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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: VTQP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00900

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245221**

2.STATE VENDOR OR MEDICAID NO.
(L2) **861017700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MAPLEWOOD**
(L4) **550 ROSELAWN AVENUE EAST**
(L5) **SAINT PAUL, MN** (L6) **55117**

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 **06/22/2017** (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 **76** (L18)

13.Total Certified Beds **76** (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
	76			
(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 Heim, HFE NE II — 06/22/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 10/05/2017 (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
04/01/1978
(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 10/05/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/01/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245221 July 11, 2017

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

Dear Ms. Jensen:

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

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

Effective May 23, 2017 the above facility is certified for:

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 11, 2017

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

RE: Project Number S5221028

Dear Ms. Jensen:

On June 20, 2017, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 13, 2017. (42 CFR 488.417 (b))

Also, we notified you in our letter of June 20, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 13, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on April 13, 2017, and lack of verification of substantial compliance with the health deficiencies at the time of our June 20, 2017 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On June 22, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 13, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 23, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 13, 2017, as of May 23, 2017.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of June 20, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 13, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective July 13, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 13, 2017, is to be rescinded.

In our letter of June 20, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 13, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 23, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR 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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 20, 2017

Ms Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

RE: Project Number S5221028

Dear Ms. Jensen:

On April 26, 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 13, 2017. 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.

However, compliance with the health and Life Safety Code (LSC) deficiencies issued pursuant to the April 13, 2017 standard survey has not yet been verified. The most serious health and LSC deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective July 13, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective July 13, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 13, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been

subject to a denial of payment. Therefore, Good Samaritan Society - Maplewood is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 13, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program

Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 13, 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. 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
Minnesota Department of Health
Email: 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

July 11, 2017

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

Re: Reinspection Results - Project Number S5221028

Dear Ms. Jensen:

On June 22, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 22, 2017, with orders received by you on April 26, 2017. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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 — ID: VTQP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00900

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245221**

2.STATE VENDOR OR MEDICAID NO.
(L2) **861017700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MAPLEWOOD**
(L4) **550 ROSELAWN AVENUE EAST**
(L5) **SAINT PAUL, MN** (L6) **55117**

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 **06/22/2017** (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 **76** (L18)

13.Total Certified Beds **76** (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
	76			
(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 Heim, HFE NE II — 06/22/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 10/05/2017 (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
04/01/1978
(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 10/05/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/01/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245221 July 11, 2017

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

Dear Ms. Jensen:

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

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

Effective May 23, 2017 the above facility is certified for:

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 11, 2017

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

RE: Project Number S5221028

Dear Ms. Jensen:

On June 20, 2017, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 13, 2017. (42 CFR 488.417 (b))

Also, we notified you in our letter of June 20, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 13, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on April 13, 2017, and lack of verification of substantial compliance with the health deficiencies at the time of our June 20, 2017 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On June 22, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 13, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 23, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 13, 2017, as of May 23, 2017.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of June 20, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 13, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective July 13, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 13, 2017, is to be rescinded.

In our letter of June 20, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 13, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 23, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR 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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 20, 2017

Ms Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

RE: Project Number S5221028

Dear Ms. Jensen:

On April 26, 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 13, 2017. 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.

However, compliance with the health and Life Safety Code (LSC) deficiencies issued pursuant to the April 13, 2017 standard survey has not yet been verified. The most serious health and LSC deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective July 13, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective July 13, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 13, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been

subject to a denial of payment. Therefore, Good Samaritan Society - Maplewood is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 13, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program

Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 13, 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. 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
Minnesota Department of Health
Email: 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

July 11, 2017

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

Re: Reinspection Results - Project Number S5221028

Dear Ms. Jensen:

On June 22, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 22, 2017, with orders received by you on April 26, 2017. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

ID: VTQP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00900

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245221**

2.STATE VENDOR OR MEDICAID NO.
(L2) **861017700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MAPLEWOOD**
(L4) **550 ROSELAWN AVENUE EAST**
(L5) **SAINT PAUL, MN** (L6) **55117**

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 **04/13/2017** (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 **76** (L18)

13.Total Certified Beds **76** (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
	76			
(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 05/22/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 05/30/2017 (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
04/01/1978
(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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 25, 2017

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

RE: Project Number S5221028

Dear Ms. Jensen:

On April 13, 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 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 CMS-2567 whereby corrections are required.

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
P.O. Box 64900
St. Paul, Minnesota 55164-0900
susanne.reuss@state.mn.us
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 May 23, 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 13, 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 13, 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

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
	245221	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117

(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 A recertification survey was conducted April 10, 11, 12, and 13, 2017. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.	F 225		5/23/17

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

Electronically Signed | 05/03/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117

(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 225	Continued From page 1 (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117

(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 225	Continued From page 2 Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to report an allegation of abuse that had been reported to staff for 1 of 5 residents (R108) reviewed for abuse. Findings include: During an interview on 4/10/17, at 6:53 p.m. R108 described nursing assistant (NA)-B as "rough and gruff" during transfers. R108 said earlier tonight after dinner, NA-B assisted the resident from the dining room back to the resident's room. R108 used a wheelchair for mobility, and the wheelchair leg was out to the side where R108 could not reach it. R108 asked NA-B to move the leg of the wheelchair closer so that the resident could rest foot on the foot pedal. R108 explained that NA-B did move the wheelchair leg closer as requested, and brought the resident back to the room. After returning to the resident's room, R108 said that NA-B told the resident "you need to show me more respect, you were very rude to me." R108 also described NA-B as "rough" when assisting R108 to move from laying in bed, to sitting up in bed. When asked if R108 reported the incident to staff, the resident confirmed telling registered nurse (RN)-E about what happened. Review of a minimum data set cognitive assessment from the reference date 2/9/17, revealed the facility assessed R108 to be cognitively intact. The facility compiled a list of reported events, and	F 225	F225 483.12 (a) (3)(4)(c)(1)-(4) Investigate/Report Allegations/Individuals Corrective Action for resident R108 The concern from R108 was reported immediately to OHFC and the alleged nursing assistant was removed from all care of residents and was suspended pending investigation. The facility immediately started an internal investigation of the allegation. R108 was notified immediately that the nursing assistant would not be taking care of them and was updated on the process and that their concerns have been addressed. How to identify other residents with the same issue The facility performed interviews of the residents that the alleged nursing assistant had also cared for and no other issues were found. Facility staff will follow the established policy and procedure for abuse and neglect and will report alleged or suspected violations involving any mistreatment or abuse immediately to the administrator; or in the absence of the administrator, to the director of nursing services or the director of social services. If an employee receives an allegation of abuse the employee is required to report to a supervisor. The charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117

(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 225	Continued From page 3 reported allegations of abuse and neglect from the past twelve months. Review of the list failed to provide evidence that the facility reported or began to investigate R108's allegation. During an interview on 4/12/17, at 11:25 a.m. the administrator and director of nursing (DON) said they were not aware of the allegation from the evening of 4/10/17. After explaining how R108 described NA-B as rough and gruff, and said NA-B told the resident to show more respect, the DON said, "Well that isn't appropriate." The DON confirmed "That is something that should have been reported, and we will do that." The administrator said that normally they talk to the resident about it, and interview the staff, and said they would start to do that immediately. The DON said "RN-E should have reported that to us immediately" and said RN-E would be retrained on reporting. During an interview on 4/12/17, at 2:56 p.m. RN-E confirmed that R108 spoke to her about being upset when NA-B called the resident rude. RN-E said R108 mentioned not wanting NA-B to take care of the resident that night. RN-E said she reported the situation to the charge nurse that evening, who confirmed that NA-B was not scheduled to take care of R108 that evening. Review of the Abuse and Neglect policy and procedure, last revised 11/16, revealed that alleged or suspected violations involving any mistreatment or abuse should be reported immediately to the administrator; or in the absence of the administrator, to the director of nursing services or the director of social services. Review of a submission report revealed the	F 225	treatment or action is required, and complete an initial investigation. If this is an allegation of employee to resident abuse, the employee will be removed from providing direct care to all residents. Additionally the employee will be placed on suspension pending the results of the internal investigation. A designated individual will then complete the documentation in the medical record. Allegations of abuse or mistreatment will be reported no later than two hours after the allegation is made to the administrator, and to other officials in accordance with state law. The investigative team (social worker, administrator, and director of nursing services) will review all incidents no later than the next working day following the incident. Recurrence will be prevented by All facility staff will receive re-education on the established policy and procedure for Abuse and Neglect. The facility will continue to provide all new staff with education during their general orientation on the established policy and procedure for Abuse and Neglect and all staff will continue to receive re-education on the policy and procedure for Abuse and Neglect annually. The facility will continue to enforce the Abuse and Neglect Policy and Procedure. Audits will be conducted to prevent recurrence as outlined below. These issues will be monitored in the following manner The Director of Nursing, Nurse Managers, and Social Service will perform audits by interviewing residents for concerns. If	

