DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		DICARE/MEDICA TI - TO BE COMI						D: VTQP Facility ID: 00900
I. MEDICARE/MEDICAID PROVIDER N (L1) 245221 2.STATE VENDOR OR MEDICAID NO. (L2) 861017700	Э.	3. NAME AND ADE (L3) GOOD SAMA (L4) 550 ROSELA (L5) SAINT PAUL	ARITAN SOCIET WN AVENUE EA	Y - MAPL		55117	 TYPE OF ACTION: Initial Termination Validation 	 Recertification CHOW Complaint
 EFFECTIVE DATE CHANGE OF OWN (L9) 	IERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	 7. On-Site Visit 8. Full Survey After Co 	9. Other omplaint
6. DATE OF SURVEY 06/22/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 12/31	DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 76 (L37) (L38)	76 (L18) 76 (L17) 19 SNF (L39)	B. Not in Comp	ce With uirements	rs:	2. Techi 3. 24 Hi 4. 7-Da 5. Life :	nical Personnel our RN y RN (Rural SNF) Safety Code A* IEETS	Following Requirements: 6. Scope of Serv 7. Medical Direc 8. Patient Room : 9. Beds/Room (L12) (L15)	ices Limit ctor
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELL.	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	/EY AGENCY APF	PROVAL	Date:
Mary Heim,	HFE NE II		06/22/2017	(L19)	Kate John	<u>sTon, Pro</u>	gram Specialist	10/05/2017 (L20)
	PART II - TO	BE COMPLETEI	O BY HCFA RE	GIONAL	OFFICE OR S	INGLE STAT	E AGENCY	
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible 	icipate		PLIANCE WITH CI TS ACT:	VIL	2. 0		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	A-1513)
	(L21)							
22. ORIGINAL DATE								
OF PARTICIPATION 04/01/1978 (L24)	23. LTC AGREEM BEGINNING (L41)		4. LTC AGREEMEN ENDING DATE (L25)		26. TERMINAT <u>VOLUNTARY</u> 01-Merger, Closur 02-Dissatisfaction	00	<u>INVOLUN</u> 05-Fail to M	L30) <u>FARY</u> eet Health/Safety eet Agreement
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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



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:

Good Samaritan Society - Maplewood July 11, 2017 Page 2

• 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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>



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

Good Samaritan Society - Maplewood June 20, 2017 Page 2

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 <u>https://dab.efile.hhs.gov</u> 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

Good Samaritan Society - Maplewood June 20, 2017 Page 3 Representative by phone at (312) 353-1502 or by e-mail at <u>Tamika.Brown@cms.hhs.gov</u>.

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Good Samaritan Society - Maplewood June 20, 2017 Page 4

> Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

¥ ato Compton

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



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,

Kumala 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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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



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:

Good Samaritan Society - Maplewood July 11, 2017 Page 2

• 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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>



Electronically delivered June 20, 2017

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RE: Project Number S5221028

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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

Good Samaritan Society - Maplewood June 20, 2017 Page 2

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 <u>https://dab.efile.hhs.gov</u> 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

Good Samaritan Society - Maplewood June 20, 2017 Page 3 Representative by phone at (312) 353-1502 or by e-mail at <u>Tamika.Brown@cms.hhs.gov</u>.

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Good Samaritan Society - Maplewood June 20, 2017 Page 4

> Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

¥ ato Compton

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



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,

Kumala 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		ICARE/MEDICA ' I - TO BE COM						ID: VTQP Facility ID: 00900
I. MEDICARE/MEDICAID PROVIDER NO. (L1) 245221 2.STATE VENDOR OR MEDICAID NO. (L2) 861017700).	3. NAME AND ADI (L3) GOOD SAMA (L4) 550 ROSELA (L5) SAINT PAUL	ARITAN SOCIET WN AVENUE EA	Y - MAPL		55117	 TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	ERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other omplaint
 6. DATE OF SURVEY 04/13/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 76 (L37) 16. STATE SURVEY AGENCY REMARK	76 (L18) 76 (L17) 19 SNF (L39) S (IF APPLICABLE S	X B. Not in Comp Requirements a ICF (L42)	ace With quirements Based On: cceptable POC pliance with Program und/or Applied Waive IID (L43)	IS:	2. Techn 3. 24 He 4. 7-Day 5. Life \$	nical Personnel our RN y RN (Rural SNF) Safety Code B* IEETS	Following Requirements: 6. Scope of Serv 7. Medical Direc 8. Patient Room 9. Beds/Room (L12) (L15)	vices Limit ctor
	5 (II AITEICABLE 5		AIIONDAIL).					
17. SURVEYOR SIGNATURE	a, HFE NE I	Date :	05/22/2017			NEY AGENCY API	ogram Speciali	Date: St 05/30/2017
		BE COMPLETEI	D BY HCFA RE	(L19) GIONAL		· · · · · · · · · · · · · · · · · · ·	<u> </u>	(L20)
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible	cipate (L21)		PLIANCE WITH CI ITS ACT:	VIL	2. 0		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCF.	A-1513)
22. ORIGINAL DATE OF PARTICIPATION 04/01/1978 (L24)	23. LTC AGREEMI BEGINNING 1 (L41)		 LTC AGREEMEN ENDING DATE (L25) 		26. TERMINAT <u>VOLUNTARY</u> 01-Merger, Closur 02-Dissatisfaction	00	INVOLUN 05-Fail to M	(L30) <u>TARY</u> leet Health/Safety leet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension o B. Rescind Sus	of Admissions:	(L44) (L45)		03-Risk of Involun 04-Other Reason fo		<u>OTHER</u> 07-Provider 00-Active	· Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/C.			30. REMARKS			
	(L28)	00140		(L31)				
31. RO RECEIPT OF CMS-1539	32	DETERMINATION C	OF APPROVAL DAT	E				
	(L32)			(L33)	DETERMINA	TION APPRO	VAL	



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:

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

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

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

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

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

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

Good Samaritan Society - Maplewood April 25, 2017 Page 4

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

Good Samaritan Society - Maplewood April 25, 2017 Page 6

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,

Inston

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES						APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUC				E SURVEY IPLETED
		245221	B. WING _				04/	13/2017
NAME OF F	PROVIDER OR SUPPLIER				ESS, CITY, STATE, Z		-	
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		550 ROSELAV	NN AVENUE EAST ., MN 55117	Г		
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F 000	INITIAL COMMENT	rs	F 00	0				
	11, 12, and 13, 201 correction (POC) w compliance upon th Because you are en signature is not req							
F 225 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with 1)-(4) INVESTIGATE/REPORT DIVIDUALS	F 22	5				5/23/17
	483.12(a) The facili	ty must-						
	(3) Not employ or o who-	therwise engage individuals						
		d guilty of abuse, neglect, propriation of property, or court of law;						
	nurse aide registry	ing entered into the State concerning abuse, neglect, atment of residents or their property; or						
	or her professional body as a result of	ary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or resident property.						
LABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE			(X6) DATE
Electron	ically Signed							05/03/2017

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

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245221	B. WING _			04/ [.]	13/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- MAPLEWOOD			50 ROSELAWN AVENUE EAST AINT PAUL, MN 55117		
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F 225	Continued From pa	ge 1	F 2	25			
	licensing authorities actions by a court of which would indicat nurse aide or other (c) In response to a exploitation, or mist (1) Ensure that all a abuse, neglect, exp including injuries of	ate nurse aide registry or s any knowledge it has of of law against an employee, te unfitness for service as a facility staff. allegations of abuse, neglect, treatment, the facility must: alleged violations involving ploitation or mistreatment, unknown source and resident property, are					
	reported immediate after the allegation cause the allegation serious bodily injury the events that caus abuse and do not re the administrator of officials (including to adult protective ser- for jurisdiction in lor	Ally, but not later than 2 hours is made, if the events that in involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to if the facility and to other o the State Survey Agency and vices where state law provides ing-term care facilities) in ate law through established					
	thoroughly investiga	that all alleged violations are ated. potential abuse, neglect,					
	exploitation, or mist investigation is in pr (4) Report the resul administrator or his	reatment while the rogress. Its of all investigations to the					
	with State law, inclu	uding to the State Survey					

If continuation sheet Page 2 of 19

		AND HUMAN SERVICES			FORM	05/22/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
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GOOD SA	AMARITAN SOCIETY	- MAPLEWOOD		550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117		
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F 225	if the alleged violati corrective action m This REQUIREMEN by: Based on interview facility failed to reported (R108) reviewed for Findings include: During an interview described nursing a gruff" during transfe after dinner, NA-B a dining room back to used a wheelchair f leg was out to the s reach it. R108 aske wheelchair closer s foot on the foot ped did move the wheel and brought the resi returning to the resid more respect, you w also described NA- R108 to move from bed. When asked if staff, the resident c nurse (RN)-E about	orking days of the incident, and on is verified appropriate ust be taken. NT is not met as evidenced <i>x</i> , and document review, the ort an allegation of abuse that to staff for 1 of 5 residents r abuse. To n 4/10/17, at 6:53 p.m. R108 assistant (NA)-B as "rough and ers. R108 said earlier tonight assisted the resident from the o the resident's room. R108 for mobility, and the wheelchair ide where R108 could not the NA-B to move the leg of the o that the resident could rest lal. R108 explained that NA-B lchair leg closer as requested, sident back to the room. After ident's room, R108 said that ent "you need to show me were very rude to me." R108 B as "rough" when assisting laying in bed, to sitting up in f R108 reported the incident to onfirmed telling registered	F 22	F225 483.12 (a) (3)(4)(c)(1)-(4 Investigate/Report Allegations/ Corrective Action for resident F The concern from R108 was re- immediately to OHFC and the nursing assistant was removed care of residents and was susp pending investigation. The faci- immediately started an internal investigation of the allegation. notified immediately that the nu assistant would not be taking of and was updated on the proce- their concerns have been addr How to identify other residents same issue The facility performed interview residents that the alleged nursi assistant had also cared for an issues were found. Facility sta the established policy and proo abuse and neglect and will rep or suspected violations involvir mistreatment or abuse immedi administrator; or in the absenc administrator, to the director of services or the director of social If an employee receives an alle abuse the employee is required	Individuals A108 eported alleged I from all bended lity R108 was ursing are of them ss and that essed. with the <i>v</i> s of the ng d no other ff will follow eedure for ort alleged ng any ately to the e of the nursing al services. egation of	
	revealed the facility cognitively intact.	d a list of reported events, and		to a supervisor. The charge nu licensed nurse will be notified immediately, assess the situati determine whether any emerge	rse or on to	

Facility ID: 00900

If continuation sheet Page 3 of 19

		& MEDICAID SERVICES			ON	<u>/IB NO.</u>	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (SURVEY PLETED
		245221	B. WING _			04/1	3/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		-	50 ROSELAWN AVENUE EAST AINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 225	reported allegations	age 3 s of abuse and neglect from nths. Review of the list failed	F 2:	25	treatment or action is required, and complete an initial investigation. If th	nis is	
	to provide evidence began to investigat	e that the facility reported or e R108's allegation.			an allegation of employee to residen abuse, the employee will be remove from providing direct care to all resid	nt ed dents.	
	administrator and d they were not awar evening of 4/10/17.	on 4/12/17, at 11:25 a.m. the lirector of nursing (DON) said e of the allegation from the After explaining how R108			Additionally the employee will be pla on suspension pending the results o internal investigation. A designated individual will then complete the	of the	
	NA-B told the residence DON said, "Well the	rough and gruff, and said ent to show more respect, the at isn't appropriate." The DON something that should have			documentation in the medical record Allegations of abuse or mistreatment be reported no later than two hours the allegation is made to the	nt will	
	administrator said t resident about it, ar they would start to	we will do that." The that normally they talk to the nd interview the staff, and said do that immediately. The DON			administrator, and to other officials in accordance with state law. The investigative team (social worker, administrator, and director of nursing	g	
		have reported that to us aid RN-E would be retrained			services) will review all incidents no than the next working day following t incident. Recurrence will be prevented by	the	
	RN-E confirmed that being upset when N RN-E said R108 m	v on 4/12/17, at 2:56 p.m. at R108 spoke to her about NA-B called the resident rude. entioned not wanting NA-B to			All facility staff will receive re-educat the established policy and procedure Abuse and Neglect. The facility will continue to provide all new staff with	e for า	
	she reported the sit that evening, who c	sident that night. RN-E said tuation to the charge nurse confirmed that NA-B was not care of R108 that evening.			education during their general orient on the established policy and proceed for Abuse and Neglect and all staff v continue to receive re-education on	dure vill the	
	procedure, last revi	e and Neglect policy and ised 11/16, revealed that ed violations involving any			policy and procedure for Abuse and Neglect annually. The facility will cor to enforce the Abuse and Neglect Po and Procedure. Audits will be condu	ntinue olicy	
	mistreatment or ab immediately to the absence of the adn	use should be reported administrator; or in the ninistrator, to the director of the director of social services.			to prevent recurrence as outlined be These issues will be monitored in the following manner The Director of Nursing, Nurse Man	elow. e	
	-	ssion report revealed the			and Social Service will perform audii interviewing residents for concerns.	ts by	

