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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: UXGC
Facility ID: 00131

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245441**

2. STATE VENDOR OR MEDICAID NO. (L2) **418840300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - ALBERT LEA**
(L4) **75507 240TH STREET**
(L5) **ALBERT LEA, MN** (L6) **56007**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **06/05/2017** (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 **95** (L18)
13.Total Certified Beds **95** (L17)

10.THE FACILITY IS CERTIFIED AS:
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 ___ 6. Scope of Services Limit
___ 3. 24 Hour RN ___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size
___ 5. Life Safety Code ___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	95			
(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 :
Kathryn Serie, Unit Supervisor 06/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/28/2017 (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
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245441

June 19, 2017

Ms. Ursula Hagstrand, Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

Dear Ms. Hagstrand:

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 June 1, 2017 the above facility is certified for:

95 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 95 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
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

An equal opportunity employer.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 19, 2017

Ms. Ursula Hagstrand, Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

RE: Project Number S5441026

Dear Ms. Hagstrand:

On May 9, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 27, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On June 5, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 31, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 27, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 1, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 27, 2017, effective June 1, 2017 and therefore remedies outlined in our letter to you dated May 9, 2017, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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(L4) **75507 240TH STREET**
(L5) **ALBERT LEA, MN** (L6) **56007**

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3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
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6. DATE OF SURVEY **04/27/2017** (L34)

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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) :

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____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
	95			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Pamela Manzke, HFE NE II 05/23/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/19/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
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B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 9, 2017

Ms. Ursula Hagstrand, Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

RE: Project Number S5441026

Dear Ms. Hagstrand:

On April 27, 2017, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street
Marshall, Minnesota 56258-2529
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 344-2723

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 June 6, 2017, 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 July 27, 2017 (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 October 27, 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

Please contact me if you have questions related to this eNotice.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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
	245441	A. BUILDING ______ B. WING ______	04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET ALBERT LEA, MN 56007**

(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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 157		6/1/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/19/2017

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
	245441	A. BUILDING ______ B. WING ______	04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET ALBERT LEA, MN 56007**

(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 157	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to notify 1 of 1 resident (R12) reviewed for notification of changes prior to discontinuing a medication. Findings include: R12's face sheet dated April 27, 2017, revealed diagnoses of obstructive and reflex uropathy (condition in which the flow of urine is blocked), benign prostatic hyperplasia (enlarged prostate), retention of urine, nontraumatic intracranial hemorrhage (stroke), and dementia.	F 157	F 157: Plan of correction: Nursing management will review current orders with R12 and all residents and/or responsible parties in the facility by 6/1/17 to ensure they are aware of current orders and are in agreement with them. The current facility "Physician order checklist" has been reviewed and updated to include notification to the resident, as well as the responsible party, when appropriate, and to document this notification in the electronic medical record. Nursing staff will be educated on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET ALBERT LEA, MN 56007**

(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 157	Continued From page 2 R12's most recent quarterly Minimum Data Set (MDS), dated 2/20/17 revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated he had no cognitive impairment. His activities of daily living (ADL) require extensive assistance by one staff person except for eating, and had an indwelling Foley catheter for elimination. R12's current ongoing care plan located in the electronic medical record (EMR) revealed staff were to discuss concerns and disease process with the resident. He understood simple, consistent, and direct sentences. He had a Brief Interview for Mental Status (BIMS) score of 13 indicating he was cognitively intact, however that may vary at times as he struggled with some recall. R12's Medication Review, dated 10/21/16, revealed orders for doxazosin mesylate (a medication used to treat enlargement of the prostate) tablet 2 milligrams (mg) give 2 mg by mouth one time a day related to obstructive and reflex uropathy. When interviewed on 4/24/17, at 2:28 p.m. R12 was able to answer questions and cognitively intact. While seated in his wheelchair in his room, R12 wiped his mouth often while he spoke. Although R12 was slow to communicate related to his speech impediment (caused by his history of stroke) he was able to make himself understood. R12 voiced concerns over having his bladder medication having been stopped previously without his knowledge. After it was stopped, he began having penile pain and complained to the nurse. He stated "she [the nurse] had figured out," and it was related to the	F 157	facilities process for notification to residents and families with order changes via a meeting on 5/23/17; with all nursing staff to be educated by 6/1/17. The "Physician order checklist" will be reviewed at this meeting as well. Random audits to ensure compliance will be conducted by nursing management for R12 and all residents in the facility who receive changes in orders. Audits will be completed weekly x 4, then monthly x 3. Audit results will be brought to the Quality Assurance Performance Improvement Committee for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING ______ B. WING ______	04/27/2017