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F 225	Continued From page 4 facility reported the incident to the State Agency on 4/12/17, after the interview with the administrator and DON on the same date.	F 225	there are concerns, the interviewer will ask the resident in the interview if this concern has been reported to a staff member. Concerns brought up during audit interviews will be addressed, reported and investigated per the Abuse and Neglect policy and procedure. These audits will be completed weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance committee for further review as needed.	
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect,	F 226		5/23/17

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F 226	Continued From page 5 exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to follow established policies and procedures to report and investigate allegations of abuse for 1 of 5 residents (R108) investigated for abuse. Findings include: Review of the Abuse and Neglect policy and procedure, last revised 11/16, revealed that alleged or suspected violations involving any mistreatment or abuse should be reported immediately to the administrator; or in the absence of the administrator, to the director of nursing services or the director of social services. The procedure required the following: If an employee receives an allegation of abuse, the employee is required to report to a supervisor. The charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required, and complete an initial investigation. If this is an allegation of employee to resident abuse, the employee will be removed from providing direct care to all residents. Additionally, the employee will be placed on suspension pending the results of the internal investigation. A designated individual will then	F 226	F226 483.12 (b)(1)-(3), 483.95(c)(1)-(3) Develop/Implement abuse/Neglect, etc. Policies Corrective Action for resident R108 The concern from R108 was reported immediately to OHFC and the alleged nursing assistant was removed from all care of residents and was suspended pending investigation. The facility immediately started an internal investigation of the allegation. R108 was notified immediately that the nursing assistant would not be taking care of them and was updated on the process and that their concerns have been addressed. How to identify other residents with the same issue The facility performed interviews of the residents that the alleged nursing assistant had also cared for and no other issues were found. Facility staff will follow the established policy and procedure for abuse and neglect and will report alleged or suspected violations involving any mistreatment or abuse immediately to the administrator; or in the absence of the administrator, to the director of nursing	

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F 226	Continued From page 6 complete the documentation in the medical record. Allegations of abuse, or mistreatment will be reported no later than two hours after the allegation is made to the administrator, and to other officials in accordance with state law. The investigative team (social worker, administrator and director of nursing services) will review all incidents no later than the next working day following the incident. During an interview on 4/10/17, at 6:53 p.m. R108 described nursing assistant (NA)-B as "rough and gruff" during transfers. R108 said earlier tonight after dinner, NA-B assisted the resident from the dining room back to the resident's room. R108 used a wheelchair for mobility, and the wheelchair leg was out to the side where R108 could not reach it. R108 asked NA-B to move the leg of the wheelchair closer so that the resident could rest foot on the foot pedal. R108 explained that NA-B did move the wheelchair leg closer as requested, and brought the resident back to the room. After returning to the resident's room, R108 said that NA-B told the resident "you need to show me more respect, you were very rude to me." R108 also described NA-B as "rough" when assisting R108 to move from laying in bed, to sitting up in bed. When asked if R108 reported the incident to staff, the resident confirmed telling registered nurse (RN)-E about what happened. Review of a minimum data set cognitive assessment from reference date 2/9/17, revealed the facility assessed R108 to be cognitively intact. The facility compiled a list of reported events, and reported allegations of abuse and neglect from the past twelve months. Review of the list failed to provide evidence that the facility reported or	F 226	services or the director of social services. If an employee receives an allegation of abuse the employee is required to report to a supervisor. The charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required, and complete an initial investigation. If this is an allegation of employee to resident abuse, the employee will be removed from providing direct care to all residents. Additionally the employee will be placed on suspension pending the results of the internal investigation. A designated individual will then complete the documentation in the medical record. Allegations of abuse or mistreatment will be reported no later than two hours after the allegation is made to the administrator, and to other officials in accordance with state law. The investigative team (social worker, administrator, and director of nursing services) will review all incidents no later than the next working day following the incident. Recurrence will be prevented by All facility staff will receive re-education on the established policy and procedure for Abuse and Neglect. The facility will continue to provide all new staff with education during their general orientation on the established policy and procedure for Abuse and Neglect and all staff will continue to receive re-education on the policy and procedure for Abuse and Neglect annually. The facility will continue to enforce the Abuse and Neglect Policy	

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F 226	Continued From page 7 began to investigate R108's allegation. During an interview on 4/12/17, at 11:25 a.m. the administrator and director of nursing (DON) said they were not aware of the allegation from the evening of 4/10/17. After explaining how R108 described NA-B as rough and gruff, and said NA-B told the resident to show more respect, the DON said, "Well that isn't appropriate." The DON confirmed "That is something that should have been reported, and we will do that." The administrator said that normally they talk to the resident about it, and interview the staff, and said they would start to do that immediately. The DON said "RN-E should have reported that to us immediately" and said RN-E would be retrained on reporting. During an interview on 4/12/17, at 2:56 p.m. RN-E confirmed that R108 spoke to her about being upset when NA-B called the resident rude. RN-E said R108 mentioned not wanting NA-B to take care of the resident that night. RN-E said she reported the situation to the charge nurse that evening, who confirmed that NA-B was not scheduled to take care of R108 that evening. Review of a submission report revealed the facility reported the incident to the State Agency on 4/12/17, after the interview with the administrator and DON on the same date.	F 226	and Procedure. Audits will be conducted to prevent recurrence as outlined below. These issues will be monitored in the following manner The Director of Nursing, Nurse Managers, and Social Service will perform audits by interviewing residents for concerns. If there are concerns, the interviewer will ask the resident in the interview if this concern has been reported to a staff member. Concerns brought up during audit interviews will be addressed, reported and investigated per the Abuse and Neglect policy and procedure. These audits will be completed weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance committee for further review as needed.	
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments,	F 242		5/23/17

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F 242	Continued From page 8 and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 4 residents (R63 and R96) reviewed for choices, were provided with choice in frequency in bathing. Findings include: R63's Minimum Data Set [MDS], dated 2/24/17, revealed R63 required physical help with part of bathing and was cognitively intact. On 4/10/17, at 8:52 a.m. R63 reported not being able to choose how many showers R63 received each week. R63 reported wanting at least two showers each week, as R63 used to shower daily before admission to the facility. R63 added "it was sort of a shock at first" when R63 only was scheduled to get one shower each week at the facility. R63 added, "I guess they haven't got enough people to do more than that" and the one shower a week schedule was "pretty rigid." R63 reported no one ever asked how many showers R63 wanted each week. On 4/12/17, at 8:52 a.m. RN-B reported R63 had received four showers in the past month. RN-B	F 242	F242 483.10 (f)(1)-(3) Self Determination-Right To Make Choices Corrective Action for resident R63 R96 Residents R63 and R96 care plans have been updated and both residents have been receiving two baths/showers per week as requested. How to identify other residents with the same issue The facility will interview residents on admission, quarterly, and with change of condition on choices regarding bathing. These choices will be care planned and followed through as indicated. Residents who request extra baths or showers in addition to their scheduled routine will receive services with reasonable accommodations of individual needs and preferences. Recurrence will be prevented by All nursing staff will receive re-education on resident bathing choices, and providing bathing choices as per resident preference. Audits will be conducted to ensure resident choice regarding bathing	