Facility ID: 00900

		E & MEDICAID SERVICES			IO	-	APPROVED 0938-0391
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245221	B. WING			04 /-	13/2017
NAME OF PROVIDER OR SU	PPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SAMARITAN SO	CIETY	- MAPLEWOOD			50 ROSELAWN AVENUE EAST AINT PAUL, MN 55117		
PREFIX (EACH DE	ICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226 SS=D 483.12(b)(1) DEVELOP/I POLICIES 483.12 (b) The facil written polici (1) Prohibit a exploitation resident pro (2) Establish investigate a (3) Include tt §483.95, (c) Abuse, n the freedom requirement provide train educates sta	ed the fiter the and l and l and l and pro- fresti- perty, polici ny suc- aining eglect from a s in § 4 ng to ff on-	age 4 e incident to the State Agency he interview with the DON on the same date. 83.95(c)(1)-(3) ENT ABUSE/NEGLECT, ETC est develop and implement d procedures that: event abuse, neglect, and dents and misappropriation of es and procedures to ch allegations, and as required at paragraph , and exploitation. In addition to abuse, neglect, and exploitation 483.12, facilities must also their staff that at a minimum t constitute abuse, neglect,	F 2		there are concerns, the interviewer ask the resident in the interview if th concern has been reported to a sta member. Concerns brought up duri audit interviews will be addressed, reported and investigated per the A and Neglect policy and procedure. audits will be completed weekly for month, monthly for one quarter, and quarterly. Audit results will be broug the quality assurance committee for further review as needed.	his ff ng buse These one d then ght to	5/23/17

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE	E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COM	PLETED
		245221	B. WING _		0 4/ ⁻	13/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 226	Continued From pa	ae 5	F 22	26		
		isappropriation of resident				
		or reporting incidents of abuse, n, or the misappropriation of				
	prevention.	anagement and resident abuse				
	Based on docume facility failed to follo procedures to repo	nt review and interview, the ow established policies and rt and investigate allegations residents (R108) investigated		F226 483.12 (b)(1)-(3), 483.95(c) Develop/Implement abuse/Negleo Policies		
	for abuse. Findings include:	(, j		Corrective Action for resident R10 The concern from R108 was repo immediately to OHFC and the alle	rted	
	procedure, last revi alleged or suspecter mistreatment or ab immediately to the absence of the adn nursing services or The procedure requ employee receives	e and Neglect policy and sed 11/16, revealed that ed violations involving any use should be reported administrator; or in the ninistrator, to the director of the director of social services. uired the following: If an an allegation of abuse, the		nursing assistant was removed fro care of residents and was susper pending investigation. The facility immediately started an internal investigation of the allegation. R1 notified immediately that the nursi assistant would not be taking care and was updated on the process their concerns have been address How to identify other residents wit	ded 08 was ng of them and that sed.	
	The charge nurse of notified immediately determine whether action is required, a investigation. If this to resident abuse, t from providing direc Additionally, the em	ed to report to a supervisor. or licensed nurse will be y, assess the situation to any emergency treatment or and complete an initial is an allegation of employee he employee will be removed ct care to all residents. aployee will be placed on g the results of the internal signated individual will then		same issue The facility performed interviews of residents that the alleged nursing assistant had also cared for and r issues were found. Facility staff w the established policy and proced abuse and neglect and will report or suspected violations involving a mistreatment or abuse immediate administrator; or in the absence of	to other vill follow ure for alleged any ly to the	

Facility ID: 00900

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT				0938-039 SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245221	B. WING _			04/1	3/2017
IAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- MAPLEWOOD			50 ROSELAWN AVENUE EAST AINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 226	Continued From pa	ige 6	F 22	26			
		nentation in the medical			services or the director of social serv	vices.	
	record. Allegations	of abuse, or mistreatment will			If an employee receives an allegatior	n of	
		r than two hours after the			abuse the employee is required to re	eport	
		to the administrator, and to			to a supervisor. The charge nurse or	•	
		cordance with state law. The			licensed nurse will be notified		
		(social worker, administrator sing services) will review all			immediately, assess the situation to determine whether any emergency		
		an the next working day			treatment or action is required, and		
	following the incide	0,			complete an initial investigation. If thi	is is	
	Ū				an allegation of employee to resident		
		on 4/10/17, at 6:53 p.m. R108			abuse, the employee will be removed		
		assistant (NA)-B as "rough and			from providing direct care to all reside		
		ers. R108 said earlier tonight assisted the resident from the			Additionally the employee will be place on suspension pending the results of		
		the resident's room. R108			internal investigation. A designated	i uie	
		for mobility, and the wheelchair			individual will then complete the		
	leg was out to the s	side where R108 could not			documentation in the medical record	I.	
		ed NA-B to move the leg of the			Allegations of abuse or mistreatment		
		o that the resident could rest			be reported no later than two hours a	after	
		al. R108 explained that NA-B			the allegation is made to the	_	
		Ichair leg closer as requested, sident back to the room. After			administrator, and to other officials in accordance with state law. The	1	
		ident's room, R108 said that			investigative team (social worker,		
		ent "you need to show me			administrator, and director of nursing	3	
		were very rude to me." R108			services) will review all incidents no I		
		B as "rough" when assisting			than the next working day following the	he	
		laying in bed, to sitting up in			incident.		
		f R108 reported the incident to onfirmed telling registered			Recurrence will be prevented by All facility staff will receive re-educati	ion on	
	nurse (RN)-E abou				the established policy and procedure		
		e elste e se			Abuse and Neglect. The facility will	-	
		um data set cognitive			continue to provide all new staff with		
		eference date 2/9/17, revealed			education during their general orienta		
		d R108 to be cognitively intact.			on the established policy and proced for Abuse and Neglect and all staff w	/ill	
		d a list of reported events, and			continue to receive re-education on t	the	
		s of abuse and neglect from			policy and procedure for Abuse and		
	the past twelve mo	nths. Review of the list failed			Neglect annually. The facility will con	itinue	

Facility ID: 00900

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TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3)	DATE	0938-039 SURVEY PLETED
IND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMP	LETED
		245221	B. WING			04/1	3/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD			50 ROSELAWN AVENUE EAST AINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	Ξ	(X5) COMPLETIOI DATE
F 226	Continued From pa	ige 7	F 2	26			
	During an interview	e R108's allegation.			and Procedure. Audits will be conducte to prevent recurrence as outlined below		
	they were not awar evening of 4/10/17. described NA-B as NA-B told the resid DON said, "Well the confirmed "That is a been reported, and administrator said t resident about it, ar they would start to said "RN-E should immediately" and s on reporting. During an interview RN-E confirmed the being upset when N RN-E said R108 m	lirector of nursing (DON) said e of the allegation from the After explaining how R108 rough and gruff, and said ent to show more respect, the at isn't appropriate." The DON something that should have we will do that." The hat normally they talk to the nd interview the staff, and said do that immediately. The DON have reported that to us aid RN-E would be retrained or 0.4/12/17, at 2:56 p.m. at R108 spoke to her about NA-B called the resident rude. entioned not wanting NA-B to sident that night. RN-E said			These issues will be monitored in the following manner The Director of Nursing, Nurse Manage and Social Service will perform audits I interviewing residents for concerns. If there are concerns, the interviewer will ask the resident in 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 Abus and Neglect policy and procedure. The audits will be completed weekly for one month, monthly for one quarter, and th quarterly. Audit results will be brought the quality assurance committee for further review as needed.	e ese ese en	
	she reported the sit that evening, who c scheduled to take c Review of a submis facility reported the on 4/12/17, after the	tuation to the charge nurse confirmed that NA-B was not care of R108 that evening. ssion report revealed the incident to the State Agency					
F 242 SS=D	RIGHT TO MAKE (F 24	42		:	5/23/17
	schedules (includin	has a right to choose activities, g sleeping and waking times), widers of health care services					

Facility ID: 00900

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/22/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· · ·	E SURVEY PLETED
		245221	B. WING	i		04 /1	13/2017
NAME OF F	PROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD			50 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	Continued From pa	ge 8	F	242			
	and plan of care an of this part.	d other applicable provisions					
		nas a right to make choices s or her life in the facility that e resident.					
	members of the con community activitie facility.	has a right to interact with mmunity and participate in s both inside and outside the NT is not met as evidenced					
	Based on interview facility failed to ens	and document review, the ure 2 of 4 residents (R63 and choices, were provided with r in bathing.			F242 483.10 (f)(1)-(3) Self Determination-Right To Make Choic Corrective Action for resident R63 F	R96	
	Findings include:				Residents R63 and R96 care plans been updated and both residents h been receiving two baths/showers	ave	
		ta Set [MDS], dated 2/24/17, red physical help with part of gnitively intact.			week as requested. How to identify other residents with same issue The facility will interview residents of	the	
	able to choose how each week. R63 rep showers each week before admission to sort of a shock at fi	a.m. R63 reported not being many showers R63 received borted wanting at least two k, as R63 used to shower daily the facility. R63 added "it was rst" when R63 only was he shower each week at the			admission, quarterly, and with chan condition on choices regarding bath These choices will be care planned followed through as indicated. Resi who request extra baths or showers addition to their scheduled routine v receive services with reasonable	ige of hing. and dents s in	
	facility. R63 added, enough people to d shower a week sch	"I guess they haven't got o more than that" and the one edule was "pretty rigid." R63 er asked how many showers			accommodations of individual need preferences. Recurrence will be prevented by All nursing staff will receive re-educ on resident bathing choices, and pr	ation	
		a.m. RN-B reported R63 had ers in the past month. RN-B			bathing choices as per resident preference. Audits will be conducte ensure resident choice regarding be		

Facility ID: 00900

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CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245221		(X2) MULT	TIPLE CONSTRUCTION	(X3) DA	0MB NO. 0938-039 (X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	A. BUILDII	NG	CO	COMPLETED	
		B. WING _			04/13/2017		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE				
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		550 ROSELAWN AVENUE EA SAINT PAUL, MN 55117	51		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORF PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		ACTION SHOULD BE	(X5) COMPLETIC DATE	
F 242	many showers R63 RN-B said she wou discussion happen 2:43 p.m., RN-B re anything related to R63 wanted each we went to R63 and as preferred each we at least two showed did not have enoug she would schedule each week. R63 ex for the added show R63's care plan his revealed R63 was each week, with a 4/12/17, R63's care showers each wee R63's bathing repor revealed R63 recei Bathing Report for R63 received three for 2/1/17 to 2/28/1 showers. R96's preference for bath/shower in a w During interview wi R96 reported, woul twice a week, but of possible because r discussed it. R96 ft to take a shower two	not recall discussing how 8 wanted each week with R63. Ild look into it to see if that ed before RN-B started. At ported she could not find discussing how many showers week. RN-B and surveyor then sked how many showers R63 ek. R63 again reported desiring rs each week but thought staff th time for that. RN-B told R63 e an additional shower for R63 cpressed R63 was very grateful ver. story, last revised 4/12/17, scheduled for one shower revision date of 4/7/17. On e plan history changed to two	F 24	42 to prevent recurrence These issues will be m following manner The Director of Nursin Managers will perform choices in bathing wee monthly for one quarter quarterly. Audit results the quality assurance of further review as need	nonitored in the g and Nurse audits of resident ekly for one month, er, and then s will be brought to committee for		

