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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: W1SB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00575

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/01/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **51** (L18)
13.Total Certified Beds **51** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 11/14/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 11/14/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245568

November 7, 2017

Ms. Elizabeth Callahan, Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

Dear Ms. Callahan:

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

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

Effective August 29, 2017 the above facility is certified for:

51 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 51 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

Electronically delivered

November 7, 2017

Ms. Elizabeth Callahan, Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

RE: Project Number S5568027

Dear Ms. Callahan:

On August 22, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 10, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 1, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 20, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 10, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 29, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 10, 2017, effective August 29, 2017 and therefore remedies outlined in our letter to you dated August 22, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: W1SB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00575

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(L1) **245568**
2.STATE VENDOR OR MEDICAID NO.
(L2) **060743600**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/10/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **51** (L18)
13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Holly Kranz, HFE NE II 09/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 10/20/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
07/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 22, 2017

Ms. Elizabeth Callahan, Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

RE: Project Number S5568027

Dear Ms. Callahan:

On August 10, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 201
Marshall, Minnesota 56258-2504
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 19, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 19, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by November 10, 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 February 10, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	08/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On August 7, 8, 9 and 10, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for	F 279		8/29/17

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

Electronically Signed | 08/28/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	08/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1	F 279		

each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.

(iv)In consultation with the resident and the resident’s representative (s)-

(A) The resident’s goals for admission and desired outcomes.

(B) The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	08/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a care plan was developed related to hemodialysis services for 1 of 1 resident (R5) reviewed who received ongoing dialysis treatments and for 1 of 2 residents (R62) reviewed for pain who was experiencing daily knee discomfort. Findings include: R5's face sheet, dated 8/10/17 listed current diagnoses of end stage renal disease and dependence on renal dialysis. R5's admission Minimum Data Set (MDS) assessment, dated 5/24/17 identified R5 was not yet receiving dialysis services upon admission. R5's current physician's orders, dated 7/21/17 listed an order for hemodialysis three times a week on Tuesdays, Thursdays and Saturdays. R5's current care plan, last updated 7/13/17, lacked any care plan focus or other care plan interventions related to hemodialysis. R5's treatment record, dated 8/17 lacked orders or treatments related to dialysis services. During observation and interview on 8/9/17, R5 was seated in his recliner in his room. R5 stated he went to dialysis three days per week, and	F 279	A comprehensive care plan was developed for the need for dialysis care for R-5. A comprehensive care plan was developed for R-62 for pain management. Care plans were developed by the MDS coordinator on 8/9/17. No other residents receive dialysis treatment within the facility. All residents experiencing pain were reviewed for comprehensive care plan development. Care plans were developed by the MDS coordinator on 8/9/17. All licensed nurses were educated on updating the care plans when changes occur through a memo issued on 8/25/17. Education will be provided by the Director of Nursing in a nursing staff meeting on 8/29/17. Audits will be conducted for accuracy in care plans in relevance to dialysis care, on one resident three times per week for four weeks by the Director of Nursing or designee. Audits will be conducted for accuracy in care plans in relevance to pain, weekly for four weeks and then monthly for two months by the Director of Nursing or designee. Audit results will be reported to the QAPI committee for review and recommendation.	

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	245568	A. BUILDING _____ B. WING _____	08/10/2017

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F 279	Continued From page 3	F 279		

nursing checked his vital signs before and after his treatments. R5 stated he had a central venous catheter (CVC) used for dialysis and that dialysis staff managed the flushing of his ports after dialysis treatment. He stated he was on a renal diet and needed to avoid things high in potassium, such as potatoes.

During interview on 8/9/17, at 9:54 a.m., registered nurse (RN)-C stated she observed R5 for large fluctuations in his weight, and ensured his central catheter dressing was dry and intact post dialysis.

During interview on 8/9/17, at 11:16 a.m. the director of nursing (DON) stated she was not sure whether dialysis interventions should be identified on the plan of care, but would check with RN-A, who primarily wrote the care plans for all of the residents.

When interviewed on 8/9/17, at 1:18 p.m. RN-A stated the care plans were updated with the Minimum Data Set (MDS) assessments; however, any nurse could update the care plan when changes occurred between quarterly assessments. RN-A confirmed the dialysis interventions should have been identified on the care plan.

The facility policy entitled Dialysis Services, dated 9/16, indicated to care plan dialysis care specific to the resident; for example, unique nutritional needs or fluid restrictions.

R62's face sheet, dated 8/10/17, identified a knee sprain, with onset date of 7/20/17.

R62's admission MDS, dated 6/26/17, indicated

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F 279	Continued From page 4	F 279		

she had not been experiencing significant discomfort upon admission to the facility.

R62's medication sheets, dated 7/17 and 8/17 identified R62 had experienced discomfort rated two (2) to (10) ten on a 10-point scale on a daily basis since 7/20/17. The medication sheets revealed R62 received multiple pain medications including tylenol, oxycodone (a narcotic) as well as topical ointment (Biofreeze).

R62's current care plan dated 8/9/17, lacked any interventions related to pain management or a care plan focus related to pain.

R62's eINTERACT assessment (a communication tool used to report changes in condition to a physician), dated 7/30/17, identified she was having pain rated a seven (7) on a 10-point scale in both the right and left knee, aggravated by movement and walking. Ice was listed as a helpful intervention, along with medications. The form indicated R62 was sent for steroid injections in the knee.