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F 242	Continued From page 9 reported she could not recall discussing how many showers R63 wanted each week with R63. RN-B said she would look into it to see if that discussion happened before RN-B started. At 2:43 p.m., RN-B reported she could not find anything related to discussing how many showers R63 wanted each week. RN-B and surveyor then went to R63 and asked how many showers R63 preferred each week. R63 again reported desiring at least two showers each week but thought staff did not have enough time for that. RN-B told R63 she would schedule an additional shower for R63 each week. R63 expressed R63 was very grateful for the added shower. R63's care plan history, last revised 4/12/17, revealed R63 was scheduled for one shower each week, with a revision date of 4/7/17. On 4/12/17, R63's care plan history changed to two showers each week. R63's bathing report for 4/1/17 to 4/12/17 revealed R63 received one shower. R63's Bathing Report for 3/1/17 to 3/30/17 revealed R63 received three showers. R63's bathing report for 2/1/17 to 2/28/17 revealed R63 received three showers. R96's preference for having more than one bath/shower in a week was not accommodated. During interview with R96 on 4/11/17, at 2:49 p.m. R96 reported, would like to have shower at least twice a week, but did not know if that was possible because no staff had asked or discussed it. R96 further stated, preference was to take a shower two times a week and required staff assist due to blindness. On 4/12/17, at 9:48 a.m. R96 confirmed R96 wanted more than one	F 242	to prevent recurrence as outlined below. These issues will be monitored in the following manner The Director of Nursing and Nurse Managers will perform audits of resident choices in bathing weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance committee for further review as needed.	

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F 242	Continued From page 10	F 242		

shower a week and that it was not offered or provided by the facility.

On 4/11/17, at 2:55 p.m. resident's daughter, responded, did not recall staff offering R96 the number of showers preferred each week.

Physician orders document revealed R96's diagnoses included cerebral infarction, dorsalgia, major depression and blindness in both eyes.

Document review of the form titled, Progress notes: dated 2/22/17, at 2:47 p.m. read, "... Resident requires extensive assist of 1 staff for bathing as [R96] is able to complete part of bath independently but requires assistance for appropriate completion..."

Document review of R96's Annual Minimum Data set (MDS) dated 2/16/17, indicated, R96 was able to understand others, able to make self-understood and required physical assistance of one staff in part of bathing activity.

The care plan dated 1/20/16, directed staff, "... BATHING: Resident requires extensive assist of one staff to transfer on/off shower/tub chair for weekly bath. Extensive assist of one staff to complete weekly shower/bath.

The "North Bath Schedule" sheets, undated, indicated R96 was scheduled for one bath/shower each week on Tuesdays.

R96's bathing preferences assessment dated 1/7/17, revealed that the number of baths preferred each week was left unanswered.

On 4/11/17, at 2:37 p.m., nursing assistant

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F 242	Continued From page 11 (NA)-C reported the facility offered one bath/shower each week on Tuesdays for R96 by the morning bath aide. On 4/11/17, at 3:08 p.m., registered nurse (RN)-B indicated speaking with R96 regarding number of bath/showers per week and R96 did have choices of how many per week, however RN-B did not document the information in R96's medical record. RN-B further explained that the bathing/shower preference (number of bath/shower per week) was not discussed with R96's daughter, just with R96. Policy and procedure titled Accommodation of resident need, dated February 2013, read, "The resident has the right to reside and receive services in the center with reasonable accommodations of individual needs and preferences..."	F 242		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights	F 279		5/23/17

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F 279	Continued From page 12 set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 279		

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F 279	Continued From page 13 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop an individualized, comprehensive plan of care regarding hospice care for 1 of 1 resident (R163) in the sample reviewed for hospice. Findings include: Document review revealed a Hospice Admission/Verbal Certification Orders form for R163, showing the resident was enrolled in hospice care for the period of 3/8/17 to 6/5/17, with the admitting diagnosis of late effect of CVA (cerebral vascular accident) with dysphagia and aphasia (difficult swallowing and language expression). The document also contained a current plan of care from the facility, dated 3/23/17, and a Hospice Interdisciplinary Care Plan form, dated 3/9/17, from the hospice provider. The facility's plan of care had two Focus related to hospice care that read, "The resident has a terminal prognosis R/T [related to] DX [diagnosis] of CVA with aphasia and dysphagia," and "The resident wishes to remain on TCU [transitional care unit] with hospice services." Information such as, "Hospice care initiated on 3/8/17" was added at the bottom of the existing Focus entries in the plan of care. There was not a Focus to address the specifics of R163's psychosocial and spiritual needs related to hospice care.	F 279	F279 483.20 (d), 483.21(b) (1) Develop Comprehensive Care Plans Corrective Action for resident R163 R163 has had an interdisciplinary review and re-development of comprehensive individualized care plan to address psychosocial and spiritual needs related to hospice care. How to identify other residents with the same issue The facility will perform an interdisciplinary review to identify residents who have hospice care. Identified residents plan of care will be reviewed and re-developed as needed to address and provide psychosocial and spiritual needs as indicated. Recurrence will be prevented by An interdisciplinary individualized care plan including psychosocial and spiritual needs will be developed for residents receiving hospice care upon admission, quarterly, and with change of condition. Re-education will be given to all nursing staff, social service staff, dietary staff, therapeutic recreation staff, and chaplain who complete care plans. Audits will be completed to ensure that an individualized comprehensive care plan is developed to include psychosocial and spiritual needs related to hospice care for residents receiving hospice as designated below.	

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F 279	Continued From page 14 When interviewed on 4/12/17 at 1:44 p.m., registered nurse (RN)-D, the nurse manager for R163, was asked which care plan the facility staff used in caring for R163 regarding hospice. RN-D replied that the facility staff used the hospice provider's Hospice Interdisciplinary Care Plan form as a reference to develop the facility's plan of care, and facility staff then used the facility's plan of care for directing care of a resident on hospice. After survey exit, on 4/14/17, the facility provided, via fax, an unsigned, undated physician's order to discontinue aid services starting 3/14/17, and an unsigned, undated physician's order to discontinue chaplain services and social services starting 3/16/17. The fax dates on the documents identified that the documents had been faxed to the facility on 4/13/17. Also provided was a Spiritual Profile form completed by the facility on 2/27/17, that showed R163 was identified as Christian, however, the specific denomination section was left blank. Section 3. 1. of this form read, "What, if any, of the following spiritual practices or resources have been important to you in the past year?" and the answer to that question that was selected read, "Visit from my clergy person/religious leader or members of my faith community."	F 279	These issues will be monitored in the following manner Social Service, Director of Nursing, and Nurse Managers will audit care plans for residents receiving hospice care. Audits will be completed to address the completion of an individualized comprehensive care plan for psychosocial and spiritual needs weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance committee for further review as needed.	
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 facility must provide the necessary care and services to attain or maintain the highest	F 309		5/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117

(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 309	Continued From page 15 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 document review and interview, the facility failed to develop an individualized, comprehensive plan of care regarding hospice care, and failed to coordinate services with the hospice provider for 1 of 1 resident (R163) in the sample reviewed for hospice. Findings include:	F 309	F309 483.24, 483.25(k) (l) Provide Care/Services For Highest Well Being Corrective Action for resident R163 R163 has had an interdisciplinary review and re-development of comprehensive individualized care plan to address psychosocial and spiritual needs related to hospice care, and coordination of	

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GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117