Facility ID: 00900

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DEPART	FORM	APPROVED						
					0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
			_					
		245221	B. WING			04/13/2017		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
GOOD SAMARITAN SOCIETY - MAPLEWOOD					50 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117			
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE	
				DEFICIENCY)				
E 0.40								
F 242	Continued From page 10 shower a week and that it was not offered or provided by the facility.		F2	242				
	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,							
		nd 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"							
	appropriate comple							
	Document review of R96's Annual Minimum Data set (MDS) dated 2/16/17, indicated, R96 was able to understand others, able to make							
		d required physical assistance						
	of one staff in part of							
	The care plan dated	d 1/20/16, directed staff, "						
		t requires extensive assist of						
		on/off shower/tub chair for						
	weekly bath. Extens complete weekly sh	sive assist of one staff to						
	Somplete Weekly SI	iowoi/batti.						
		hedule" sheets, undated,						
	indicated R96 was s bath/shower each v							
	Satir Shower Each V	took on ruosuays.						
		erences assessment dated						
		at the number of baths k was left unanswered.						
	protoneu each wee	at was lott unanowered.						
	On 4/11/17, at 2:37	p.m., nursing assistant						

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
	of COnnection	IDENTIFICATION NOMBER.	A. BUILDIN	G	CON	IFLEIED
		245221	B. WING		04/	13/2017
	PROVIDER OR SUPPLIER	- MAPLEWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 242 F 279 SS=D	 (NA)-C reported the bath/shower each with morning bath a On 4/11/17, at 3:08 indicated speaking bath/showers per word ocument the information record. RN-B further bathing/shower per word R96's daughter, just Policy and proceduresident need, date resident has the rig services in the cent accommodations of preferences" 483.20(d);483.21(b) COMPREHENSIVE 483.20 (d) Use. A facility massessments compromoths in the resider resident here as the resident has the resider the resident has the resident has the resident has the rig services in the cent accommodations of preferences" 483.20(d);483.21(b) COMPREHENSIVE 483.20 (d) Use. A facility resident has the rig services in the cent accommodations of preferences" 483.21(b) Comprehensive (1) The facility must have been been been been been been been be	e facility offered one week on Tuesdays for R96 by ide. a p.m., registered nurse (RN)-B with R96 regarding number of veek and R96 did have choices eek, however RN-B did not mation in R96's medical er explained that the efference (number of eek) was not discussed with st with R96. are titled Accommodation of ed February 2013, read, "The pht to reside and receive ter with reasonable f individual needs and b)(1) DEVELOP E CARE PLANS must maintain all resident bleted within the previous 15 lent's active record and use the assments to develop, review dent's comprehensive care	F 24			5/23/17

Facility ID: 00900

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/22/2017 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245221	B. WING	i		04/	13/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD			550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	set forth at §483.10 includes measurab to meet a resident's and psychosocial n comprehensive ass care plan must des (i) The services tha or maintain the resi physical, mental, ar required under §48 (ii) Any services tha under §483.24, §48 provided due to the under §483.10, incl treatment under §4 (iii) Any specialized rehabilitative servic provide as a result recommendations. findings of the PAS rationale in the resi (iv)In consultation v resident's represen (A) The resident's g desired outcomes. (B) The resident's p future discharge. Fa whether the resider community was ass	(c)(2) and §483.10(c)(3), that le objectives and timeframes a medical, nursing, and mental eeds that are identified in the sessment. The comprehensive cribe the following - t are to be furnished to attain dent's highest practicable ind psychosocial well-being as 3.24, §483.25 or §483.40; and it would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative (s)- goals for admission and preference and potential for acilities must document it's desire to return to the sessed and any referrals to ies and/or other appropriate	F	279			

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES	I		OM	FORM / IB NO.	05/22/2017 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (E SURVEY PLETED
		245221	B. WING	i		04 /1	13/2017
	PROVIDER OR SUPPLIER	- MAPLEWOOD		55	TREET ADDRESS, CITY, STATE, ZIP CODE 50 ROSELAWN AVENUE EAST AINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 279	plan, as appropriate requirements set for section. This REQUIREMEN by: Based on docume facility failed to dev comprehensive pla care for 1 of 1 resion reviewed for hospic Findings include: Document review r Admission/Verbal C R163, showing the hospice care for the with the admitting of (cerebral vascular at aphasia (difficult sw expression). The document also care from the faciliti Hospice Interdiscip 3/9/17, from the ho plan of care had tw care that read, "The prognosis R/T [relation with aphasia and do wishes to remain o with hospice care initia the bottom of the e plan of care. There	s in the comprehensive care e, in accordance with the orth in paragraph (c) of this NT is not met as evidenced nt review and interview, the elop an individualized, n of care regarding hospice dent (R163) in the sample ce. evealed a Hospice Certification Orders form for resident was enrolled in e period of 3/8/17 to 6/5/17, diagnosis of late effect of CVA accident) with dysphagia and vallowing and language o contained a current plan of ty, dated 3/23/17, and a linary Care Plan form, dated spice provider. The facility's to Focus related to hospice e resident has a terminal ted to] DX [diagnosis] of CVA ysphagia," and "The resident n TCU [transitional care unit] es." Information such as, tted on 3/8/17" was added at xisting Focus entries in the e was not a Focus to address 63's psychosocial and spiritual	F	279	F279 483.20 (d), 483.21(b) (1) Deve Comprehensive Care Plans Corrective Action for resident R163 R163 has had an interdisciplinary re and re-development of comprehensi individualized care plan to address psychosocial and spiritual needs rela- to hospice care. How to identify other residents with t same issue The facility will perform an interdiscip review to identify residents who have hospice care. Identified residents pla- care will be reviewed and re-develop needed to address and provide psychosocial and spiritual needs as indicated. Recurrence will be prevented by An interdisciplinary individualized ca plan including psychosocial and spir needs will be developed for resident receiving hospice care upon admiss quarterly, and with change of conditi Re-education will be given to all nurs staff, social service staff, dietary staff therapeutic recreation staff, and cha who complete care plans. Audits will comprehensive care plan is develop include psychosocial and spiritual ne- related to hospice care for residents receiving hospice as designated below	view ive ated the plinary an of bed as re itual s ion, on. sing ff, plain l be ialized ed to beds	

Facility ID: 00900

PRINTED: 05/22/2017 FORM APPROVED

		& MEDICAID SERVICES	1				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245221	B. WING _			04/	13/2017
NAME OF	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD			ROSELAWN AVENUE EAST NT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETIOI DATE
F 279 F 309 SS=D	registered nurse (R R163, was asked w used in caring for F replied that the faci provider's Hospice form as a reference of care, and facility plan of care for dire hospice. After survey exit, or via fax, an unsigned discontinue aid ser unsigned, undated discontinue chaplai starting 3/16/17. Th identified that the d the facility on 4/13/ Spiritual Profile forr 2/27/17, that showe Christian, however, section was left bla read, "What, if any, practices or resource you in the past year question that was s clergy person/religi faith community." 483.24, 483.25(k)(I FOR HIGHEST WE 483.24 Quality of life quality of life is a fu applies to all care a residents. Each resi facility must provide	on 4/12/17 at 1:44 p.m., RN)-D, the nurse manager for which care plan the facility staff R163 regarding hospice. RN-D lity staff used the hospice Interdisciplinary Care Plan to develop the facility's plan staff then used the facility's ecting care of a resident on the 4/14/17, the facility provided, d, undated physician's order to vices starting 3/14/17, and an physician's order to in services and social services the fax dates on the documents ocuments had been faxed to 17. Also provided was a m completed by the facility on ed R163 was identified as the specific denomination nk. Section 3. 1. of this form of the following spiritual ces have been important to r?" and the answer to that selected read, "Visit from my ous leader or members of my) PROVIDE CARE/SERVICES ELL BEING	F 2	T fr S N r v v o c a n o t l fr	These issues will be monitored in ollowing manner Social Service, Director of Nursing Nurse Managers will audit care pla esidents receiving hospice care. Vill be completed to address the completion of an individualized comprehensive care plan for psyca and spiritual needs weekly for one nonthly for one quarter, and then quarterly. Audit results will be brow he quality assurance committee f urther review as needed.	g, and ans for Audits hosocial month, ught to	5/23/17

Facility ID: 00900

If continuation sheet Page 15 of 19

		AND HUMAN SERVICES				FORM	05/22/2017 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245221	B. WING			04/	13/2017
NAME OF I	PROVIDER OR SUPPLIER		· [ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD			0 ROSELAWN AVENUE EAST AINT PAUL, MN 55117		
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F 309	well-being, consister comprehensive ass 483.25 Quality of ca Quality of care is a applies to all treatm facility residents. Bu assessment of a re- that residents recei- accordance with pri- practice, the compre- care plan, and the re- but not limited to th (k) Pain Manageme The facility must er- provided to residen consistent with pro- the comprehensive and the residents' g (I) Dialysis. The fac- residents who requi- services, consisten of practice, the com- care plan, and the re- preferences. This REQUIREMED by: Based on docume facility failed to dev comprehensive pla- care, and failed to dev comprehensive pla- care, and failed to dev comple reviewed for	I, mental, and psychosocial ent with the resident's sessment and plan of care. are fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered residents' choices, including e following: ent. sure that pain management is ts who require such services, fessional standards of practice, person-centered care plan, goals and preferences. cility must ensure that ire dialysis receive such t with professional standards nprehensive person-centered residents' goals and NT is not met as evidenced nt review and interview, the elop an individualized, n of care regarding hospice coordinate services with the r 1 of 1 resident (R163) in the	F3	09	F309 483.24, 483.25(k) (l) Provide Care/Services For Highest Well Be Corrective Action for resident R163 R163 has had an interdisciplinary r and re-development of comprehen individualized care plan to address psychosocial and spiritual needs re-	eing 3 review isive	
	practice, the compr care plan, and the in but not limited to the (k) Pain Manageme The facility must ere provided to residen consistent with prot the comprehensive and the residents' (g (l) Dialysis. The face residents who requiservices, consisten of practice, the com care plan, and the in preferences. This REQUIREMEN by: Based on docume facility failed to dev comprehensive plan care, and failed to dev hospice provider for	rehensive person-centered residents' choices, including e following: ent. Issure that pain management is ts who require such services, fessional standards of practice, person-centered care plan, goals and preferences. cility must ensure that ire dialysis receive such t with professional standards hprehensive person-centered residents' goals and NT is not met as evidenced Int review and interview, the elop an individualized, n of care regarding hospice coordinate services with the r 1 of 1 resident (R163) in the			Care/Services For Highest Well Be Corrective Action for resident R163 R163 has had an interdisciplinary r and re-development of comprehen	eing S review sive elated	

