological medications for 2 of 6 residents (R28, R17) receiving psychoactive medications. Findings include: R28's medical record failed to reveal an assessment to support adding Tramadol to R28's drug regimen; and failed to identify which, if any non-pharmacological interventions had been tried and were effective or non-effective in minimizing R28's pain. A review of R28's medical record revealed Tramadol 50 milligrams (mg) three times a day for pain had been ordered by the physician on 6/28/16. The order indicated the Tramadol was to be given at the same time as a regularly scheduled Tylenol 1000 mg, which was ordered three times a day. On 7/21/16, the physician ordered the Tramadol to continue until all tablets on the medication card were gone. A review of the medication administration record revealed the last dose of Tramadol was given at 11:45 a.m. on 7/24/16. During an interview on 7/26/16, at 9:13 a.m. R28 stated having constant back pain of 10/10 (10 being the worst) and it was 10/10 at the moment of the interview. R28 stated the physician had been told about the pain, but R28 felt the physician was not doing anything to relieve the	F 329	R 28□s Tramadol was discontinued on 7/24/16. Pain data collection and pain assessments were completed on 7/29/16. R 28□s Care Plan has been updated to include non-pharmacological interventions. DNS and Social Worker will meet with HealthEast hospice to address communication of pain assessments and integration of hospice and SNF Care Plans to address pain appropriately. R17□s Care Plan was revised on 7/28/16 during the survey visit to include monitoring of side effects related to the use of the antidepressants. The Care Plan was revised on 7/28/16 to address the use of the anti-anxiety medication and the monitoring of potential side effects. All residents on psychoactive medication and those identified as having pain, will be reviewed to ensure medication side effects are care planned/in MAR and being monitored and managed; and those with pain have had assessments and care planning of non-pharmacological interventions and efficacy monitoring is in place. The DNS or designee will provide re-education for the nurses on the facility policy and procedure for monitoring for side effects of psychoactive medications and ensuring this information is in the Medical Record (MAR and Care Plan). Also re-education will be provided for nursing staff on policy and procedure for identifying and assessing pain,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. BUILDING _____ B. WING _____	07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 4 pain. At this time R28 was not observed to be exhibiting non-verbal signs of pain, such as grimacing and was able to maneuver the wheelchair independently. R28 was also observed at random times throughout the survey not exhibiting any verbal or non-verbal signs of pain during meals, when in activities, when watching TV or sitting in the wheelchair in the room, or when maneuvering the wheelchair up and down the hallways. On 7/26/16, at 3:50 p.m. R28 was interviewed regarding non-pharmacological pain interventions. R28 stated when at home ice packs, heating pads and changing positions helped, but these things were not being offered at the facility. On 7/26/16, at 3:52 p.m. registered nurse (RN)-B was interviewed regarding R28's pain. RN-B stated R28 would complain of pain "very rarely", but when RN-B asked on a daily basis if R28 had pain, R28 would say ther pain was 10/10. RN-B stated R28 did not show any non-verbal signs of pain. RN-B stated non-pharmacological interventions such as rest and conversations had been tried. RN-B stated there were ice packs and heat available, but had not used them for R28. On 7/28/16, at 2:37 p.m. RN-C, the hospice nurse, stated the resident wasn't showing any outward signs of pain, but was verbalizing the pain at a level of 10, so the decision was made to add Tramadol to R28's pain management plan. RN-C stated non-pharmacological interventions which worked best for R28 were distractions, activities, coloring and visiting with others. RN-C stated the hospice care plan did not address	F 329	implementing non-pharmacological pain interventions and appropriate monitoring of efficacy and for side effects. Audits will be conducted by DNS or designee for R17, R28 and random other residents experiencing pain or receiving psychoactive medications weekly X 4, then monthly x 3 to ensure appropriate assessments and implementation of interventions for pain and monitoring for side effects is in place. Results of these audits will be taken to QAPI Committee for further recommendations.	