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F 309	Continued From page 16 Document review revealed a Hospice Admission/Verbal Certification Orders form for R163, showing the resident was enrolled in hospice care for the period of 3/8/17 to 6/5/17, with the admitting diagnosis of late effect of CVA (cerebral vascular accident) with dysphagia and aphasia (difficult swallowing and language expression). The document also contained a current plan of care from the facility, dated 3/23/17, and a Hospice Interdisciplinary Care Plan form, dated 3/9/17, from the hospice provider. The facility's plan of care had two Focus related to hospice care that read, "The resident has a terminal prognosis R/T [related to] DX [diagnosis] of CVA with aphasia and dysphagia," and "The resident wishes to remain on TCU [transitional care unit] with hospice services." Phrases like, "Hospice care initiated on 3/8/17" were added at the bottom of the existing Focus entries in the plan of care. There was not a Focus to address the specifics of R163's psychosocial and spiritual needs related to hospice care. When interviewed on 4/12/17, at 1:44 p.m., registered nurse (RN)-D, the nurse manager for R163, was asked which care plan the facility staff used in caring for R163 regarding hospice. She replied that the facility staff used the hospice provider's Hospice Interdisciplinary Care Plan form as a reference to develop the facility's plan of care, and facility staff then used the facility's plan of care for directing care of a resident on hospice. A binder for R163's hospice care was kept at the nursing station and contained Communication Note forms from the hospice provider's nurses	F 309	services with the hospice provider. How to identify other residents with the same issue The facility will perform an interdisciplinary review to identify residents who have hospice care. Identified residents plan of care will be reviewed and re-developed as needed to provide psychosocial and spiritual needs and coordination of services with the hospice provider as indicated. Recurrence will be prevented by An interdisciplinary individualized care plan including psychosocial and spiritual needs and coordination of services with the hospice provider will be developed for residents receiving hospice care upon admission, quarterly, and with change of condition. Re-education will be given to all nursing staff, social service staff, therapeutic recreation staff, dietary staff, and chaplain who complete care plans. Audits will be completed to ensure that an individualized comprehensive care plan is developed to include psychosocial and spiritual needs related to hospice care and that hospice services have been coordinated for residents receiving hospice as designated below. These issues will be monitored in the following manner Social Service, Director of Nursing, and Nurse Managers will audit care plans for residents receiving hospice care. Audits will be completed regarding the completion of an individualized comprehensive care plan for psychosocial and spiritual needs and that services with hospice provider was coordinated weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117

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F 309	Continued From page 17 and home health aides that they would complete and leave in the binder after a visit to R163. That form contained a line that read, "Date of Next Visit:" where the hospice staff would write the date of their anticipated next visit. The last Communication Note form completed by a hospice nursing assistant in the binder was dated 3/13/17 and showed that the next visit date was 3/14/17. The last Communication Note form completed by a hospice nurse in the binder was dated 4/6/17 and showed that the next visit date was "Next Wk." When the nurse on R163's unit, licensed practical nurse (LPN)-B, was interviewed on 04/12/2017 at 9:23 a.m. she stated that she was not sure when hospice staff visited R163 and suggested that the hospice visit schedule may be in the resident's care plan. She then added that the hospice aide may call the facility before coming to see the resident. Nursing assistant (NA)-A was interviewed at the same time and asked when hospice staff visits R163. NA-A responded that she was not sure when hospice staff visited R163. She thought that she had seen hospice staff with R163, but could not remember the exact date. On 4/12/17 at 9:43 a.m., RN-D explained that the hospice staff for R163 leaves Communication Note forms in the resident's hospice binder regarding the next visit. She stated that she believed the hospice nurse and aide were coming once weekly to see R163. She was not sure if R163 was seen by a hospice clergy or social worker. She then explained that when the hospice aide is on site, the hospice aide tells facility staff what services the hospice aide will	F 309	for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance committee for further review as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	04/13/2017

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GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117

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F 309	Continued From page 18 provide on that day. After survey exit, on 4/14/17, the facility provided, via fax, an unsigned, undated physician's order to discontinue aid services starting 3/14/17 and an unsigned, undated physician's order to discontinue chaplain services and social services starting 3/16/17. The fax dates on the documents identified that the documents had been faxed to the facility 4/13/17, date of survey exit. Also provided was a Spiritual Profile form completed by the facility on 2/27/17 that showed R163 was identified as Christian, however, the specific denomination section was left blank. Section 3. 1. of this form read, "What, if any, of the following spiritual practices or resources have been important to you in the past year?" and the answer to that question that was selected read, "Visit from my clergy person/religious leader or members of my faith community."	F 309		

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	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/12/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	**550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117**

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K 000	INITIAL COMMENTS FIRE SAFETY 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 - Maplewood 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 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Maplewood Good Samaritan Center is a 2-story building with no basement. The building was constructed at three different times. In 1965 the nursing home was built and was determined to be of Type II(111) construction. In 1967 an addition was constructed to the south of the main building, that was determined to be of Type II(111) construction. In 1997 an addition was constructed to the south and west of the 1967 building that was determined to be of Type II(111) construction. Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkler protected and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The sleeping rooms in the 1997 addition have single smoke detectors that annunciate outside the room and at the nurse's station in accordance with the Minnesota	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.

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	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/12/2017**

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GOOD SAMARITAN SOCIETY - MAPLEWOOD	**550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117**

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K 000	Continued From page 1 State Fire Code. The facility has a capacity of 96 beds and had a census of 96 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 25, 2017

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

Re: State Nursing Home Licensing Orders - Project Number S5221028

Dear Ms. Jensen:

The above facility was surveyed on April 10, 2017 through April 13, 2017 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 licensing orders 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 Minnesota Department of Health orders 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 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

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
	00900	A. BUILDING: _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117

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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 April 10, 11, 12 and 13, 2017, 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	2 000		

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2 000	Continued From page 2 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.	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 document review and interview, the facility failed to develop an individualized, comprehensive plan of care regarding hospice care for 1 of 1 resident (R163) in the sample reviewed for hospice. Findings include: Document review revealed a Hospice Admission/Verbal Certification Orders form for R163, showing the resident was enrolled in hospice care for the period of 3/8/17 to 6/5/17, with the admitting diagnosis of late effect of CVA (cerebral vascular accident) with dysphagia and	2 560	Corrected	5/23/17

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2 560	Continued From page 3	2 560		

aphasia (difficult swallowing and language expression).

The document also contained a current plan of care from the facility, dated 3/23/17, and a Hospice Interdisciplinary Care Plan form, dated 3/9/17, from the hospice provider. The facility's plan of care had two Focus related to hospice care that read, "The resident has a terminal prognosis R/T [related to] DX [diagnosis] of CVA with aphasia and dysphagia," and "The resident wishes to remain on TCU [transitional care unit] with hospice services." Information such as, "Hospice care initiated on 3/8/17" was added at the bottom of the existing Focus entries in the plan of care. There was not a Focus to address the specifics of R163's psychosocial and spiritual needs related to hospice care.

When interviewed on 4/12/17 at 1:44 p.m., registered nurse (RN)-D, the nurse manager for R163, was asked which care plan the facility staff used in caring for R163 regarding hospice. RN-D replied that the facility staff used the hospice provider's Hospice Interdisciplinary Care Plan form as a reference to develop the facility's plan of care, and facility staff then used the facility's plan of care for directing care of a resident on hospice.

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2 560	Continued From page 4 R163 was identified as Christian, however, the specific denomination section was left blank. Section 3. 1. of this form read, "What, if any, of the following spiritual practices or resources have been important to you in the past year?" and the answer to that question that was selected read, "Visit from my clergy person/religious leader or members of my faith community." SUGGESTED METHOD OF CORRECTION: The facility director of nursing and/or designee could assure that individualized, comprehensive plans of care are developed to assure coordination of care for residents receiving hospice care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
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.	2 830		5/23/17

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GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117

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2 830	Continued From page 5 This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to develop an individualized, comprehensive plan of care regarding hospice care for 1 of 1 resident (R163) in the sample reviewed for hospice. Findings include: Document review revealed a Hospice Admission/Verbal Certification Orders form for R163, showing the resident was enrolled in hospice care for the period of 3/8/17 to 6/5/17, with the admitting diagnosis of late effect of CVA (cerebral vascular accident) with dysphagia and aphasia (difficult swallowing and language expression). The document also contained a current plan of care from the facility, dated 3/23/17, and a Hospice Interdisciplinary Care Plan form, dated 3/9/17, from the hospice provider. The facility's plan of care had two Focus related to hospice care that read, "The resident has a terminal prognosis R/T [related to] DX [diagnosis] of CVA with aphasia and dysphagia," and "The resident wishes to remain on TCU [transitional care unit] with hospice services." Information such as, "Hospice care initiated on 3/8/17" was added at the bottom of the existing Focus entries in the plan of care. There was not a Focus to address the specifics of R163's psychosocial and spiritual needs related to hospice care. When interviewed on 4/12/17 at 1:44 p.m., registered nurse (RN)-D, the nurse manager for R163, was asked which care plan the facility staff used in caring for R163 regarding hospice. RN-D replied that the facility staff used the hospice	2 830	Corrected	