Facility ID: 00900

If continuation sheet Page 16 of 19

	-	AND HUMAN SERVICES					APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			()	E SURVEY PLETED
		245221	B. WING _			04/1	13/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- MAPLEWOOD			0 ROSELAWN AVENUE EAST AINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	R163, showing the hospice care for the with the admitting d (cerebral vascular a aphasia (difficult sw expression). The document also care from the facilit Hospice Interdiscip 3/9/17, from the hosp plan of care had tw care that read, "The prognosis R/T [relat with aphasia and dy wishes to remain or with hospice service care initiated on 3/8 of the existing Focu There was not a Focu Th	evealed a Hospice Certification Orders form for resident was enrolled in a period of 3/8/17 to 6/5/17, liagnosis of late effect of CVA accident) with dysphagia and vallowing and language contained a current plan of y, dated 3/23/17, and a linary Care Plan form, dated spice provider. The facility's o Focus related to hospice e resident has a terminal ted to] DX [diagnosis] of CVA ysphagia," and "The resident n TCU [transitional care unit] es." Phrases like, "Hospice 0/17" were added at the bottom is entries in the plan of care. Is cus to address the specifics of al and spiritual needs related on 4/12/17, at 1:44 p.m., N)-D, the nurse manager for which care plan the facility staff t163 regarding hospice. She lity staff used the hospice Interdisciplinary Care Plan to develop the facility's plan staff then used the facility's plan staff then used the facility's forting care of a resident on	F 3(09	services with the hospice provider. How to identify other residents with same issue The facility will perform an interdisc review to identify residents who has hospice care. Identified residents p care will be reviewed and re-develous needed to provide psychosocial and spiritual needs and coordination of services with the hospice provider indicated. Recurrence will be prevented by An interdisciplinary individualized of plan including psychosocial and spineeds and coordination of services the hospice provider will be develous residents receiving hospice care up admission, quarterly, and with char condition. Re-education will be given nursing staff, social service staff, therapeutic recreation staff, dietary and chaplain who complete care p Audits will be completed to ensure individualized comprehensive care developed to include psychosocial spiritual needs related to hospice of 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 Nurse Managers will audit care pla residents receiving hospice care. A will be completed regarding the completion of an individualized comprehensive care plan for psych and spiritual needs and that service	a the ciplinary ve blan of oped as d as are iritual s with ped for oon nge of en to all r staff, lans. that an plan is and care en he , and ns for vudits	
	A binder for R163's nursing station and				completion of an individualized comprehensive care plan for psych	es with	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00900

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PRINTED: 05/22/2017 FORM APPROVED

IAIEMENI	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	E SURVEY
ND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:		à	CON	IPLETED
		245221	B. WING		04/	/13/2017
NAME OF I	PROVIDER OR SUPPLIER	•	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD		550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 309	and leave in the bin form contained a li Visit:" where the ho date of their anticip Communication No hospice nursing as 3/13/17 and showe 3/14/17. The last (completed by a hos dated 4/6/17 and s was "Next Wk." When the nurse or nurse (LPN)-B, wa 9:23 a.m. she state hospice staff visite hospice visit scheo care plan. She the may call the facility resident. Nursing assistant (same time and ask R163. NA-A respo when hospice staff that she had seen could not remembe On 4/12/17 at 9:43 hospice staff for R ¹ Note forms in the r regarding the next	ides that they would complete inder after a visit to R163. That ine that read, "Date of Next ospice staff would write the bated next visit. The last ote form completed by a sistant in the binder was dated ad that the next visit date was Communication Note form spice nurse in the binder was howed that the next visit date is interviewed on 04/12/2017 at ad that she was not sure when d R163 and suggested that the fulle may be in the resident's en added that the hospice aide before coming to see the NA)-A was interviewed at the sed when hospice staff visits inded that she was not sure visited R163. She thought hospice staff with R163, but	F 309	for one month, monthly for one and then quarterly. Audit results brought to the quality assuranc committee for further review as	s will be e	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER SUPPLIER DENTIFICATION NUMBER: 245221 (X2) MULTIPLE CONSTRUCTION A BUILONG (X3) DATE SUPPLY COMPLETED B. WING NAME OF PROVIDER OR SUPPLIER 245221 STREET ADDRESS, CITY, STATE, ZIP CODE 550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117 (X4) ID PHETK TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICENCY MUST BE PRECEDED BY FULL TAG D PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COROS AMERITAN SOCIETY - MAPLEWOOD D PROVIDERS PLAN OF CORRECTIVE ACTION SUMMARY STATEMENT OF DEFICIENCIES preceded by the PRECEDED BY FULL TAG D PROVIDERS PLAN OF CORRECTIVE ACTION SUMMARY STATEMENT OF DEFICIENCIES provide on that day. D PROVIDERS PLAN OF CORRECTIVE ACTION SUMMARY STATEMENT OF DEFICIENCIES provide on that day. F 309 F 309 Continue of From page 18 provide on that day. F 309 F 309 After survey exit, on 4/14/17, the facility provided, via fax, an unsigned, undated physician's order to discontinue aid services and social services starting 3/16/17. Tate of survey exit. Also provided was a Spiritual Profile form completed by the facility 07/17. that showed R163 was identified as Christian, however, the specific denomination section was left blank. Section 3, 1. of this form 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."			AND HUMAN SERVICES				FORM	05/22/2017 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - MAPLEWOOD STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 309 Continue dradaed to this continue chapted 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 R	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	(X3) DAT	E SURVEY
GOOD SAMARITAN SOCIETY - MAPLEWOOD 550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117 (X4) ID PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES INT PAUL, MN 55117 (X4) ID PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 309 Continued From page 18 provide on that day. F 309 F 309 After survey exit, on 4/14/17, the facility provided, via fax, an unsigned, undated physician's order to discontinue aid 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 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			245221	B. WING			04/	13/2017
GOOD SAMARITAN SOCIETY - MAPLEWOOD SAINT PAUL, MN 55117 Image: Control of the contr	NAME OF F	PROVIDER OR SUPPLIER					•	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 309 Continued From page 18 provide on that day. F 309 F 309 F 309 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	GOOD SA	AMARITAN SOCIETY	- MAPLEWOOD		-			
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	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
	TAG	Continued From pa provide on that day After survey exit, or via fax, an unsigned discontinue aid serv unsigned, undated discontinue chaplai starting 3/16/17. Th identified that the da the facility 4/13/17, provided was a Spin by the facility on 2/2 identified as Christic denomination section 1. of this form read, spiritual practices of important to you in answer to that quest	ge 18 h 4/14/17, the facility provided, d, undated physician's order to vices starting 3/14/17 and an physician's order to n services and social services the fax dates on the documents ocuments had been faxed to date of survey exit. Also ritual Profile form completed 27/17 that showed R163 was an, however, the specific on was left blank. Section 3. , "What, if any, of the following r resources have been the past year?" and the stion that was selected read, by person/religious leader or	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)		

Facility ID: 00900

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	MENT OF HEALTH			ŦS	221026	FORM	04/24/2017 APPROVED 0.0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE S COMPLI	
		245221		B. WING		04/1	2/2017
	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIET	Y - MAPLEWOOD			LAWN AVENUE MN 55117	*	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
	Minnesota Departm Fire Marshal Divisio Good Samaritan So in compliance with participation in Med Subpart 483.70(a), 2012 edition of Nati Association (NFPA) Code (LSC), Chapt Maplewood Good S building with no bas constructed at three nursing home was of Type II(111) cons was constructed to that was determine construction. In 199 to the south and we was determined to	Survey was conduct nent of Public Safety on. At the time of this ociety - Maplewood we the requirements for licare/Medicaid at 42 Life Safety from Fire ional Fire Protection of Standard 101, Life er 19 Existing Health Samaritan Center is a sement. The building e different times. In the built and was determ struction. In 1967 an the south of the maid d to be of Type II(111) of an addition was c est of the 1967 buildi be of Type II(111) co al building and the 2	- State s survey, was found 2 CFR, e, and the Safety n Care. a 2-story y was 1965 the nined to be addition in building, 1) onstructed ng that onstruction.			24	
	meet the constructi buildings, the facilit building. The building is fully fire alarm system w corridors and space are monitored for a notification. Other h heat detection or sr fire alarm system in	on type allowed for e y was surveyed as o sprinkler protected vith smoke detection es open to the corrid utomatic fire departs hazardous areas hav moke detection that h accordance with th re Code. The sleepin	and has a in the ors that ment ve either are on the e	ti H			
LABORATO	in the 1997 addition that annunciate out	have single smoke side the room and a ccordance with the N	detectors t the ⁄linnesota	NATURE	TITLE		(X6) DATE
M LEON MUCH							2002010011

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.

DEPART	MENT OF HEALTH	AND HUMAN SERV & MEDICAID SERV	ICES			FORM	04/24/2017 APPROVED 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE S COMPLE	URVEY ETED
		245221		B. WING		04/1	2/2017
	PROVIDER OR SUPPLIER				TATE, ZIP CODE		
GOODS	SAMARITAN SOCIET	IY - MAPLEWOOD		EWOOD, M	AWN AVENUE N 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI F BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 000	Continued From pa State Fire Code.	age 1		K 000			
	The facility has a ca census of 96 at the	apacity of 96 beds as time of the survey.	nd had a				1
	The requirement at MET.	42 CFR, Subpart 48	33.70(a) is	84			
			1				
			23 		Υ. Υ		
					6		
		а					
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If continuation sheet Page 2 of



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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Good Samaritan Society - Maplewood April 25, 2017 Page 2

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

Minneso	ta Department of He	alth				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMPI	
		00900	B. WING		04/1	3/2017
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		ELAWN AVEI NUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa	hether a violation has been				
	requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	a rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these tt a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 05/03/17

STATE FORM

If continuation sheet 1 of 22

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00900	B. WING		04/	13/2017
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
iood s/	AMARITAN SOCIETY		ELAWN AVEN AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for St enter the word "con text. You must then State licensure pro completion date, th corrected prior to e Minnesota Departm					
	this Department's s and the following c Please indicate in y correction that you	and 13, 2017, surveyors of staff visited the above provider orrection orders are issued. your electronic plan of have reviewed these orders, te when they will be completed				
	the State Licensing federal software. Ta	nent of Health is documenting g Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "IL statute/rule out of o "Summary Stateme and replaces the "T correction order. T findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as owing the surveyors findings Method of Correction and prrection.				
	PI FASE DISBEGA	ARD THE HEADING OF THE				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00900	B. WING		04/13/2017	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		SELAWN AVE AUL, MN 55 [.]			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ige 2	2 000			
	APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC	N WHICH STATES, IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 560	MN Rule 4658.040 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			5/23/17
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The c must include the inc	of plan of care. The n of care must list measurable tables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plar ota Statutes, section 626.557 agraph (b).	1			
	by: Based on documer facility failed to dev comprehensive pla	ent is not met as evidenced nt review and interview, the elop an individualized, n of care regarding hospice dent (R163) in the sample ce.		Corrected		
	Findings include:					
	R163, showing the hospice care for the with the admitting c	evealed a Hospice Certification Orders form for resident was enrolled in e period of 3/8/17 to 6/5/17, liagnosis of late effect of CVA accident) with dysphagia and				