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GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

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F 157	Continued From page 3 discontinuation of the bladder medication and called the doctor. Once the medication was restarted, the pain went away. R12 indicated he was upset that he was not included with the decision to discontinue the medication and subsequent notification related to changes in his care. R12 also stated he believed staff felt he was "mentally retarded" because of his speech impediment. R12's nursing progress notes, dated 9/27/16 revealed a fax sent to his primary care physician (PCP) from the pharmacist requesting to discontinue his doxazosin related to (r/t) unnecessary medication (med) regarding his doxazosin and his indwelling catheter. An order was received from the primary care provider (PCP) to discontinue (d/c) the med on 10/11/16. A nursing progress note communication, dated 9/28/16 made by staff to R12's daughter indicated "she would go with what her father says because it's his body." No further notes were documented regarding any discussion with the resident on any of his care during that time. A nursing progress note, dated 10/19/16, indicated a fax was sent to the PCP which stated, "Since we dc'd the doxazosin daily on 10/11/16, elder c/o [complains of] severe pain- penis hurts- awake most of night shift. may we start doxazosin 2 mg po daily? Reply on 10/20/16 was YES. Dr [PCP]." A nursing progress note, dated 10/20/16 at 3:39 a.m., indicated the resident received "Tylenol Extra Strength Tablet 500 MG Give 1 tablet by mouth every 8 hours as needed for H/A [headache] pain c/o 12/10 penile pain with	F 157		

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F 157	Continued From page 4	F 157		

urination."

A nursing progress note, dated 10/20/16, at 10:09 p.m. indicated "In response to fax of 'Since we dc'd Doxazosin 2 mg (po) daily on 10-11-16 Elder c/o severe pain- penis hurts- awake most of the night shift. May we start Doxazosin 2 mg (po) daily?' [PCP] replied with 'yes'."

A PCP progress note, dated 11/2/16 indicated "We recently tried stopping his doxazosin; however, he noted significant increase in bladder pain when off that medication. He is otherwise feeling well now that we have started that medication again. He denies significant other symptoms. He is otherwise feeling very well." [diagnosis] Dx: Urinary spasms. He does have good significant benefit from the doxazosin and it decreases significant pain for him. I will keep him on that medication indefinitely. We will hold off stopping it at this time. He is comfortable with this plan."

There was no nursing note documented in the electronic medical record that R12 was notified of the discontinuance of his bladder medication and/or change of treatment by nursing staff.

During interview on 4/26/2017, at 7:13 a.m. registered nurse (RN)-A stated staff had discontinued his medication for his "prostate," doxazosin, on 10/11/16 per physician order. The resident started experiencing penile pain on 10/17/16, and was placed back on his medication on 10/20/16. When asked how they inform residents of a change to their medication regimen, she stated they tell the resident. "Most of the time they document that they tell them a med is discontinued." It was her expectation this

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F 157	Continued From page 5 was the responsibility of the floor nurse to inform the resident who received the order to d/c the medication from the physician at that time. She was unable to find documentation to support R12 was informed about the above mentioned medication being discontinued. RN-A does believe however, it was discussed later at the time when he noticed the pain and that it had been discontinued. During interview on 4/27/17, at 10:07 a.m. the director of nursing (DON) stated it was her expectation that nursing would notify the resident of a change in medication or treatment and document that notification in the resident's EMR. Staff had a checklist to complete with any medication change/order and notification to the resident is on the checklist. Review of the facility's Notification of Change policy, dated November 2016 revealed the facility must immediately inform the resident when there is a need to discontinue or change an existing form of treatment or to commence a new form of treatment. Review of the facility's undated untitled checklist, received on 4/27/17 from the DON revealed staff were to contact the family member or responsible party if indicated. There was no mention specific to notification of the resident.	F 157		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the	F 309		6/1/17