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2 830	Continued From page 6 provider's Hospice Interdisciplinary Care Plan form as a reference to develop the facility's plan of care, and facility staff then used the facility's plan of care for directing care of a resident on hospice. After survey exit, on 4/14/17, the facility provided, via fax, an unsigned, undated physician's order to discontinue aid services starting 3/14/17, and an unsigned, undated physician's order to discontinue chaplain services and social services starting 3/16/17. The fax dates on the documents identified that the documents had been faxed to the facility on 4/13/17. Also provided was a Spiritual Profile form completed by the facility on 2/27/17, that showed R163 was identified as Christian, however, the specific denomination section was left blank. Section 3. 1. of this form read, "What, if any, of the following spiritual practices or resources have been important to you in the past year?" and the answer to that question that was selected read, "Visit from my clergy person/religious leader or members of my faith community." SUGGESTED METHOD OF CORRECTION: The director of nursing could develop policies and procedures related to development of plan of care for hospice care, educate staff regarding these polices, and audit resident records for compliance to these policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights	21830		5/23/17

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21830	Continued From page 7 Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the	21830		

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21830	Continued From page 8	21830		

resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this

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21830	Continued From page 9 subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 4 residents (R63 and R96) reviewed for choices, were provided with choice in frequency in bathing. Findings include: R63's Minimum Data Set [MDS], dated 2/24/17, revealed R63 required physical help with part of bathing and was cognitively intact. On 4/10/17, at 8:52 a.m. R63 reported not being able to choose how many showers R63 received each week. R63 reported wanting at least two showers each week, as R63 used to shower daily before admission to the facility. R63 added "it was sort of a shock at first" when R63 only was scheduled to get one shower each week at the facility. R63 added, "I guess they haven't got enough people to do more than that" and the one shower a week schedule was "pretty rigid." R63 reported no one ever asked how many showers R63 wanted each week. On 4/12/17, at 8:52 a.m. RN-B reported R63 had received four showers in the past month. RN-B reported she could not recall discussing how many showers R63 wanted each week with R63. RN-B said she would look into it to see if that discussion happened before RN-B started. At	21830	Corrected	

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21830	Continued From page 10 2:43 p.m., RN-B reported she could not find anything related to discussing how many showers R63 wanted each week. RN-B and surveyor then went to R63 and asked how many showers R63 preferred each week. R63 again reported desiring at least two showers each week but thought staff did not have enough time for that. RN-B told R63 she would schedule an additional shower for R63 each week. R63 expressed R63 was very grateful for the added shower. R63's care plan history, last revised 4/12/17, revealed R63 was scheduled for one shower each week, with a revision date of 4/7/17. On 4/12/17, R63's care plan history changed to two showers each week. R63's bathing report for 4/1/17 to 4/12/17 revealed R63 received one shower. R63's Bathing Report for 3/1/17 to 3/30/17 revealed R63 received three showers. R63's bathing report for 2/1/17 to 2/28/17 revealed R63 received three showers. R96's preference for having more than one bath/shower in a week was not accommodated. During interview with R96 on 4/11/17, at 2:49 p.m. R96 reported, would like to have shower at least twice a week, but did not know if that was possible because no staff had asked or discussed it. R96 further stated, preference was to take a shower two times a week and required staff assist due to blindness. On 4/12/17, at 9:48 a.m. R96 confirmed R96 wanted more than one shower a week and that it was not offered or provided by the facility. On 4/11/17, at 2:55 p.m. resident's daughter,	21830		

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21830	Continued From page 11 responded, did not recall staff offering R96 the number of showers preferred each week. Physician orders document revealed R96's diagnoses included cerebral infarction, dorsalgia, major depression and blindness in both eyes. Document review of the form titled, Progress notes: dated 2/22/17, at 2:47 p.m. read, "... Resident requires extensive assist of 1 staff for bathing as [R96] is able to complete part of bath independently but requires assistance for appropriate completion..." Document review of R96's Annual Minimum Data set (MDS) dated 2/16/17, indicated, R96 was able to understand others, able to make self-understood and required physical assistance of one staff in part of bathing activity. The care plan dated 1/20/16, directed staff, "... BATHING: Resident requires extensive assist of one staff to transfer on/off shower/tub chair for weekly bath. Extensive assist of one staff to complete weekly shower/bath. The "North Bath Schedule" sheets, undated, indicated R96 was scheduled for one bath/shower each week on Tuesdays. R96's bathing preferences assessment dated 1/7/17, revealed that the number of baths preferred each week was left unanswered. On 4/11/17, at 2:37 p.m., nursing assistant (NA)-C reported the facility offered one bath/shower each week on Tuesdays for R96 by the morning bath aide. On 4/11/17, at 3:08 p.m., registered nurse (RN)-B	21830		

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21830	Continued From page 12 indicated speaking with R96 regarding number of bath/showers per week and R96 did have choices of how many per week, however RN-B did not document the information in R96's medical record. RN-B further explained that the bathing/shower preference (number of bath/shower per week) was not discussed with R96's daughter, just with R96. Policy and procedure titled Accommodation of resident need, dated February 2013, read, "The resident has the right to reside and receive services in the center with reasonable accommodations of individual needs and preferences..." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that upon admission and periodically, residents are asked about bathing preferences/frequency, and involved with decisions regarding choices. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an	21980		5/23/17

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21980	Continued From page 13 individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of	21980		

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21980	Continued From page 14 the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to report an allegation of abuse that had been reported to staff for 1 of 5 residents (R108) reviewed for abuse. Findings include: During an interview on 4/10/17, at 6:53 p.m. R108 described nursing assistant (NA)-B as "rough and gruff" during transfers. R108 said earlier tonight after dinner, NA-B assisted the resident from the dining room back to the resident's room. R108 used a wheelchair for mobility, and the wheelchair leg was out to the side where R108 could not reach it. R108 asked NA-B to move the leg of the wheelchair closer so that the resident could rest foot on the foot pedal. R108 explained that NA-B did move the wheelchair leg closer as requested, and brought the resident back to the room. After returning to the resident's room, R108 said that NA-B told the resident "you need to show me more respect, you were very rude to me." R108 also described NA-B as "rough" when assisting R108 to move from laying in bed, to sitting up in bed. When asked if R108 reported the incident to staff, the resident confirmed telling registered nurse (RN)-E about what happened. Review of a minimum data set cognitive assessment from the reference date 2/9/17, revealed the facility assessed R108 to be cognitively intact. The facility compiled a list of reported events, and reported allegations of abuse and neglect from	21980	Corrected	

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21980	Continued From page 15 the past twelve months. Review of the list failed to provide evidence that the facility reported or began to investigate R108's allegation. During an interview on 4/12/17, at 11:25 a.m. the administrator and director of nursing (DON) said they were not aware of the allegation from the evening of 4/10/17. After explaining how R108 described NA-B as rough and gruff, and said NA-B told the resident to show more respect, the DON said, "Well that isn't appropriate." The DON confirmed "That is something that should have been reported, and we will do that." The administrator said that normally they talk to the resident about it, and interview the staff, and said they would start to do that immediately. The DON said "RN-E should have reported that to us immediately" and said RN-E would be retrained on reporting. During an interview on 4/12/17, at 2:56 p.m. RN-E confirmed that R108 spoke to her about being upset when NA-B called the resident rude. RN-E said R108 mentioned not wanting NA-B to take care of the resident that night. RN-E said she reported the situation to the charge nurse that evening, who confirmed that NA-B was not scheduled to take care of R108 that evening. Review of the Abuse and Neglect policy and procedure, last revised 11/16, revealed that alleged or suspected violations involving any mistreatment or abuse should be reported immediately to the administrator; or in the absence of the administrator, to the director of nursing services or the director of social services. Review of a submission report revealed the facility reported the incident to the State Agency on 4/12/17, after the interview with the	21980		