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IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		ELAWN AVENI AUL, MN 5511				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 560	Continued From pa	age 3	2 560				
	aphasia (difficult swallowing and language expression).						
	Hospice Interdiscip 3/9/17, from the ho plan of care had tw care that read, "Th prognosis R/T [rela with aphasia and d wishes to remain o with hospice service "Hospice care initia the bottom of the e plan of care. There the specifics of R11 needs related to ho When interviewed registered nurse (F R163, was asked w used in caring for F replied that the fact provider's Hospice form as a reference of care, and facility plan of care for dire hospice.	ty, dated 3/23/17, and a plinary Care Plan form, dated pspice provider. The facility's vo Focus related to hospice e resident has a terminal ated to] DX [diagnosis] of CVA hysphagia," and "The resident on TCU [transitional care unit] ces." Information such as, ated on 3/8/17" was added at existing Focus entries in the e was not a Focus to address 63's psychosocial and spiritual ospice care. on 4/12/17 at 1:44 p.m., RN)-D, the nurse manager for which care plan the facility staff R163 regarding hospice. RN-D ility staff used the hospice Interdisciplinary Care Plan e to develop the facility's plan r staff then used the facility's ecting care of a resident on n 4/14/17, the facility provided,					
	via fax, an unsigne discontinue aid ser unsigned, undated discontinue chapla starting 3/16/17. The identified that the of the facility on 4/13/ Also provided was	d, undated physician's order to vices starting 3/14/17, and an physician's order to in services and social services he fax dates on the documents documents had been faxed to 17, the date of survey exit. a Spiritual Profile form acility on 2/27/17, that showed					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED	
		00900	_			04/13/2017	
	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE, ZIP CODE			J4/13/2017	
	AMARITAN SOCIETY	- MAPLEWOOD 550 ROS	ELAWN AVEN AUL, MN 5511	UEEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 560	Continued From pa	age 4	2 560				
	specific denominat Section 3. 1. of this the following spiritu been important to y answer to that ques "Visit from my clerg members of my fair SUGGESTED MET The facility director could assure that in plans of care are de	d as Christian, however, the ion section was left blank. a form read, "What, if any, of ial practices or resources have you in the past year?" and the stion that was selected read, gy person/religious leader or th community." THOD OF CORRECTION: of nursing and/or designee ndividualized, comprehensive eveloped to assure e for residents receiving					
	(21) days.	R CORRECTION: Twenty-one					
2 830	Proper Nursing Ca Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in e resident assessment and scribed in parts 4658.0400 and ing home resident must be our possible unless there is a the attending physician that the ain in bed or the resident	d t			5/23/17	

	T OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	•		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD	ELAWN AVE AUL, MN 55 ⁻				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLET DATE	
2 830	Continued From pa	age 5	2 830				
	by: Based on document facility failed to dev comprehensive pla	ent is not met as evidenced nt review and interview, the elop an individualized, n of care regarding hospice dent (R163) in the sample ce.		Corrected			
	Findings include:						
	R163, showing the hospice care for the with the admitting c (cerebral vascular a	evealed a Hospice Certification Orders form for resident was enrolled in e period of 3/8/17 to 6/5/17, diagnosis of late effect of CVA accident) with dysphagia and vallowing and language					
	care from the facilit Hospice Interdiscip 3/9/17, from the ho plan of care had tw care that read, "The prognosis R/T [rela with aphasia and dy wishes to remain of with hospice servic "Hospice care initia the bottom of the explan of care. There	o contained a current plan of ty, dated 3/23/17, and a linary Care Plan form, dated spice provider. The facility's to Focus related to hospice e resident has a terminal ted to] DX [diagnosis] of CVA ysphagia," and "The resident n TCU [transitional care unit] es." Information such as, ted on 3/8/17" was added at xisting Focus entries in the e was not a Focus to address 53's psychosocial and spiritual pspice care.					
	registered nurse (R R163, was asked w used in caring for F	on 4/12/17 at 1:44 p.m., RN)-D, the nurse manager for which care plan the facility staff R163 regarding hospice. RN-D lity staff used the hospice					

	ta Department of He					APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY		ELAWN AVEN AUL, MN 551			
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2 830	Continued From pa	ige 6	2 830			
	form as a reference of care, and facility	Interdisciplinary Care Plan to develop the facility's plan staff then used the facility's ecting care of a resident on				
	via fax, an unsigned discontinue aid ser unsigned, undated discontinue chaplai starting 3/16/17. The identified that the d the facility on 4/13/ Spiritual Profile for 2/27/17, that showe Christian, however, section was left bla read, "What, if any, practices or resour- you in the past year question that was s	n 4/14/17, the facility provided, d, undated physician's order to vices starting 3/14/17, and an physician's order to n services and social services he fax dates on the documents ocuments had been faxed to 17. Also provided was a m completed by the facility on ed R163 was identified as the specific denomination nk. Section 3. 1. of this form of the following spiritual ces have been important to r?" and the answer to that selected read, "Visit from my ous leader or members of my				
	The director of nurs procedures related care for hospice ca these polices, and	THOD OF CORRECTION: sing could develop policies and to development of plan of re, educate staff regarding audit resident records for e policies and procedures.	I			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21830	MN St. Statute 144 Residents of HC Fa	.651 Subd. 10 Patients & ac.Bill of Rights	21830			5/23/17
linnesota De TATE FORM	epartment of Health		6899	TQP11	IK IS I	ion sheet 7 of 2

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00900	B. WING		04/	13/2017
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		10/2011
GOODS	AMARITAN SOCIETY	- MAPLEWOOD 550 ROS	ELAWN AVEN	JE EAST		
	1	SAINT P/	AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21830	Continued From pa	ige 7	21830			
	Subd. 10. Particip notification of family	pation in planning treatment; y members.				
	in the planning of the includes the opport alternatives with inco- opportunity to reque- care conferences, a family member or of both. In the event the present, a family member or of both. In the event the present, a family mem- chosen by the reside conferences. (b) If a resident we unconscious or com- communicate, the f efforts as required the either a family mem- writing by the reside an emergency that admitted to the faci- family member to p- planning, unless the to believe the reside directive to the com- specified in writing member included in notifying a family me- forts, consistent we planning, the facility efforts, consistent we practice, to determine executed an advan- esident's health car- this paragraph, "rea- (1) examining the resident;	Il have the right to participate heir health care. This right unity to discuss treatment and dividual caregivers, the est and participate in formal and the right to include a other chosen representative or that the resident cannot be ember or other representative lent may be included in such who enters a facility is natose or is unable to acility shall make reasonable under paragraph (c) to notify aber or a person designated in ent as the person to contact in the resident has been lity. The facility shall allow the articipate in treatment e facility knows or has reason ent has an effective advance trary or knows the resident has that they do not want a family in treatment planning. After ember but prior to allowing a varticipate in treatment y must make reasonable with reasonable medical ne if the resident has ce directive relative to the re decisions. For purposes of asonable efforts" include: e personal effects of the e medical records of the				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		FLETED
		00900	B. WING		04/	13/2017
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
GOOD S	AMARITAN SOCIETY		BELAWN AVENI AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
21830	Continued From pa	ige 8	21830			
	(3) inquiring of an family member con- whether the resider directive and wheth physician to whom care; and (4) inquiring of the resident normally g whether the resider directive. If a facilit designated emerges member to participa accordance with the liable to resident fo the notification of the emergency contact family member was patient's privacy rig (c) In making rea family member or of the facility shall atter members or a design examining the pers and the medical reo possession of the facility to notify a family me emergency contact admission, the facil social service agen agency that the res the facility has been member or designat county social service enforcement agence identifying and notifi designated emergents service agency or lite	session of the facility; ny emergency contact or tacted under this section in thas executed an advance her the resident normally goes for the physician to whom the oes for care, if known, in thas executed an advance y notifies a family member or incy contact or allows a family ate in treatment planning in is paragraph, the facility is not r damages on the grounds that he family member or or the participation of the simproper or violated the hts. asonable efforts to notify a lesignated emergency contact empt to identify family gnated emergency contact by onal effects of the resident cords of the resident in the acility. If the facility is unable ember or designated within 24 hours after the ity shall notify the county cy or local law enforcement ident has been admitted and n unable to notify a family ated emergency contact. The cagency and local law cy shall assist the facility in fying a family member or ency contact. A county social ocal law enforcement agency y in implementing this	t			

Minneso	ta Department of He	alth	-		-	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00900	B. WING		04/1	3/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		ELAWN AVE AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21830	Continued From pa	ge 9	21830			
	damages on the gro the family member	able to the resident for ounds that the notification of or emergency contact or the family member was improper ent's privacy rights.				
	by: Based on interview facility failed to ensu	ent is not met as evidenced and document review, the ure 2 of 4 residents (R63 and choices, were provided with r in bathing.		Corrected		
	Findings include:					
		ta Set [MDS], dated 2/24/17, red physical help with part of gnitively intact.				
	able to choose how each week. R63 rep showers each week before admission to sort of a shock at fi scheduled to get or facility. R63 added, enough people to d shower a week sch	a.m. R63 reported not being many showers R63 received ported wanting at least two k, as R63 used to shower daily the facility. R63 added "it was rst" when R63 only was he shower each week at the "I guess they haven't got o more than that" and the one edule was "pretty rigid." R63 er asked how many showers week.	;			
Minnesota D	received four show reported she could many showers R63 RN-B said she wou	a.m. RN-B reported R63 had ers in the past month. RN-B not recall discussing how wanted each week with R63. Id look into it to see if that ed before RN-B started. At				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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GOODS	AMARITAN SOCIETY		ELAWN AVEN			
		SAINT P	AUL, MN 5511	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
21830	Continued From pa	age 10	21830			
	anything related to R63 wanted each w went to R63 and as preferred each wee at least two showed did not have enoug she would schedule each week. R63 ex for the added show R63's care plan his revealed R63 was each week, with a 4/12/17, R63's care showers each wee R63's bathing repo revealed R63 recei Bathing Report for R63 received three	tory, last revised 4/12/17, scheduled for one shower revision date of 4/7/17. On e plan history changed to two				
	bath/shower in a w During interview wi R96 reported, woul twice a week, but of possible because r discussed it. R96 fe to take a shower tw staff assist due to b a.m. R96 confirmed	or having more than one eek was not accommodated. th R96 on 4/11/17, at 2:49 p.m Id like to have shower at least lid not know if that was no staff had asked or urther stated, preference was vo times a week and required blindness. On 4/12/17, at 9:48 d R96 wanted more than one d that it was not offered or illity.				
	On 4/11/17, at 2:55	p.m. resident's daughter,				
nesota De	epartment of Health		μ			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	• • •		
GOOD S	AMARITAN SOCIETY		ELAWN AVEN AUL, MN 5511				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21830	Continued From pa	age 11	21830				
	responded, did not recall staff offering R96 the number of showers preferred each week.						
	diagnoses included	ocument revealed R96's I cerebral infarction, dorsalgia, and blindness in both eyes.					
	notes: dated 2/22/1 Resident requires e bathing as [R96] is	of the form titled, Progress 7, at 2:47 p.m. read, " extensive assist of 1 staff for able to complete part of bath equires assistance for etion"					
	set (MDS) dated 2/ to understand othe	d required physical assistance	e				
	BATHING: Resider one staff to transfe	d 1/20/16, directed staff, " nt requires extensive assist of r on/off shower/tub chair for sive assist of one staff to nower/bath.					
	The "North Bath So indicated R96 was bath/shower each y						
	1/7/17, revealed the	erences assessment dated at the number of baths ek was left unanswered.					
	(NA)-C reported the	p.m., nursing assistant facility offered one week on Tuesdays for R96 by ide.					
nesota D	On 4/11/17, at 3:08 epartment of Health	p.m., registered nurse (RN)-E	3				

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21830	Continued From pa	age 12	21830			
	bath/showers per v of how many per w document the infor record. RN-B furthe bathing/shower per bath/shower per we R96's daughter, jus Policy and procedu resident need, date resident has the rig services in the cen	rre titled Accommodation of ed February 2013, read, "The off to reside and receive				
	The director of nurs assure that upon a residents are asked	ency, and involved with				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21980	MN St. Statute 626 Maltreatment of Vu	5.557 Subd. 3 Reporting - Inerable Adults	21980			5/23/17
	reporter who has revulnerable adult is or who has knowle has sustained a ph reasonably explain	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the common entry point. If an				