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F 309	Continued From page 6 facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure services were coordinated with the hospice agency for 1 of 1 resident (R5) reviewed who received hospice services. Findings include:	F 309	F 309: Plan of Correction Hospice agency has updated "Nursing Home Document" to include space for documentation of next planned visit. This document will be kept in the hospice chart at the nurse's station. The document will	

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F 309	Continued From page 7 The Minimum Data Set (MDS) assessment dated 4/11/17, for a significant change in status indicated R5 required extensive staff assistance with bed mobility, transfers, dressing, toileting and personal hygiene. The MDS also identified R5 received hospice services. The hospice plan of treatment dated 4/11/17, identified the hospice registered nurse (RN) would visit 2 times per week and as needed and the social worker would visit 1 time a month and as needed. In addition, the plan identified a volunteer would visit. Emergency contact information and numbers to reach the hospice agency was readily available to staff. When interviewed on 4/26/17, at 9:20 a.m. licensed practical nurse (LPN)-A indicated the hospice nurse comes on Thursdays and verified she was unaware the hospice nurse was scheduled to visit 2 times weekly. When interviewed on 4/26/17, at 10:43 a.m. registered nurse (RN)-A indicated the hospice agency was to document in their visit note when the next scheduled visit would occur, but verified it was not documented. When interviewed on 4/26/17, at 10:53 a.m. director of nursing (DON) verified there was an communication issue as the next scheduled hospice skilled nurse visit should be documented in the note and that had not occurred. When interviewed on 4/26/17, at 12:40 p.m. the hospice nurse indicated she comes on Mondays and Fridays stating, "I write it on the hospice calendar in the resident room". However, when	F 309	be completed by each hospice staff member and volunteer at the completion of their visit. The hospice agency will also continue to provide calendars to the residents who receive hospice services that will be kept in resident rooms. All hospice staff members and volunteers will write their name on the date of their next planned visit. Nursing management has ensured all rooms of the residents receiving hospice care have "hospice calendars" and that their charts contain the updated "Nursing Home Document". Hospice agency staff were provided with education on these procedures on 5/8/17. Facility nursing staff will be provided with education via a meeting on 5/23/17; with all nursing staff to be educated by 6/1/17. Education will include the processes of communication of the scheduled visits dates of hospice staff and communication with the hospice agency. Random audits to ensure compliance will be conducted by nursing management for R5 and residents that are receiving hospice services. Audits will be conducted weekly x 4, then monthly x 3. Audit results will be brought to the Quality Assurance Performance Improvement Committee for Review.	

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F 309	Continued From page 8 during an observation of the hospice calendar in R5's room, it did not indicate any future visits. Review of Hospice Services in a Skilled Nursing Facility, revised 3/17, did not address the hospice agency's communication of the visit schedule with the facility staff.	F 309		

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

F5441026

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Good Samaritan Society Albert Lea was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 05/17/2017

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 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society - Albert Lea, is a 1-story building. The building was constructed at 6 different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1968, an addition was constructed and was determined to be of Type II(111) construction. In 1975, an addition was constructed and was determined to be of Type II (111) construction. In 1980, an addition was constructed and was determined to be of Type II(111) construction. In 1997, an addition was constructed and was determined to be of Type II(111) construction In 1998, an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 5 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. 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.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 95 beds and had a census of 87 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483,	K 363		5/19/17

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K 363	Continued From page 3 and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363	K 363 Plan of Correction: All doors were corrected by maintenance staff by adjusting the hinges. Maintenance will conduct monthly audits on seven random doors monthly x 7 months.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 363	Continued From page 4 Findings Include: On facility tour between 10:00 AM and 02:00 PM on 4/27/2017, based on observation and interview revealed that the following include: Rooms 4905,4906, 4811 did not latch when tested. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 363		

Electronically delivered
May 9, 2017

Ms. Ursula Hagstrand, Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5441026

Dear Ms. Hagstrand:

The above facility was surveyed on April 24, 2017 through April 27, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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 contact Kathryn Serie, Unit Supervisor at (507) 476-4233 or at Kathryn.serie@state.mn.us .