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21980	Continued From page 16 administrator and DON on the same date. Based on interview, and document review, the facility failed to report an allegation of abuse that had been reported to staff for 1 of 5 residents (R108) reviewed for abuse. Findings include: During an interview on 4/10/17, at 6:53 p.m. R108 described nursing assistant (NA)-B as "rough and gruff" during transfers. R108 said earlier tonight after dinner, NA-B assisted the resident from the dining room back to the resident's room. R108 used a wheelchair for mobility, and the wheelchair leg was out to the side where R108 could not reach it. R108 asked NA-B to move the leg of the wheelchair closer so that the resident could rest foot on the foot pedal. R108 explained that NA-B did move the wheelchair leg closer as requested, and brought the resident back to the room. After returning to the resident's room, R108 said that NA-B told the resident "you need to show me more respect, you were very rude to me." R108 also described NA-B as "rough" when assisting R108 to move from laying in bed, to sitting up in bed. When asked if R108 reported the incident to staff, the resident confirmed telling registered nurse (RN)-E about what happened. Review of a minimum data set cognitive assessment from the reference date 2/9/17, revealed the facility assessed R108 to be	21980		

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21980	Continued From page 17 cognitively intact. The facility compiled a list of reported events, and reported allegations of abuse and neglect from the past twelve months. Review of the list failed to provide evidence that the facility reported or began to investigate R108's allegation. During an interview on 4/12/17, at 11:25 a.m. the administrator and director of nursing (DON) said they were not aware of the allegation from the evening of 4/10/17. After explaining how R108 described NA-B as rough and gruff, and said NA-B told the resident to show more respect, the DON said, "Well that isn't appropriate." The DON confirmed "That is something that should have been reported, and we will do that." The administrator said that normally they talk to the resident about it, and interview the staff, and said they would start to do that immediately. The DON said "RN-E should have reported that to us immediately" and said RN-E would be retrained on reporting. During an interview on 4/12/17, at 2:56 p.m. RN-E confirmed that R108 spoke to her about being upset when NA-B called the resident rude. RN-E said R108 mentioned not wanting NA-B to take care of the resident that night. RN-E said she reported the situation to the charge nurse that evening, who confirmed that NA-B was not scheduled to take care of R108 that evening. Review of the Abuse and Neglect policy and procedure, last revised 11/16, revealed that alleged or suspected violations involving any mistreatment or abuse should be reported immediately to the administrator; or in the absence of the administrator, to the director of nursing services or the director of social services.	21980		

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	00900	A. BUILDING: _____ B. WING _____	04/13/2017

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21980	Continued From page 18 Review of a submission report revealed the facility reported the incident to the State Agency on 4/12/17, after the interview with the administrator and DON on the same date. SUGGESTED METHOD OF CORRECTION: The Administrator, director of nursing and/or designee could assure that all potential allegations of abuse are immediately reported to appropriate staff, followed through with reporting to State agency and thoroughly investigated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to follow established policies and procedures to report and investigate allegations of abuse for 1 of 5 residents (R108) investigated	21995	Corrected	5/23/17

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21995	Continued From page 19 for abuse. Findings include: Review of the Abuse and Neglect policy and procedure, last revised 11/16, revealed that alleged or suspected violations involving any mistreatment or abuse should be reported immediately to the administrator; or in the absence of the administrator, to the director of nursing services or the director of social services. The procedure required the following: If an employee receives an allegation of abuse, the employee is required to report to a supervisor. The charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required, and complete an initial investigation. If this is an allegation of employee to resident abuse, the employee will be removed from providing direct care to all residents. Additionally, the employee will be placed on suspension pending the results of the internal investigation. A designated individual will then complete the documentation in the medical record. Allegations of abuse, or mistreatment will be reported no later than two hours after the allegation is made to the administrator, and to other officials in accordance with state law. The investigative team (social worker, administrator and director of nursing services) will review all incidents no later than the next working day following the incident. During an interview on 4/10/17, at 6:53 p.m. R108 described nursing assistant (NA)-B as "rough and gruff" during transfers. R108 said earlier tonight after dinner, NA-B assisted the resident from the dining room back to the resident's room. R108 used a wheelchair for mobility, and the wheelchair	21995		

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21995	Continued From page 20	21995		

leg was out to the side where R108 could not reach it. R108 asked NA-B to move the leg of the wheelchair closer so that the resident could rest foot on the foot pedal. R108 explained that NA-B did move the wheelchair leg closer as requested, and brought the resident back to the room. After returning to the resident's room, R108 said that NA-B told the resident "you need to show me more respect, you were very rude to me." R108 also described NA-B as "rough" when assisting R108 to move from laying in bed, to sitting up in bed. When asked if R108 reported the incident to staff, the resident confirmed telling registered nurse (RN)-E about what happened.

Review of a minimum data set cognitive assessment from reference date 2/9/17, revealed the facility assessed R108 to be cognitively intact.

The facility compiled a list of reported events, and reported allegations of abuse and neglect from the past twelve months. Review of the list failed to provide evidence that the facility reported or began to investigate R108's allegation.

During an interview on 4/12/17, at 11:25 a.m. the administrator and director of nursing (DON) said they were not aware of the allegation from the evening of 4/10/17. After explaining how R108 described NA-B as rough and gruff, and said NA-B told the resident to show more respect, the DON said, "Well that isn't appropriate." The DON confirmed "That is something that should have been reported, and we will do that." The administrator said that normally they talk to the resident about it, and interview the staff, and said they would start to do that immediately. The DON said "RN-E should have reported that to us immediately" and said RN-E would be retrained on reporting.

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21995	Continued From page 21 During an interview on 4/12/17, at 2:56 p.m. RN-E confirmed that R108 spoke to her about being upset when NA-B called the resident rude. RN-E said R108 mentioned not wanting NA-B to take care of the resident that night. RN-E said she reported the situation to the charge nurse that evening, who confirmed that NA-B was not scheduled to take care of R108 that evening. Review of a submission report revealed the facility reported the incident to the State Agency on 4/12/17, after the interview with the administrator and DON on the same date. SUGGESTED METHOD OF CORRECTION: The Administrator, director of nursing and/or designee could assure that staff follow the policy and procedure for reporting potential allegations of abuse to the administrator and follow protocol for reporting to the State agency and conducting a thourough investigaton. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21995		

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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 April 10, 11, 12 and 13, 2017, 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	2 000		

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2 000	Continued From page 2 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.	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 document review and interview, the facility failed to develop an individualized, comprehensive plan of care regarding hospice care for 1 of 1 resident (R163) in the sample reviewed for hospice. Findings include: Document review revealed a Hospice Admission/Verbal Certification Orders form for R163, showing the resident was enrolled in hospice care for the period of 3/8/17 to 6/5/17, with the admitting diagnosis of late effect of CVA (cerebral vascular accident) with dysphagia and	2 560		

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2 560	Continued From page 3	2 560		

aphasia (difficult swallowing and language expression).

The document also contained a current plan of care from the facility, dated 3/23/17, and a Hospice Interdisciplinary Care Plan form, dated 3/9/17, from the hospice provider. The facility's plan of care had two Focus related to hospice care that read, "The resident has a terminal prognosis R/T [related to] DX [diagnosis] of CVA with aphasia and dysphagia," and "The resident wishes to remain on TCU [transitional care unit] with hospice services." Information such as, "Hospice care initiated on 3/8/17" was added at the bottom of the existing Focus entries in the plan of care. There was not a Focus to address the specifics of R163's psychosocial and spiritual needs related to hospice care.

When interviewed on 4/12/17 at 1:44 p.m., registered nurse (RN)-D, the nurse manager for R163, was asked which care plan the facility staff used in caring for R163 regarding hospice. RN-D replied that the facility staff used the hospice provider's Hospice Interdisciplinary Care Plan form as a reference to develop the facility's plan of care, and facility staff then used the facility's plan of care for directing care of a resident on hospice.