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		- COMPLETED	
	00900		B. WING		04/13/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		ELAWN AVEN			
0(0)15		SAIN I P/	AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21980	Continued From pa	lge 13	21980			
	the individual is adr reporter is not requi- maltreatment of the to admission, unless (1) the individual wa another facility and believe the vulnera previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this s as described above (c) Nothing in thi known or suspecter knows or has reaso been made to the of (d) Nothing in thi reporter from also r agency. (e) A mandated n reason to believe th 626.5572, subdivisi (5), occurred must subdivision. If the time believes that a agency will determine the reported error w the criteria under sec 17, paragraph (c), of facility may provide directly to the lead how the event mee	as admitted to the facility from the reporter has reason to ble adult was maltreated in the knows or has reason to believe is a vulnerable adult as defined 2, subdivision 21, clause (4). required to report under the vection may voluntarily report e. s section requires a report of d maltreatment, if the reporter on to know that a report has common entry point. s section shall preclude a reporting to a law enforcement reporter who knows or has nat an error under section ion 17, paragraph (c), clause make a report under this reporter or a facility, at any an investigation by a lead ne or should determine that vas not neglect according to ection 626.5572, subdivision clause (5), the reporter or e to the common entry point or agency information explaining ts the criteria under section				
linnas etc. D	directly to the lead how the event mee 626.5572, subdivis (5). The lead ager	agency information explaining				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00900	B. WING		04/13/2017
IAME OF F	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY		ELAWN AVE AUL, MN 55 ⁻		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
21980	Continued From pa	ge 14	21980		
	the report under su	bdivision 9c.			
	by: Based on interview facility failed to repo	ent is not met as evidenced , and document review, the ort an allegation of abuse that to staff for 1 of 5 residents r abuse.		Corrected	
	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 "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.				
	assessment from the	um data set cognitive ne reference date 2/9/17, assessed R108 to be			
		d a list of reported events, and s of abuse and neglect from			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00900	B. WING		04/	13/2017
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
OOD S	AMARITAN SOCIETY		ELAWN AVEN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21980	Continued From pa	ige 15	21980			
	to provide evidence	nths. Review of the list failed that the facility reported or e R108's allegation.				
	administrator and of they were not awar evening of 4/10/17. described NA-B as NA-B told the resid DON said, "Well the confirmed "That is been reported, and administrator said t resident about it, and they would start to said "RN-E should	on 4/12/17, at 11:25 a.m. the lirector of nursing (DON) said e of the allegation from the After explaining how R108 rough and gruff, and said ent to show more respect, the at isn't appropriate." The DON something that should have we will do that." The hat normally they talk to the nd interview the staff, and said do that immediately. The DON have reported that to us aid RN-E would be retrained				
	RN-E confirmed that being upset when N RN-E said R108 m take care of the res she reported the sit that evening, who c	on 4/12/17, at 2:56 p.m. at R108 spoke to her about NA-B called the resident rude. entioned not wanting NA-B to sident that night. RN-E said tuation to the charge nurse confirmed that NA-B was not care of R108 that evening.				
	procedure, last revi alleged or suspecter mistreatment or ab immediately to the absence of the adm	e and Neglect policy and sed 11/16, revealed that ed violations involving any use should be reported administrator; or in the ninistrator, to the director of the director of social services.				
	facility reported the	ssion report revealed the incident to the State Agency e interview with the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00900	B. WING		04/	13/2017
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
GOOD SA	AMARITAN SOCIETY	- MAPLEWOOD	ELAWN AVEN AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21980	Continued From pa	ge 16	21980			
	administrator and D	ON on the same date.				
	Based on interview	, and document review, the				
	facility failed to repo	ort an allegation of abuse that				
	had been reported to staff for 1 of 5 residents (R108) reviewed for abuse.					
	Findings include:					
	described nursing a gruff" during transfe after dinner, NA-B a dining room back to used a wheelchair f leg was out to the s reach it. R108 aske wheelchair closer s foot on the foot ped did move the wheel and brought the rest NA-B told the rest more respect, you w also described NA- R108 to move from bed. When asked if	on 4/10/17, at 6:53 p.m. R108 assistant (NA)-B as "rough and ers. R108 said earlier tonight assisted the resident from the o the resident's room. R108 for mobility, and the wheelchai ide where R108 could not id NA-B to move the leg of the o that the resident could rest lal. R108 explained that NA-B chair leg closer as requested, ident back to the room. After ident's room, R108 said that ent "you need to show me were very rude to me." R108 B as "rough" when assisting laying in bed, to sitting up in R108 reported the incident to onfirmed telling registered t what happened.	ł			
		um data set cognitive ne reference date 2/9/17,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00900	B. WING		04/13/2017	
NAME OF F	PROVIDER OR SUPPLIEF		DDRESS, CITY, ST			
OOD S	AMARITAN SOCIET		ELAWN AVEN AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21980	Continued From p	page 17	21980			
	cognitively intact.					
	reported allegation the past twelve m to provide evidence began to investiga During an intervie administrator and they were not awa evening of 4/10/12 described NA-B a NA-B told the resi DON said, "Well t confirmed "That is been reported, an administrator said resident about it, a they would start to said "RN-E should	led a list of reported events, and ns of abuse and neglect from onths. Review of the list failed ce that the facility reported or ate R108's allegation. w on 4/12/17, at 11:25 a.m. the director of nursing (DON) said are of the allegation from the 7. After explaining how R108 s rough and gruff, and said dent to show more respect, the hat isn't appropriate." The DON s something that should have id we will do that." The I that normally they talk to the and interview the staff, and said o do that immediately. The DON d have reported that to us said RN-E would be retrained				
	During an intervie RN-E confirmed the being upset when RN-E said R108 r take care of the re- she reported the se that evening, who scheduled to take Review of the Abu procedure, last re-	w on 4/12/17, at 2:56 p.m. hat R108 spoke to her about NA-B called the resident rude. mentioned not wanting NA-B to esident that night. RN-E said situation to the charge nurse confirmed that NA-B was not care of R108 that evening. use and Neglect policy and vised 11/16, revealed that				
noosto D	mistreatment or a immediately to the absence of the ad	ted violations involving any buse should be reported a administrator; or in the Iministrator, to the director of or the director of social services				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	00900 B. WING			- 04/13/2017		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MAPLEWOOD	SELAWN AVEN AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21980	Continued From pa	ge 18	21980			
	facility reported the on 4/12/17, after the	ssion report revealed the incident to the State Agency e interview with the OON on the same date.				
	The Administrator, designee could ass allegations of abuse appropriate staff, fo	THOD OF CORRECTION: director of nursing and/or ure that all potential e are immediately reported to illowed through with reporting d thoroughly investigated.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one	•			
21995	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4a Reporting - Inerable Adults	21995			5/23/17
	(a) Each facility sh ongoing written pro applicable licensing of suspected maltre facility has an interr mandated reporter requirements of this internally. However	I reporting of maltreatment. all establish and enforce an ocedure in compliance with rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting s section by reporting r, the facility remains aplying with the immediate ents of this section.				
	by: Based on documen facility failed to follo procedures to repo	ent is not met as evidenced at review and interview, the bw established policies and rt and investigate allegations residents (R108) investigated		Corrected		

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00900	B. WING		04/	13/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		ELAWN AVEN UL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	age 19	21995			
	for abuse.					
	Findings include:					
	procedure, last revi alleged or suspecter mistreatment or ab immediately to the absence of the adm nursing services or The procedure required employee receives employee is required The charge nurse of notified immediatel determine whether action is required, a investigation. If this to resident abuse, t from providing direc Additionally, the em suspension pending investigation. A des complete the docur record. Allegations be reported no late allegation is made other officials in act investigative team and director of nurs incidents no later th following the incide During an interview described nursing a gruff" during transfe after dinner, NA-B dining room back to	se and Neglect policy and ised 11/16, revealed that ed violations involving any use should be reported administrator; or in the ninistrator, to the director of the director of social services. uired the following: If an an allegation of abuse, the ed to report to a supervisor. or licensed nurse will be y, assess the situation to any emergency treatment or and complete an initial is an allegation of employee the employee will be removed ct care to all residents. nployee will be placed on g the results of the internal signated individual will then mentation in the medical of abuse, or mistreatment will r than two hours after the to the administrator, and to cordance with state law. The (social worker, administrator sing services) will review all han the next working day nt. r on 4/10/17, at 6:53 p.m. R108 assistant (NA)-B as "rough and ers. R108 said earlier tonight assisted the resident from the o the resident's room. R108 for mobility, and the wheelchair				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00900		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		04/	04/13/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	_	
OOD S	AMARITAN SOCIETY		SELAWN AVEN PAUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21995	Continued From pa	age 20	21995			
	reach it. R108 aske wheelchair closer s foot on the foot peo did move the whee and brought the res returning to the resid more respect, you also described NA- R108 to move from bed. When asked i staff, the resident of nurse (RN)-E about Review of a minimu assessment from r the facility assesse The facility compile reported allegation the past twelve mo to provide evidence began to investigat During an interview administrator and of they were not awar evening of 4/10/17	side where R108 could not ed NA-B to move the leg of the so that the resident could rest dal. R108 explained that NA-E lchair leg closer as requested sident back to the room. After ident's room, R108 said that ent "you need to show me were very rude to me." R108 B as "rough" when assisting n laying in bed, to sitting up in f R108 reported the incident to confirmed telling registered it what happened. um data set cognitive eference date 2/9/17, reveale d R108 to be cognitively intact ed a list of reported events, an s of abuse and neglect from nths. Review of the list failed e that the facility reported or the R108's allegation. or 4/12/17, at 11:25 a.m. the director of nursing (DON) said re of the allegation from the . After explaining how R108 rough and gruff, and said	d t. d			
	DON said, "Well th confirmed "That is been reported, and administrator said is resident about it, a they would start to said "RN-E should	ent to show more respect, the at isn't appropriate." The DON something that should have I we will do that." The that normally they talk to the nd interview the staff, and said do that immediately. The DON have reported that to us aid RN-E would be retrained				

TATEMENT OF DEFICIENCIE ND PLAN OF CORRECTION	C of Health ES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00900	B. WING			13/2017
AME OF PROVIDER OR SUF		T ADDRESS, CITY, ST	ATE, ZIP CODE		15/2017
OOD SAMARITAN SO		OSELAWN AVENU			
(X4) ID SUMMA	RY STATEMENT OF DEFICIENCIES	PAUL, MN 5511	PROVIDER'S PLAN OF	CORRECTION	(X5)
REFIX (EACH DEFI	CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET
21995 Continued Fre	om page 21	21995			
RN-E confirm being upset w RN-E said R1 take care of t she reported that evening, scheduled to Review of a s facility reported on 4/12/17, at	erview on 4/12/17, at 2:56 p.m. ed that R108 spoke to her about when NA-B called the resident rude 08 mentioned not wanting NA-B the resident that night. RN-E said the situation to the charge nurse who confirmed that NA-B was not take care of R108 that evening. ubmission report revealed the ed the incident to the State Agency fter the interview with the and DON on the same date.	t			
The Administ designee cou and procedur of abuse to th	D METHOD OF CORRECTION: rator, director of nursing and/or ld assure that staff follow the polic e for reporting potential allegation le administrator and follow protoco o the State agency and conductin nvestigaton.	s ol			
TIME PERIO (21) days.	D FOR CORRECTION: Twenty-or	ne			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00900			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,		04	/13/2017
		550 ROS	SELAWN AVENUE E			
OOD SA	MARITAN SOCIETY - MA	APLEWOOD SAINT P	AUL, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 000	Initial Comments		2 000			
	*****ATTEN	TION*****				
	NH LICENSING C	ORRECTION ORDER				
	144A.10, this correcti pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of find the Minnesota Depart Determination of whe corrected requires co requirements of the ru number and MN Rule When a rule contains comply with any of the lack of compliance. L re-inspection with any result in the assessm	ther a violation has been				
	that may result from r orders provided that a	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a for non-compliance.				
	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic sure orders consistent with ment of Health 14-01, available at e.mn.us/divs/fpc/profinfo/inf icensing orders are				