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
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F 329	Continued From page 5	F 329		

non-pharmacological interventions; and she would provide documentation of R28's pain assessment to support the addition of the Tramadol.

Documentation provided by RN-C was a hospice note dated 6/21/16, indicating R28's pain was constant, on-going, 10/10, and in the back. The documentation also indicated the progression of pain was unchanged, affected R28's mood and R28 stated always being in pain, and it never got better than a "10." The documentation did not identify any non-pharmacological interventions. A Case Communication note dated 6/24/16, between the physician and RN-C indicated RN-C had spoken to the physician about R28's pain control and the Tramadol was added for pain control. The documentation did not address non-pharmacological interventions.

A 5/2/16, Pain Assessment completed by the facility indicated R28 "states is in pain all the time" but the current medication regimen of Tylenol 1000 mg three times a day was working. A non-pharmacological intervention of "rest." was identified. However, this intervention was not on R28's care plan.

R17's admission Minimum Data Set (MDS), dated 6/25/16, revealed R17 received antidepressant medications on 7 of 7 days and 5 of 7 days in the assessment reference period.

R17's physician progress notes, dated 6/21/16, revealed medication prescriptions for mirtazapine (anti-depressant) and lorazepam (antianxiety). R17's Order summary report, dated 7/28/16,

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	245285	A. BUILDING _____ B. WING _____	07/28/2016

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GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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F 329	Continued From page 6	F 329		

revealed R17 was prescribed the following medications: citalopram (antidepressant), lorazepam and mirtazapine.

R17's care plan, dated 7/6/16 to 7/28/16 did not include directions to monitor for side effects of psychotropics, until amended after surveyor notification on 7/28/16. The care plan did not indicate R17 was using an as needed antianxiety medication.

Review of the July 2016 medication and treatment administration record (MAR/TAR) and progress notes from 6/18/16 to 7/28/16, did not include any evidence staff were monitoring R17 for side effects for psychotropic medications. Review of R17's MAR/TAR for July revealed R17 was administered antidepressant medication on a scheduled daily basis and an as needed lorazepam was used eleven times.

On 7/28/16, at 10:03 a.m. the social service director (LSW)-B and a registered nurse (RN)-D confirmed the side effect monitoring was not included in the care plan and there was no evidence in R17's record staff were monitoring R17 for side effects of psychotropic medications. RN-D reported she thought R17's hospice team, not the facility, was responsible for psychotropic side effect monitoring.

The Unnecessary Medication policy, dated 9/2012, directed staff to ensure "Monitoring for efficacy and adverse consequences through areas such as vital signs as appropriate."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/28/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE	**1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division on August 12, 2015. At the time of this survey dated July 28,2016, Good Samaritan Society - Inver Grove Heights was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Good Samaritan Society - Inver Grove Heights, is a 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1981 and 1983, additions were constructed to the North Wing that was determined to be of Type II(111) construction. In 1999 an addition was added to the South Wing that was determined to be of Type II (111) construction. Because the original building and the 3 additions are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 32 at the time of the 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.

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
August 9, 2016

Ms. Pamela Schultz, Administrator
Good Samaritan Society - Inver Grove Heights
1301 50th Street East
Inver Grove Heights, MN 55077

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5285025

Dear Ms. Schultz:

The above facility was surveyed on July 25, 2016 through July 28, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss, Unit Supervisor at (651) 201-3793.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)
cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00022	A. BUILDING: _____ B. WING _____	07/28/2016

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GOOD SAMARITAN SOCIETY - INVER GROVE HEIGH	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 7/25/16 through 7/28/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a plan of care to include a system to monitor for side effects of psychotropic medications for 1 of 6 residents (R17) reviewed for unnecessary medications. Findings include: R17's admission Minimum Data Set (MDS), dated 6/25/16, revealed R17 received antidepressant medications on 7 of 7 days and 5 of 7 days in the assessment reference period. R17's physician progress notes, dated 6/21/16, revealed medication prescriptions for mirtazapine (anti-depressant) and lorazepam (antianxiety). R17's Order summary report, dated 7/28/16, revealed R17 was prescribed the following medications: citalopram (antidepressant),	2 560		