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 contact me if you have questions related to this eNotice.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00131	A. BUILDING: ______ B. WING ______	04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET ALBERT LEA, MN 56007**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to 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

Minnesota Department of Health

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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 April 24, 25, 26 and 27th, 2016 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		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths.	2 265		6/1/17

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2 265	Continued From page 3	2 265		
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to notify 1 of 1 resident (R12) reviewed for notification of changes prior to discontinuing a medication. Findings include: R12's face sheet dated April 27, 2017, revealed diagnoses of obstructive and reflex uropathy (condition in which the flow of urine is blocked), benign prostatic hyperplasia (enlarged prostate), retention of urine, nontraumatic intracranial hemorrhage (stroke), and dementia. R12's most recent quarterly Minimum Data Set (MDS), dated 2/20/17 revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated he had no cognitive impairment. His activities of daily living (ADL) require extensive assistance by one staff person except for eating, and had an indwelling Foley catheter for elimination. R12's current ongoing care plan located in the electronic medical record (EMR) revealed staff were to discuss concerns and disease process with the resident. He understood simple, consistent, and direct sentences. He had a Brief Interview for Mental Status (BIMS) score of 13 indicating he was cognitively intact, however that may vary at times as he struggled with some recall. R12's Medication Review, dated 10/21/16, revealed orders for doxazosin mesylate (a medication used to treat enlargement of the		Corrected	

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2 265	Continued From page 4 prostate) tablet 2 milligrams (mg) give 2 mg by mouth one time a day related to obstructive and reflex uropathy. When interviewed on 4/24/17, at 2:28 p.m. R12 was able to answer questions and cognitively intact. While seated in his wheelchair in his room, R12 wiped his mouth often while he spoke. Although R12 was slow to communicate related to his speech impediment (caused by his history of stroke) he was able to make himself understood. R12 voiced concerns over having his bladder medication having been stopped previously without his knowledge. After it was stopped, he began having penile pain and complained to the nurse. He stated "she [the nurse] had figured out," and it was related to the discontinuation of the bladder medication and called the doctor. Once the medication was restarted, the pain went away. R12 indicated he was upset that he was not included with the decision to discontinue the medication and subsequent notification related to changes in his care. R12 also stated he believed staff felt he was "mentally retarded" because of his speech impediment. R12's nursing progress notes, dated 9/27/16 revealed a fax sent to his primary care physician (PCP) from the pharmacist requesting to discontinue his doxazosin related to (r/t) unnecessary medication (med) regarding his doxazosin and his indwelling catheter. An order was received from the primary care provider (PCP) to discontinue (d/c) the med on 10/11/16. A nursing progress note communication, dated 9/28/16 made by staff to R12's daughter indicated "she would go with what her father says because it's his body." No further notes were documented	2 265		

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2 265	Continued From page 5	2 265		

regarding any discussion with the resident on any of his care during that time.

A nursing progress note, dated 10/19/16, indicated a fax was sent to the PCP which stated, "Since we dc'd the doxazosin daily on 10/11/16, elder c/o [complains of] severe pain- penis hurts- awake most of night shift. may we start doxazosin 2 mg po daily? Reply on 10/20/16 was YES. Dr [PCP]."

A nursing progress note, dated 10/20/16 at 3:39 a.m., indicated the resident received "Tylenol Extra Strength Tablet 500 MG Give 1 tablet by mouth every 8 hours as needed for H/A [headache] pain c/o 12/10 penile pain with urination."

A nursing progress note, dated 10/20/16, at 10:09 p.m. indicated "In response to fax of 'Since we dc'd Doxazosin 2 mg (po) daily on 10-11-16 Elder c/o severe pain- penis hurts- awake most of the night shift. May we start Doxazosin 2 mg (po) daily?' [PCP] replied with 'yes'."