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

TITLE

(X6) DATE

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00900	B. WING		04/13/2017	
AME OF PR	OVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		
OOD SAN	MARITAN SOCIETY - MA	APLEWOOD	ELAWN AVENUE E AUL, MN 55117	AST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
	you electronically. All is necessary for State enter the word "correc- text. You must then in State licensure proce completion date, the corrected prior to elec Minnesota Department On April 10, 11, 12 ar this Department's sta and the following corr Please indicate in you	a orders being submitted to though no plan of correction e Statutes/Rules, please cted" in the box available for ndicate in the electronic ss, under the heading date your orders will be ctronically submitting to the nt of Health.	2 000			
	And identify the date of Minnesota Department the State Licensing C federal software. Tag assigned to Minnesot Nursing Homes. The assigned tag nur column entitled "ID F statute/rule out of cor "Summary Statement and replaces the "To correction order. This findings which are in after the statement, "evidence by." Followi	when they will be completed. Int of Health is documenting correction Orders using numbers have been ta state statutes/rules for The state statutes/rules for The state statutes/rules for The state number appears in the far left Prefix Tag." The state npliance is listed in the to of Deficiencies" column Comply" portion of the to column also includes the violation of the state statute This Rule is not met as ng the surveyors findings ethod of Correction and				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00900	B. WING		04/13/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	•	
GOOD SA	MARITAN SOCIETY - MA	APLEWOOD	SELAWN AVENUE E PAUL, MN 55117	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	APPLIES TO FEDER THIS WILL APPEAR THERE IS NO REQU	WHICH STATES, OF CORRECTION." THIS CAL DEFICIENCIES ONLY. ON EACH PAGE. JIREMENT TO SUBMIT A TION FOR VIOLATIONS OF	2 000			
2 560	Plan of Care; Contents of comprehensive plan objectives and timeta long- and short-term and mental and psyci identified in the comp assessment. The co must include the indiv required by Minnesot subdivision 14, parag	plan of care. The of care must list measurable bles to meet the resident's goals for medical, nursing, hosocial needs that are rehensive resident mprehensive plan of care vidual abuse prevention plan a Statutes, section 626.557,	2 560			
	facility failed to develop comprehensive plan of care for 1 of 1 resident reviewed for hospice. Findings include: Document review rev Admission/Verbal Ce R163, showing the ret hospice care for the p with the admitting dia	op an individualized, of care regarding hospice nt (R163) in the sample				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00900	B. WING		04/13/2017	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
GOOD SA	MARITAN SOCIETY - MA	APLEWOOD	SELAWN AVENUE E AUL, MN 55117	AST		
(X4) ID	SUMMARY ST			PROVIDER'S PLAN ((X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	COMPLET
2 560	Continued From page	e 3	2 560			
	aphasia (difficult swa expression).	llowing and language				
	care from the facility, Hospice Interdisciplin 3/9/17, from the hosp plan of care had two care that read, "The r prognosis R/T [relate with aphasia and dys wishes to remain on with hospice services "Hospice care initiate the bottom of the exis plan of care. There w the specifics of R163 needs related to hosp When interviewed on registered nurse (RN R163, was asked wh used in caring for R1 replied that the facility provider's Hospice In form as a reference t of care, and facility st	contained a current plan of dated 3/23/17, and a hary Care Plan form, dated bice provider. The facility's Focus related to hospice resident has a terminal d to] DX [diagnosis] of CVA sphagia," and "The resident TCU [transitional care unit] s." Information such as, ed on 3/8/17" was added at sting Focus entries in the was not a Focus to address 's psychosocial and spiritual pice care. 4/12/17 at 1:44 p.m.,)-D, the nurse manager for ich care plan the facility staff 63 regarding hospice. RN-D y staff used the hospice iterdisciplinary Care Plan o develop the facility's plan taff then used the facility's ting care of a resident on				
	via fax, an unsigned, discontinue aid servio unsigned, undated pl discontinue chaplain starting 3/16/17. The identified that the doo	fax dates on the documents cuments had been faxed to				
	Also provided was a	7, the date of survey exit. Spiritual Profile form ility on 2/27/17, that showed				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED 04/13/2017	
		00900	B. WING			
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			10/2011
OOD SA	MARITAN SOCIETY - MA	PLEWOOD	SELAWN AVENUE E	AST		
	SUMMARY ST		AUL, MN 55117	PROVIDER'S PLAN ((25)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From page	e 4	2 560			
	specific denomination Section 3. 1. of this for the following spiritual been important to you answer to that question "Visit from my clergy members of my faith SUGGESTED METH The facility director of	as Christian, however, the o section was left blank. form read, "What, if any, of practices or resources have u in the past year?" and the for that was selected read, person/religious leader or community." OD OF CORRECTION: f nursing and/or designee vidualized, comprehensive				
	plans of care are dev coordination of care f hospice care.	eloped to assure				
2 830	receive nursing care a custodial care, and su individual needs and the comprehensive re plan of care as desc 4658.0405. A nursing of bed as much as po written order from the	General eneral. A resident must and treatment, personal and upervision based on preferences as identified in esident assessment and ribed in parts 4658.0400 and g home resident must be out possible unless there is a e attending physician that the in bed or the resident	2 830			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00900			04/13/2017	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	04	13/2017
	MARITAN SOCIETY - MA	STOROS	ELAWN AVENUE E	AST		
300D 3A	MARITAN SOCIETT - MA	SAINT P	AUL, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AU CROSS-REFERENCED TC DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	e 5	2 830			
	This MN Requirement by: Based on document r facility failed to develor comprehensive plan of care for 1 of 1 resider reviewed for hospice. Findings include: Document review rev Admission/Verbal Cer R163, showing the re hospice care for the p with the admitting dia (cerebral vascular act aphasia (difficult swale expression). The document also co care from the facility, Hospice Interdisciplin 3/9/17, from the hosp plan of care had two care that read, "The r prognosis R/T [related with aphasia and dys wishes to remain on with hospice services "Hospice care initiate the bottom of the exis plan of care. There w	t is not met as evidenced review and interview, the op an individualized, of care regarding hospice nt (R163) in the sample ealed a Hospice rtification Orders form for sident was enrolled in period of 3/8/17 to 6/5/17, gnosis of late effect of CVA cident) with dysphagia and lowing and language ontained a current plan of dated 3/23/17, and a ary Care Plan form, dated ice provider. The facility's Focus related to hospice esident has a terminal d to] DX [diagnosis] of CVA phagia," and "The resident ICU [transitional care unit] " Information such as, d on 3/8/17" was added at sting Focus entries in the vas not a Focus to address s psychosocial and spiritual				
	R163, was asked whit used in caring for R10	4/12/17 at 1:44 p.m.,)-D, the nurse manager for ch care plan the facility staff 63 regarding hospice. RN-D / staff used the hospice				

STATE FORM

	OF DEFICIENCIES OF CORRECTION	h (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED	
		00900	B. WING		04	04/13/2017	
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		13/2011	
	MARITAN SOCIETY - M	APLEWOOD	SELAWN AVENUE E PAUL, MN 55117	AST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
2 830	Continued From page	e 6	2 830				
	form as a reference t of care, and facility s	terdisciplinary Care Plan to develop the facility's plan taff then used the facility's ting care of a resident on					
	via fax, an unsigned, discontinue aid servic unsigned, undated pl discontinue chaplain starting 3/16/17. The identified that the doo the facility on 4/13/17 Spiritual Profile form 2/27/17, that showed Christian, however, t section was left bland read, "What, if any, o practices or resource you in the past year? question that was se	4/14/17, the facility provided, undated physician's order to ces starting 3/14/17, and an hysician's order to services and social services fax dates on the documents cuments had been faxed to 7. Also provided was a completed by the facility on I R163 was identified as he specific denomination k. Section 3. 1. of this form of the following spiritual es have been important to " and the answer to that lected read, "Visit from my us leader or members of my					
	The director of nursir procedures related to care for hospice care these polices, and au	OD OF CORRECTION: ng could develop policies and o development of plan of e, educate staff regarding udit resident records for policies and procedures.					
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one					
21830	MN St. Statute 144.6 Residents of HC Fac	51 Subd. 10 Patients &	21830				

STATE FORM

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED	
		00900	B. WING			04/13/2017	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	04	13/2017	
		550 ROS	ELAWN AVENUE E				
GOOD SA	MARITAN SOCIETY - MA	SAINT P	AUL, MN 55117				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE & CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE	
21830	Continued From page 7		21830				
	Subd. 10. Participat notification of family n	tion in planning treatment; nembers.					
	in the planning of their includes the opportun- alternatives with indiv opportunity to requess care conferences, and family member or oth both. In the event that present, a family mem- chosen by the resider conferences. (b) If a resident wh unconscious or coma communicate, the face efforts as required un either a family member	t and participate in formal d the right to include a er chosen representative or at the resident cannot be hber or other representative nt may be included in such o enters a facility is tose or is unable to ility shall make reasonable der paragraph (c) to notify er or a person designated in					
	an emergency that th admitted to the facility family member to par	 The facility shall allow the 					
	to believe the residen directive to the contra specified in writing tha member included in tu notifying a family mer family member to par	t has an effective advance iry or knows the resident has at they do not want a family reatment planning. After nber but prior to allowing a ticipate in treatment					
	efforts, consistent with practice, to determine executed an advance esident's health care						
	resident;	personal effects of the nedical records of the					

Minnesota Depa STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00900	B. WING			
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE	04	/13/2017
		550 ROS	SELAWN AVENUE E			
GOOD SA	MARITAN SOCIETY - MA	APLEWOOD SAINT P	AUL, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
21830	Continued From page	e 8	21830			
	family member contain whether the resident directive and whether physician to whom the care; and (4) inquiring of the resident normally goe whether the resident directive. If a facility designated emergency member to participate accordance with this liable to resident for of the notification of the emergency contact of family member was in patient's privacy right (c) In making rease family member or design examining the person and the medical reco possession of the facility social service agency agency that the resident the facility has been to member or designate county social service enforcement agency identifying and notifyi designated emergency	remergency contact or cted under this section has executed an advance r the resident has a e resident normally goes for physician to whom the es for care, if known, has executed an advance notifies a family member or cy contact or allows a family e in treatment planning in paragraph, the facility is not damages on the grounds that family member or r the participation of the mproper or violated the s. onable efforts to notify a signated emergency contact, not to identify family ated emergency contact by hal effects of the resident rds of the resident in the ility. If the facility is unable nber or designated vithin 24 hours after the v shall notify the county v or local law enforcement ent has been admitted and unable to notify a family ed emergency contact. The agency and local law shall assist the facility in ng a family member or cy contact. A county social and law enforcement agency				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00900	B. WING		04/13/2017	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		10/2011
GOOD SA	MARITAN SOCIETY - MA	PLEWOOD	ELAWN AVENUE E	AST		
			AUL, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21830	Continued From page	9 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:					
		Set [MDS], dated 2/24/17, d physical help with part of nitively intact.				
	able to choose how m each week. R63 repo showers each week, a before admission to th sort of a shock at first scheduled to get one facility. R63 added, "I enough people to do shower a week sched	shower each week at the guess they haven't got more than that" and the one fule was "pretty rigid." R63 asked how many showers				
	received four showers reported she could no many showers R63 w RN-B said she would	.m. RN-B reported R63 had s in the past month. RN-B ot recall discussing how vanted each week with R63. look into it to see if that before RN-B started. At				

Minnesota Department or STATE FORM

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00900	B. WING		04	l/13/2017
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
OOD SA	MARITAN SOCIETY - MA	APLEWOOD	SELAWN AVENUE E	AST		
			AUL, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
21830	Continued From page 10		21830			
	anything related to di R63 wanted each we went to R63 and aske preferred each week, at least two showers did not have enough she would schedule a each week. R63 expr for the added shower R63's care plan histo revealed R63 was sc each week, with a rev 4/12/17, R63's care p showers each week. R63's bathing report revealed R63 receive Bathing Report for 3/ R63 received three s	ry, last revised 4/12/17, heduled for one shower vision date of 4/7/17. On blan history changed to two for 4/1/17 to 4/12/17				
	bath/shower in a wee During interview with R96 reported, would twice a week, but did					
	to take a shower two staff assist due to blir a.m. R96 confirmed F	ther stated, preference was times a week and required ndness. On 4/12/17, at 9:48 R96 wanted more than one hat it was not offered or				
	On 4/11/17, at 2:55 p	m resident's daughter				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00900	B. WING		04	04/13/2017	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
OOD SA	MARITAN SOCIETY - MA		ELAWN AVENUE E AUL, MN 55117	AST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
21830	Continued From page	9 11	21830				
	responded, did not re number of showers p	call staff offering R96 the referred 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"						
	set (MDS) dated 2/16 to understand others,	equired physical assistance					
	BATHING: Resident r one staff to transfer o	I/20/16, directed staff, " equires extensive assist of n/off shower/tub chair for ve assist of one staff to wer/bath.					
	The "North Bath Sche indicated R96 was sc bath/shower each we						
	R96's bathing prefere 1/7/17, revealed that preferred each week						
	On 4/11/17, at 2:37 p. (NA)-C reported the fa bath/shower each we the morning bath aide	acility offered one ek on Tuesdays for R96 by					
	On 4/11/17. at 3:08 p.	.m., registered nurse (RN)-B					