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	00022	A. BUILDING: _____ B. WING _____	07/28/2016

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GOOD SAMARITAN SOCIETY - INVER GROVE HEIGH	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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2 560	Continued From page 3 lorazepam and mirtazapine. R17's care plan, dated 7/6/16 to 7/28/16, did not include directions to monitor for side effects of psychotropics, until amended after surveyor notification on 7/28/16. The care plan did not indicate R17 was also using an as needed antianxiety medication. Review of the July 2016 medication and treatment administration record (MAR/TAR) and order summary, dated 7/28/16, did not direct staff to monitor R17 for side effects of psychotropic medications. On 7/28/16, at 10:03 a.m. the social service director (LSW)-B and a registered nurse (RN)-D confirmed the side effect monitoring was not included in the care plan and there was no evidence in R17's record staff were monitoring R17 for side effects of psychotropic medications. The Unnecessary Medication policy, dated 9/2012, directed staff to ensure "Monitoring for efficacy and adverse consequences through areas such as vital signs as appropriate." Based on interview and document review, the facility failed to develop a plan of care to include a system to monitor for side effects of psychotropic medications for 1 of 6 residents (R17) reviewed for unnecessary medications. Findings include: R17's admission Minimum Data Set (MDS), dated 6/25/16, revealed R17 received antidepressant medications on 7 of 7 days and 5 of 7 days in the	2 560		

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2 560	Continued From page 4 assessment reference period. R17's physician progress notes, dated 6/21/16, revealed medication prescriptions for mirtazapine (anti-depressant) and lorazepam (antianxiety). R17's Order summary report, dated 7/28/16, revealed R17 was prescribed the following medications: citalopram (antidepressant), lorazepam and mirtazapine. R17's care plan, dated 7/6/16 to 7/28/16, did not include directions to monitor for side effects of psychotropics, until amended after surveyor notification on 7/28/16. The care plan did not indicate R17 was also using an as needed antianxiety medication. Review of the July 2016 medication and treatment administration record (MAR/TAR) and order summary, dated 7/28/16, did not direct staff to monitor R17 for side effects of psychotropic medications. On 7/28/16, at 10:03 a.m. the social service director (LSW)-B and a registered nurse (RN)-D confirmed the side effect monitoring was not included in the care plan and there was no evidence in R17's record staff were monitoring R17 for side effects of psychotropic medications. The Unnecessary Medication policy, dated 9/2012, directed staff to ensure "Monitoring for efficacy and adverse consequences through areas such as vital signs as appropriate." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan	2 560		

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2 560	Continued From page 5 revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately identify, assess, and monitor clinical indicators for the	21540		

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21540	Continued From page 6 continual use of psychopharmacological medications for 2 of 6 residents (R28, R17) receiving psychoactive medications. Findings include: R28's medical record failed to reveal an assessment to support adding Tramadol to R28's drug regimen; and failed to identify which, if any non-pharmacological interventions had been tried and were effective or non-effective in minimizing R28's pain. A review of R28's medical record revealed Tramadol 50 milligrams (mg) three times a day for pain had been ordered by the physician on 6/28/16. The order indicated the Tramadol was to be given at the same time as a regularly scheduled Tylenol 1000 mg, which was ordered three times a day. On 7/21/16, the physician ordered the Tramadol to continue until all tablets on the medication card were gone. A review of the medication administration record revealed the last dose of Tramadol was given at 11:45 a.m. on 7/24/16. During an interview on 7/26/16, at 9:13 a.m. R28 stated having constant back pain of 10/10 (10 being the worst) and it was 10/10 at the moment of the interview. R28 stated the physician had been told about the pain, but R28 felt the physician was not doing anything to relieve the pain. At this time R28 was not observed to be exhibiting non-verbal signs of pain, such as grimacing and was able to maneuver the wheelchair independently. R28 was also observed at random times throughout the survey not exhibiting any verbal or non-verbal signs of pain during meals, when in activities, when watching TV or sitting in the wheelchair in the	21540		

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21540	Continued From page 7	21540		

room, or when maneuvering the wheelchair up and down the hallways.