After survey exit, on 4/14/17, the facility provided, via fax, an unsigned, undated physician's order to discontinue aid services starting 3/14/17, and an unsigned, undated physician's order to discontinue chaplain services and social services starting 3/16/17. The fax dates on the documents identified that the documents had been faxed to the facility on 4/13/17, the date of survey exit. Also provided was a Spiritual Profile form completed by the facility on 2/27/17, that showed

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2 560	Continued From page 4 R163 was identified as Christian, however, the specific denomination section was left blank. Section 3. 1. of this form read, "What, if any, of the following spiritual practices or resources have been important to you in the past year?" and the answer to that question that was selected read, "Visit from my clergy person/religious leader or members of my faith community." SUGGESTED METHOD OF CORRECTION: The facility director of nursing and/or designee could assure that individualized, comprehensive plans of care are developed to assure coordination of care for residents receiving hospice care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
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.	2 830		

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2 830	Continued From page 5 This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to develop an individualized, comprehensive plan of care regarding hospice care for 1 of 1 resident (R163) in the sample reviewed for hospice. Findings include: Document review revealed a Hospice Admission/Verbal Certification Orders form for R163, showing the resident was enrolled in hospice care for the period of 3/8/17 to 6/5/17, with the admitting diagnosis of late effect of CVA (cerebral vascular accident) with dysphagia and aphasia (difficult swallowing and language expression). The document also contained a current plan of care from the facility, dated 3/23/17, and a Hospice Interdisciplinary Care Plan form, dated 3/9/17, from the hospice provider. The facility's plan of care had two Focus related to hospice care that read, "The resident has a terminal prognosis R/T [related to] DX [diagnosis] of CVA with aphasia and dysphagia," and "The resident wishes to remain on TCU [transitional care unit] with hospice services." Information such as, "Hospice care initiated on 3/8/17" was added at the bottom of the existing Focus entries in the plan of care. There was not a Focus to address the specifics of R163's psychosocial and spiritual needs related to hospice care. When interviewed on 4/12/17 at 1:44 p.m., registered nurse (RN)-D, the nurse manager for R163, was asked which care plan the facility staff used in caring for R163 regarding hospice. RN-D replied that the facility staff used the hospice	2 830		

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2 830	Continued From page 6 provider's Hospice Interdisciplinary Care Plan form as a reference to develop the facility's plan of care, and facility staff then used the facility's plan of care for directing care of a resident on hospice. After survey exit, on 4/14/17, the facility provided, via fax, an unsigned, undated physician's order to discontinue aid services starting 3/14/17, and an unsigned, undated physician's order to discontinue chaplain services and social services starting 3/16/17. The fax dates on the documents identified that the documents had been faxed to the facility on 4/13/17. Also provided was a Spiritual Profile form completed by the facility on 2/27/17, that showed R163 was identified as Christian, however, the specific denomination section was left blank. Section 3. 1. of this form read, "What, if any, of the following spiritual practices or resources have been important to you in the past year?" and the answer to that question that was selected read, "Visit from my clergy person/religious leader or members of my faith community." SUGGESTED METHOD OF CORRECTION: The director of nursing could develop policies and procedures related to development of plan of care for hospice care, educate staff regarding these polices, and audit resident records for compliance to these policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights	21830		

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21830	Continued From page 7 Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the	21830		

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resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117

(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
21830	Continued From page 9	21830		

subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure 2 of 4 residents (R63 and R96) reviewed for choices, were provided with choice in frequency in bathing.

Findings include:

R63's Minimum Data Set [MDS], dated 2/24/17, revealed R63 required physical help with part of bathing and was cognitively intact.

On 4/10/17, at 8:52 a.m. R63 reported not being able to choose how many showers R63 received each week. R63 reported wanting at least two showers each week, as R63 used to shower daily before admission to the facility. R63 added "it was sort of a shock at first" when R63 only was scheduled to get one shower each week at the facility. R63 added, "I guess they haven't got enough people to do more than that" and the one shower a week schedule was "pretty rigid." R63 reported no one ever asked how many showers R63 wanted each week.

On 4/12/17, at 8:52 a.m. RN-B reported R63 had received four showers in the past month. RN-B reported she could not recall discussing how many showers R63 wanted each week with R63. RN-B said she would look into it to see if that discussion happened before RN-B started. At

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21830	Continued From page 10 2:43 p.m., RN-B reported she could not find anything related to discussing how many showers R63 wanted each week. RN-B and surveyor then went to R63 and asked how many showers R63 preferred each week. R63 again reported desiring at least two showers each week but thought staff did not have enough time for that. RN-B told R63 she would schedule an additional shower for R63 each week. R63 expressed R63 was very grateful for the added shower. R63's care plan history, last revised 4/12/17, revealed R63 was scheduled for one shower each week, with a revision date of 4/7/17. On 4/12/17, R63's care plan history changed to two showers each week. R63's bathing report for 4/1/17 to 4/12/17 revealed R63 received one shower. R63's Bathing Report for 3/1/17 to 3/30/17 revealed R63 received three showers. R63's bathing report for 2/1/17 to 2/28/17 revealed R63 received three showers. R96's preference for having more than one bath/shower in a week was not accommodated. During interview with R96 on 4/11/17, at 2:49 p.m. R96 reported, would like to have shower at least twice a week, but did not know if that was possible because no staff had asked or discussed it. R96 further stated, preference was to take a shower two times a week and required staff assist due to blindness. On 4/12/17, at 9:48 a.m. R96 confirmed R96 wanted more than one shower a week and that it was not offered or provided by the facility. On 4/11/17, at 2:55 p.m. resident's daughter,	21830		

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responded, did not recall staff offering R96 the number of showers preferred each week.

Physician orders document revealed R96's diagnoses included cerebral infarction, dorsalgia, major depression and blindness in both eyes.

Document review of the form titled, Progress notes: dated 2/22/17, at 2:47 p.m. read, "... Resident requires extensive assist of 1 staff for bathing as [R96] is able to complete part of bath independently but requires assistance for appropriate completion..."

Document review of R96's Annual Minimum Data set (MDS) dated 2/16/17, indicated, R96 was able to understand others, able to make self-understood and required physical assistance of one staff in part of bathing activity.

The care plan dated 1/20/16, directed staff, "... BATHING: Resident requires extensive assist of one staff to transfer on/off shower/tub chair for weekly bath. Extensive assist of one staff to complete weekly shower/bath.

The "North Bath Schedule" sheets, undated, indicated R96 was scheduled for one bath/shower each week on Tuesdays.

R96's bathing preferences assessment dated 1/7/17, revealed that the number of baths preferred each week was left unanswered.

On 4/11/17, at 2:37 p.m., nursing assistant (NA)-C reported the facility offered one bath/shower each week on Tuesdays for R96 by the morning bath aide.

On 4/11/17, at 3:08 p.m., registered nurse (RN)-B

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21830	Continued From page 12 indicated speaking with R96 regarding number of bath/showers per week and R96 did have choices of how many per week, however RN-B did not document the information in R96's medical record. RN-B further explained that the bathing/shower preference (number of bath/shower per week) was not discussed with R96's daughter, just with R96. Policy and procedure titled Accommodation of resident need, dated February 2013, read, "The resident has the right to reside and receive services in the center with reasonable accommodations of individual needs and preferences..." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that upon admission and periodically, residents are asked about bathing preferences/frequency, and involved with decisions regarding choices. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an	21980		

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21980	Continued From page 13 individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of	21980		

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21980	Continued From page 14 the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to report an allegation of abuse that had been reported to staff for 1 of 5 residents (R108) reviewed for abuse. Findings include: During an interview on 4/10/17, at 6:53 p.m. R108 described nursing assistant (NA)-B as "rough and gruff" during transfers. R108 said earlier tonight after dinner, NA-B assisted the resident from the dining room back to the resident's room. R108 used a wheelchair for mobility, and the wheelchair leg was out to the side where R108 could not reach it. R108 asked NA-B to move the leg of the wheelchair closer so that the resident could rest foot on the foot pedal. R108 explained that NA-B did move the wheelchair leg closer as requested, and brought the resident back to the room. After returning to the resident's room, R108 said that NA-B told the resident "you need to show me more respect, you were very rude to me." R108 also described NA-B as "rough" when assisting R108 to move from laying in bed, to sitting up in bed. When asked if R108 reported the incident to staff, the resident confirmed telling registered nurse (RN)-E about what happened. Review of a minimum data set cognitive assessment from the reference date 2/9/17, revealed the facility assessed R108 to be cognitively intact. The facility compiled a list of reported events, and reported allegations of abuse and neglect from	21980		