STATEMENT	a Department of Healt FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00900	B. WING		04	/13/2017
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
GOOD SA	MARITAN SOCIETY - MA	APLEWOOD	ELAWN AVENUE E AUL, MN 55117	AST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21830	bath/showers per we of how many per we document the informa record. RN-B further bathing/shower prefe bath/shower per wee R96's daughter, just Policy and procedure resident need, dated	ith R96 regarding number of ek and R96 did have choices ek, however RN-B did not ation in R96's medical explained that the rence (number of k) was not discussed with with R96. • titled Accommodation of February 2013, read, "The to reside and receive • with reasonable	21830			
	The director of nursin assure that upon adn residents are asked a preferences/frequence decisions regarding of	cy, and involved with				
21980	Maltreatment of Vuln Subd. 3. Timing of reporter who has rea vulnerable adult is be or who has knowledg has sustained a phys reasonably explained	report. (a) A mandated	21980			

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If continuation sheet 13 of 22

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		00900	B. WING		04	04/13/2017	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		10/2011	
	MARITAN SOCIETY - M	API EWOOD 550 ROS	ELAWN AVENUE E	EAST			
		SAINT P	AUL, MN 55117				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
21980	Continued From page	e 13	21980				
	the individual is admireporter is not require maltreatment of the i to admission, unless (1) the individual was another facility and the believe the vulnerable previous facility; or (2) the reporter known that the individual is a in section 626.5572, (b) A person not re- provisions of this sec as described above. (c) Nothing in this known or suspected knows or has reason been made to the co	a admitted to the facility from the reporter has reason to e adult was maltreated in the ows or has reason to believe a vulnerable adult as defined subdivision 21, clause (4). equired to report under the ction may voluntarily report section requires a report of maltreatment, if the reporter to know that a report has					
	reporter from also rep agency. (e) A mandated re reason to believe tha 626.5572, subdivisio (5), occurred must m subdivision. If the re time believes that an agency will determine	porting to a law enforcement porter who knows or has t an error under section n 17, paragraph (c), clause ake a report under this porter or a facility, at any investigation by a lead e or should determine that us not neglect according to					
	17, paragraph (c), cla facility may provide to directly to the lead ag how the event meets 626.5572, subdivisio (5). The lead agence	tion 626.5572, subdivision ause (5), the reporter or to the common entry point or gency information explaining the criteria under section n 17, paragraph (c), clause y shall consider this king an initial disposition of					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00900	B. WING		04	/13/2017
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	1	
OOD SA	MARITAN SOCIETY - MA	PLEWOOD	ELAWN AVENUE E AUL, MN 55117	AST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From page	e 14	21980			
	the report under subdivision 9c.					
	by: Based on interview, a facility failed to report	t is not met as evidenced and document review, the an allegation of abuse that staff for 1 of 5 residents 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					
	and brought the reside returning to the reside NA-B told the residen more respect, you we also described NA-B R108 to move from la bed. When asked if R	hair leg closer as requested, ent back to the room. After ent's room, R108 said that t "you need to show me ere very rude to me." R108 as "rough" when assisting hying in bed, to sitting up in 108 reported the incident to firmed telling registered what happened.				
	Review of a minimum assessment from the revealed the facility a cognitively intact.	reference date 2/9/17,				
		a list of reported events, and f abuse and neglect from				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED		
		00900	B. WING					
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	. ZIP CODE	04	04/13/2017		
		550 ROS	ELAWN AVENUE E					
300D SA	MARITAN SOCIETY - MA	SAINT P	AUL, MN 55117					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLE ⁻ DATE		
21980	Continued From page	e 15	21980					
	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.							
	being upset when NA RN-E said R108 men take care of the resid she reported the situa that evening, who con	R108 spoke to her about A-B called the resident rude. Itioned not wanting NA-B to ent that night. RN-E said ation to the charge nurse nfirmed that NA-B was not re of R108 that evening.						
	procedure, last revise alleged or suspected mistreatment or abus immediately to the ad absence of the admin							
		on report revealed the ncident to the State Agency interview with the						

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY
		00900	B. WING		04/13/2017	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE	1 04	10/2011
	MARITAN SOCIETY - MA	STOROS	ELAWN AVENUE E	AST		
		SAINT P	AUL, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE ⁻ DATE
21980	Continued From page	e 16	21980			
	administrator and DO	N on the same date.				
	5 1 1 1 1					
	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 a					
	Findings include:					
	described nursing ass gruff" during transfers after dinner, NA-B ass dining room back to th used a wheelchair for leg was out to the sid reach it. R108 asked wheelchair closer so foot on the foot pedal did move the wheelch and brought the reside NA-B told the residen more respect, you we also described NA-B R108 to move from la bed. When asked if R staff, the resident con	n 4/10/17, at 6:53 p.m. R108 sistant (NA)-B as "rough and a. R108 said earlier tonight sisted the resident from the he resident's room. R108 mobility, and the wheelchair e where R108 could not NA-B to move the leg of the that the resident could rest . R108 explained that NA-B hair leg closer as requested, ent back to the room. After ent's room, R108 said that t "you need to show me tre very rude to me." R108 as "rough" when assisting hying in bed, to sitting up in 108 reported the incident to firmed telling registered				
	nurse (RN)-E about w Review of a minimum					
	revealed the facility a					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00900	B. WING		04/13/2017	
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		04	/13/2017
		550 ROS	SELAWN AVENUE E			
500D 5A	MARITAN SOCIETY - M	SAINT P	AUL, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE
21980	Continued From pag	e 17	21980			
	cognitively intact.					
	reported allegations the past twelve mont	a list of reported events, and of abuse and neglect from hs. Review of the list failed that the facility reported or R108's allegation.				
	administrator and dir they were not aware evening of 4/10/17. A described NA-B as ro NA-B told the resider DON said, "Well that confirmed "That is so been reported, and w administrator said that resident about it, and they would start to do said "RN-E should hat	on 4/12/17, at 11:25 a.m. the ector of nursing (DON) said of the allegation from the After explaining how R108 ough and gruff, and said ht to show more respect, the isn't appropriate." The DON omething that should have we will do that." The at normally they talk to the d interview the staff, and said o that immediately. The DON ave reported that to us id RN-E would be retrained				
	RN-E confirmed that being upset when NA RN-E said R108 mer take care of the resic she reported the situ that evening, who co	on 4/12/17, at 2:56 p.m. R108 spoke to her about A-B called the resident rude. Intioned not wanting NA-B to Jent that night. RN-E said ation to the charge nurse Infirmed that NA-B was not re of R108 that evening.				
	procedure, last revise alleged or suspected mistreatment or abus immediately to the ad absence of the admin	and Neglect policy and ed 11/16, revealed that l violations involving any se should be reported dministrator; or in the nistrator, to the director of ne director of social services.				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00900	B. WING		04	/13/2017
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	1 •	
GOOD SA	MARITAN SOCIETY - MA	APLEWOOD	SELAWN AVENUE E	AST		
(X4) ID	SUMMARY ST		PAUL, MN 55117	PROVIDER'S PLAN		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	COMPLET
21980	Continued From page	e 18	21980			
	The Administrator, di designee could assur allegations of abuse a appropriate staff, follo	OD OF CORRECTION: rector of nursing and/or re that all potential are immediately reported to owed through with reporting thoroughly investigated.				
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-one				
21995	MN St. Statute 626.5 Maltreatment of Vulne	57 Subd. 4a Reporting - erable Adults	21995			
	(a) Each facility shall ongoing written proc applicable licensing r of suspected maltrea facility has an interna mandated reporter m requirements of this s internally. However,	the facility remains lying with the immediate				
	by: Based on document i facility failed to follow procedures to report	It is not met as evidenced review and interview, the restablished policies and and investigate allegations sidents (R108) investigated				

Minnesota Department of Health STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
				B. WING		
	ROVIDER OR SUPPLIER	00900 STREET A	DDRESS, CITY, STATE		04	1/13/2017
		550 ROS	ELAWN AVENUE E			
JOOD SA	MARITAN SOCIETY - MA	SAINT P	AUL, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From page	e 19	21995			
	for abuse.					
	Findings include:					
	procedure, last revise alleged or suspected mistreatment or abus immediately to the ad absence of the admir nursing services or th The procedure require employee receives an employee is required The charge nurse or notified immediately, determine whether ar action is required, an investigation. If this is to resident abuse, the from providing direct Additionally, the emp suspension pending t investigation. A desig complete the docume record. Allegations of be reported no later t allegation is made to other officials in acco investigative team (so and director of nursin incidents no later that following the incident	Iministrator; or in the histrator, to the director of he director of social services. ed the following: If an h allegation of abuse, the to report to a supervisor. licensed nurse will be assess the situation to hy emergency treatment or d complete an initial an allegation of employee e employee will be removed care to all residents. loyee will be placed on the results of the internal nated individual will then entation in the medical abuse, or mistreatment will han two hours after the the administrator, and to rdance with state law. The bocial worker, administrator g services) will review all in the next working day				
	after dinner, NA-B as dining room back to t	s. R108 said earlier tonight sisted the resident from the he resident's room. R108 r mobility, and the wheelchair				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00900	B. WING		04/13/2017		
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE				
OOD SA	MARITAN SOCIETY - M	APLEWOOD	SELAWN AVENUE E AUL, MN 55117	A31			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE DATE	
21995	Continued From pag	je 20	21995				
	reach it. R108 asked wheelchair closer so foot on the foot peda did move the wheeld and brought the reside returning to the reside more respect, you w also described NA-E R108 to move from 1 bed. When asked if staff, the resident co nurse (RN)-E about Review of a minimur assessment from ref the facility assessed The facility compiled reported allegations the past twelve mon	m data set cognitive ference date 2/9/17, revealed R108 to be cognitively intact. I a list of reported events, and of abuse and neglect from ths. Review of the list failed that the facility reported or					
	administrator and dir they were not aware evening of 4/10/17. A described NA-B as r NA-B told the reside DON said, "Well that confirmed "That is so been reported, and v administrator said th resident about it, and they would start to d said "RN-E should h	on 4/12/17, at 11:25 a.m. the rector of nursing (DON) said of the allegation from the After explaining how R108 rough and gruff, and said nt to show more respect, the t isn't appropriate." The DON omething that should have we will do that. "The lat normally they talk to the d interview the staff, and said o that immediately. The DON ave reported that to us id RN-E would be retrained					

	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED 04/13/2017	
		00900				
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,		02	13/2017
	MARITAN SOCIETY - MA	API EWOOD	SELAWN AVENUE E	AST		
	1	SAINT P	AUL, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From page	21	21995			
	RN-E confirmed that is being upset when NA RN-E said R108 men take care of the residuate care of the residuate care of the residuate that evening, who core scheduled to take care Review of a submissi facility reported the in on 4/12/17, after the in administrator and DO SUGGESTED METH The Administrator, dire designee could assure and procedure for reporting to the St a thourough investigate the state of t	N on the same date. OD OF CORRECTION: rector of nursing and/or re that staff follow the policy porting potential allegations histrator and follow protocol ate agency and conducting				