On 7/26/16, at 3:50 p.m. R28 was interviewed regarding non-pharmacological pain interventions. R28 stated when at home ice packs, heating pads and changing positions helped, but these things were not being offered at the facility.

On 7/26/16, at 3:52 p.m. registered nurse (RN)-B was interviewed regarding R28's pain. RN-B stated R28 would complain of pain "very rarely", but when RN-B asked on a daily basis if R28 had pain, R28 would say ther pain was 10/10. RN-B stated R28 did not show any non-verbal signs of pain. RN-B stated non-pharmacological interventions such as rest and conversations had been tried. RN-B stated there were ice packs and heat available, but had not used them for R28.

On 7/28/16, at 2:37 p.m. RN-C, the hospice nurse, stated the resident wasn't showing any outward signs of pain, but was verbalizing the pain at a level of 10, so the decision was made to add Tramadol to R28's pain management plan. RN-C stated non-pharmacological interventions which worked best for R28 were distractions, activities, coloring and visiting with others. RN-C stated the hospice care plan did not address non-pharmacological interventions; and she would provide documentation of R28's pain assessment to support the addition of the Tramadol.

Documentation provided by RN-C was a hospice note dated 6/21/16, indicating R28's pain was constant, on-going, 10/10, and in the back. The documentation also indicated the progression of

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21540	Continued From page 8	21540		

pain was unchanged, affected R28's mood and R28 stated always being in pain, and it never got better than a "10." The documentation did not identify any non-pharmacological interventions. A Case Communication note dated 6/24/16, between the physician and RN-C indicated RN-C had spoken to the physician about R28's pain control and the Tramadol was added for pain control. The documentation did not address non-pharmacological interventions.

A 5/2/16, Pain Assessment completed by the facility indicated R28 "states is in pain all the time" but the current medication regimen of Tylenol 1000 mg three times a day was working. A non-pharmacological intervention of "rest." was identified. However, this intervention was not on R28's care plan.

R17's admission Minimum Data Set (MDS), dated 6/25/16, revealed R17 received antidepressant medications on 7 of 7 days and 5 of 7 days in the assessment reference period.

R17's physician progress notes, dated 6/21/16, revealed medication prescriptions for mirtazapine (anti-depressant) and lorazepam (antianxiety). R17's Order summary report, dated 7/28/16, revealed R17 was prescribed the following medications: citalopram (antidepressant), lorazepam and mirtazapine.

R17's care plan, dated 7/6/16 to 7/28/16 did not include directions to monitor for side effects of psychotropics, until amended after surveyor notification on 7/28/16. The care plan did not indicate R17 was using an as needed antianxiety

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medication.

Review of the July 2016 medication and treatment administration record (MAR/TAR) and progress notes from 6/18/16 to 7/28/16, did not include any evidence staff were monitoring R17 for side effects for psychotropic medications. Review of R17's MAR/TAR for July revealed R17 was administered antidepressant medication on a scheduled daily basis and an as needed lorazepam was used eleven times.

On 7/28/16, at 10:03 a.m. the social service director (LSW)-B and a registered nurse (RN)-D confirmed the side effect monitoring was not included in the care plan and there was no evidence in R17's record staff were monitoring R17 for side effects of psychotropic medications. RN-D reported she thought R17's hospice team, not the facility, was responsible for psychotropic side effect monitoring.

The Unnecessary Medication policy, dated 9/2012, directed staff to ensure "Monitoring for efficacy and adverse consequences through areas such as vital signs as appropriate."

SUGGESTED METHOD OF CORRECTION:
The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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21540	Continued From page 10 (21) days.	21540		