A PCP progress note, dated 11/2/16 indicated "We recently tried stopping his doxazosin; however, he noted significant increase in bladder pain when off that medication. He is otherwise feeling well now that we have started that medication again. He denies significant other symptoms. He is otherwise feeling very well." [diagnosis] Dx: Urinary spasms. He does have good significant benefit from the doxazosin and it decreases significant pain for him. I will keep him on that medication indefinitely. We will hold off stopping it at this time. He is comfortable with this plan."

There was no nursing note documented in the

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2 265	Continued From page 6 electronic medical record that R12 was notified of the discontinuance of his bladder medication and/or change of treatment by nursing staff. During interview on 4/26/2017, at 7:13 a.m. registered nurse (RN)-A stated staff had discontinued his medication for his "prostate," doxazosin, on 10/11/16 per physician order. The resident started experiencing penile pain on 10/17/16, and was placed back on his medication on 10/20/16. When asked how they inform residents of a change to their medication regimen, she stated they tell the resident. "Most of the time they document that they tell them a med is discontinued." It was her expectation this was the responsibility of the floor nurse to inform the resident who received the order to d/c the medication from the physician at that time. She was unable to find documentation to support R12 was informed about the above mentioned medication being discontinued. RN-A does believe however, it was discussed later at the time when he noticed the pain and that it had been discontinued. During interview on 4/27/17, at 10:07 a.m. the director of nursing (DON) stated it was her expectation that nursing would notify the resident of a change in medication or treatment and document that notification in the resident's EMR. Staff had a checklist to complete with any medication change/order and notification to the resident is on the checklist. Review of the facility's Notification of Change policy, dated November 2016 revealed the facility must immediately inform the resident when there is a need to discontinue or change an existing form of treatment or to commence a new form of treatment.	2 265		

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2 265	Continued From page 7 Review of the facility's undated untitled checklist, received on 4/27/17 from the DON revealed staff were to contact the family member or responsible party if indicated. There was no mention specific to notification of the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff regarding the need to include the resident in changes to medical regimen and update policy, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure services were	2 830	Corrected	6/1/17

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2 830	Continued From page 8	2 830		

coordinated with the hospice agency for 1 of 1 resident (R5) reviewed who received hospice services.

Findings include:

The Minimum Data Set (MDS) assessment dated 4/11/17, for a significant change in status indicated R5 required extensive staff assistance with bed mobility, transfers, dressing, toileting and personal hygiene. The MDS also identified R5 received hospice services.

The hospice plan of treatment dated 4/11/17, identified the hospice registered nurse (RN) would visit 2 times per week and as needed and the social worker would visit 1 time a month and as needed. In addition, the plan identified a volunteer would visit. Emergency contact information and numbers to reach the hospice agency was readily available to staff.

When interviewed on 4/26/17, at 9:20 a.m. licensed practical nurse (LPN)-A indicated the hospice nurse comes on Thursdays and verified she was unaware the hospice nurse was scheduled to visit 2 times weekly.

When interviewed on 4/26/17, at 10:43 a.m. registered nurse (RN)-A indicated the hospice agency was to document in their visit note when the next scheduled visit would occur, but verified it was not documented.

When interviewed on 4/26/17, at 10:53 a.m. director of nursing (DON) verified there was an communication issue as the next scheduled hospice skilled nurse visit should be documented in the note and that had not occurred.

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2 830	Continued From page 9 When interviewed on 4/26/17, at 12:40 p.m. the hospice nurse indicated she comes on Mondays and Fridays stating, "I write it on the hospice calendar in the resident room". However, when during an observation of the hospice calendar in R5's room, it did not indicate any future visits. Review of Hospice Services in a Skilled Nursing Facility, revised 3/17, did not address the hospice agency's communication of the visit schedule with the facility staff. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee, could provide education to nursing staff about the importance of coordinating care with the agencies providing hospice care to residents at the facility. The DON or designee, could audit to be sure the hospice visit schedules are available to nursing staff and the respective resident and family. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		