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21980	Continued From page 15 the past twelve months. Review of the list failed to provide evidence that the facility reported or began to investigate R108's allegation. During an interview on 4/12/17, at 11:25 a.m. the administrator and director of nursing (DON) said they were not aware of the allegation from the evening of 4/10/17. After explaining how R108 described NA-B as rough and gruff, and said NA-B told the resident to show more respect, the DON said, "Well that isn't appropriate." The DON confirmed "That is something that should have been reported, and we will do that." The administrator said that normally they talk to the resident about it, and interview the staff, and said they would start to do that immediately. The DON said "RN-E should have reported that to us immediately" and said RN-E would be retrained on reporting. During an interview on 4/12/17, at 2:56 p.m. RN-E confirmed that R108 spoke to her about being upset when NA-B called the resident rude. RN-E said R108 mentioned not wanting NA-B to take care of the resident that night. RN-E said she reported the situation to the charge nurse that evening, who confirmed that NA-B was not scheduled to take care of R108 that evening. Review of the Abuse and Neglect policy and procedure, last revised 11/16, revealed that alleged or suspected violations involving any mistreatment or abuse should be reported immediately to the administrator; or in the absence of the administrator, to the director of nursing services or the director of social services. Review of a submission report revealed the facility reported the incident to the State Agency on 4/12/17, after the interview with the	21980		

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21980	Continued From page 16 administrator and DON on the same date. Based on interview, and document review, the facility failed to report an allegation of abuse that had been reported to staff for 1 of 5 residents (R108) reviewed for abuse. Findings include: During an interview on 4/10/17, at 6:53 p.m. R108 described nursing assistant (NA)-B as "rough and gruff" during transfers. R108 said earlier tonight after dinner, NA-B assisted the resident from the dining room back to the resident's room. R108 used a wheelchair for mobility, and the wheelchair leg was out to the side where R108 could not reach it. R108 asked NA-B to move the leg of the wheelchair closer so that the resident could rest foot on the foot pedal. R108 explained that NA-B did move the wheelchair leg closer as requested, and brought the resident back to the room. After returning to the resident's room, R108 said that NA-B told the resident "you need to show me more respect, you were very rude to me." R108 also described NA-B as "rough" when assisting R108 to move from laying in bed, to sitting up in bed. When asked if R108 reported the incident to staff, the resident confirmed telling registered nurse (RN)-E about what happened. Review of a minimum data set cognitive assessment from the reference date 2/9/17, revealed the facility assessed R108 to be	21980		

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21980	Continued From page 17 cognitively intact. The facility compiled a list of reported events, and reported allegations of abuse and neglect from the past twelve months. Review of the list failed to provide evidence that the facility reported or began to investigate R108's allegation. During an interview on 4/12/17, at 11:25 a.m. the administrator and director of nursing (DON) said they were not aware of the allegation from the evening of 4/10/17. After explaining how R108 described NA-B as rough and gruff, and said NA-B told the resident to show more respect, the DON said, "Well that isn't appropriate." The DON confirmed "That is something that should have been reported, and we will do that." The administrator said that normally they talk to the resident about it, and interview the staff, and said they would start to do that immediately. The DON said "RN-E should have reported that to us immediately" and said RN-E would be retrained on reporting. During an interview on 4/12/17, at 2:56 p.m. RN-E confirmed that R108 spoke to her about being upset when NA-B called the resident rude. RN-E said R108 mentioned not wanting NA-B to take care of the resident that night. RN-E said she reported the situation to the charge nurse that evening, who confirmed that NA-B was not scheduled to take care of R108 that evening. Review of the Abuse and Neglect policy and procedure, last revised 11/16, revealed that alleged or suspected violations involving any mistreatment or abuse should be reported immediately to the administrator; or in the absence of the administrator, to the director of nursing services or the director of social services.	21980		

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21980	Continued From page 18 Review of a submission report revealed the facility reported the incident to the State Agency on 4/12/17, after the interview with the administrator and DON on the same date. SUGGESTED METHOD OF CORRECTION: The Administrator, director of nursing and/or designee could assure that all potential allegations of abuse are immediately reported to appropriate staff, followed through with reporting to State agency and thoroughly investigated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to follow established policies and procedures to report and investigate allegations of abuse for 1 of 5 residents (R108) investigated	21995		

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21995	Continued From page 19 for abuse. Findings include: Review of the Abuse and Neglect policy and procedure, last revised 11/16, revealed that alleged or suspected violations involving any mistreatment or abuse should be reported immediately to the administrator; or in the absence of the administrator, to the director of nursing services or the director of social services. The procedure required the following: If an employee receives an allegation of abuse, the employee is required to report to a supervisor. The charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required, and complete an initial investigation. If this is an allegation of employee to resident abuse, the employee will be removed from providing direct care to all residents. Additionally, the employee will be placed on suspension pending the results of the internal investigation. A designated individual will then complete the documentation in the medical record. Allegations of abuse, or mistreatment will be reported no later than two hours after the allegation is made to the administrator, and to other officials in accordance with state law. The investigative team (social worker, administrator and director of nursing services) will review all incidents no later than the next working day following the incident. During an interview on 4/10/17, at 6:53 p.m. R108 described nursing assistant (NA)-B as "rough and gruff" during transfers. R108 said earlier tonight after dinner, NA-B assisted the resident from the dining room back to the resident's room. R108 used a wheelchair for mobility, and the wheelchair	21995		

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21995	Continued From page 20	21995		

leg was out to the side where R108 could not reach it. R108 asked NA-B to move the leg of the wheelchair closer so that the resident could rest foot on the foot pedal. R108 explained that NA-B did move the wheelchair leg closer as requested, and brought the resident back to the room. After returning to the resident's room, R108 said that NA-B told the resident "you need to show me more respect, you were very rude to me." R108 also described NA-B as "rough" when assisting R108 to move from laying in bed, to sitting up in bed. When asked if R108 reported the incident to staff, the resident confirmed telling registered nurse (RN)-E about what happened.

Review of a minimum data set cognitive assessment from reference date 2/9/17, revealed the facility assessed R108 to be cognitively intact.

The facility compiled a list of reported events, and reported allegations of abuse and neglect from the past twelve months. Review of the list failed to provide evidence that the facility reported or began to investigate R108's allegation.

During an interview on 4/12/17, at 11:25 a.m. the administrator and director of nursing (DON) said they were not aware of the allegation from the evening of 4/10/17. After explaining how R108 described NA-B as rough and gruff, and said NA-B told the resident to show more respect, the DON said, "Well that isn't appropriate." The DON confirmed "That is something that should have been reported, and we will do that." The administrator said that normally they talk to the resident about it, and interview the staff, and said they would start to do that immediately. The DON said "RN-E should have reported that to us immediately" and said RN-E would be retrained on reporting.

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21995	Continued From page 21 During an interview on 4/12/17, at 2:56 p.m. RN-E confirmed that R108 spoke to her about being upset when NA-B called the resident rude. RN-E said R108 mentioned not wanting NA-B to take care of the resident that night. RN-E said she reported the situation to the charge nurse that evening, who confirmed that NA-B was not scheduled to take care of R108 that evening. Review of a submission report revealed the facility reported the incident to the State Agency on 4/12/17, after the interview with the administrator and DON on the same date. SUGGESTED METHOD OF CORRECTION: The Administrator, director of nursing and/or designee could assure that staff follow the policy and procedure for reporting potential allegations of abuse to the administrator and follow protocol for reporting to the State agency and conducting a thourough investigaton. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21995		