During observation and interview on 8/7/17, at 5:07 p.m. R62 stated she had been experiencing pain in her left knee for at least a couple of weeks after a recent fall. R62 rated the discomfort as 10 on a 10-point scale at night. R62 was rubbing her knee during the interview.

During interview on 8/8/17, at 1:54 p.m. licensed practical nurse (LPN)-A stated R62 began experiencing knee discomfort on 7/20/17, after a fall and was still being reported at a moderate level. LPN-A stated she monitored R62's pain level after scheduled and as needed pain medications and documented the responses.

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F 279	Continued From page 5 LPN-A explained that several faxes had been sent to physicians related to R62's pain regimen and several order changes made. LPN-A stated R62's discomfort was worst at night. During interview on 8/8/17, at 2:00 p.m. registered nurse (RN)-B stated R62's pain level varied on a daily basis, but was worst in the evenings. She stated ice and sometimes heat were helpful to control the discomfort, as well as narcotic pan medications and that the pain had been occurring since at least 7/21/17. During observation and interview on 8/8/17, at 2:44 p.m. R62 stated she thought her pain was better today, a 6 or 7 on a 10-point scale. R62 did not demonstrate non-verbal signs of pain at this time. When interviewed on 8/9/17, at 1:18 p.m. RN-A, who typically updated the care plans, stated all nursing staff could update the care plan and would have expected R62's pain and the implemented interventions to have been a part of the comprehensive plan of care. She indicated since the issue with knee pain had occurred between MDS assessment timeframe's, she had not yet developed a care plan related to this problem since it was not a problem upon R62's admission to the facility. The facility policy entitled Pain Management, last revised 5/17 indicated the interdisciplinary team will develop both pharmacological and non-pharmacological approaches on care plans for residents experiencing pain.	F 279		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		8/29/17

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F 328	Continued From page 6 (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care	F 328		

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F 328	Continued From page 7 and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow manufacturer's instructions during the administration of insulin for 1 of 2 residents (R21) observed who received insulin via an insulin pen. Findings include: On 8/7/17, at 7:21 p.m. registered nurse (RN)-B was observed preparing and administering insulin to R21 via a Lantus SoloStar pen. RN-B removed the cap from the pen and then attached a disposable needle to the rubber stopper located at end of the pen. After attaching the needle to the SoloStar pen, RN-B dialed-up 74 units and administered the insulin into R21's stomach. RN-B did not prime the SoloStar pen prior to dialing up and administering the prescribed insulin dose. When interviewed at this time, RN-B confirmed she had not primed the SoloStar pen prior to dialing the prescribed insulin dosage.	F 328	The process for administering insulin by the SoloStar pen for R-21, was changed to meet manufacturer's instructions, by the Director of Nursing on 8/10/17. Audits were performed on all residents receiving insulin injections from the SoloStar pen, for priming accuracy per manufacturer's instructions, by the Director of Nursing on 8/10/17. Education was provided to RN-B on 8/11/17 regarding the correct process when administering insulin from the SoloStar pen, by the Director of Nursing. Education will be provided by the Staff Development Registered Nurse, to all licensed nurses at nursing staff meeting on 8/29/17. Audits will be conducted on all licensed	

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F 328	Continued From page 8 RN-B further indicated she had never primed an insulin pen nor been instructed to do so prior to dialing the prescribed dose. When interviewed on 8/8/17, at 4:14 p.m. licensed practical nurse (LPN)-B stated there is no need to prime an insulin pen nor waste 2 units prior to dialing up the dose and subsequent administration. LPN-B further indicated the insulin pens "self prime" after applying the needle. When interviewed on 8/9/17, at 9:43 a.m. the director of nursing (DON) explained she would apply the needle, dial the prescribed dose on the insulin pen and then administer to the resident. The DON indicated she would not waste nor prime the insulin pen prior, confirming she had not been taught to implement this step. When interviewed on 8/10/17, at 10:23 a.m. the pharmacist from Lewis Drug stated insulin pens should be used according to manufacturer's guidelines when administering insulin via an insulin pen. The Lantus SoloStar pen manufacturer's Instructions included: Always perform the safety test before each injection. This ensures you get an accurate dose by ensuring that pen and needle work properly and removes air bubbles. Select a dose of 2 units by turning the dosage selector. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. Hold the pen with the needle pointing upwards. Tap the insulin reservoir so that any air bubbles rise up towards the needle. Press the injection button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety	F 328	nurses that administer insulin injections for four weeks by the Director of Nursing or designee. Audit results will be reported to the QAPI committee for review and recommendation.	

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F 328	Continued From page 9 test several times before insulin is seen.	F 328		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to	F 356		8/29/17

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F 356	Continued From page 10 residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to include current census information on the daily nursing staffing posting. This had the potential to affect any of the 50 residents, visitors and/or staff who wish to review the information. Findings include: During the initial tour on 8/7/17, at 2:25 p.m. it was noted the daily nursing staffing posting was dated 8/7/17, but it did not include the current resident census. On subsequent days, 8/8/17 and 8/9/17, the daily nursing staffing posting did not include the current resident census. When interviewed on 8/9/17, at 9:22 a.m. the health information manager (HIM) verified the census information was not present on the daily nurse staffing posting for the above listed days. The policy Nursing Staff Daily Posting Requirements, revised 12/15, directs the resident census to be posted daily and updated each shift as appropriate.	F 356	The nursing staff daily posting was revised to meet the regulation regarding resident census, by the Health Information Manager on 8/9/17. The Health Information Manager was educated on 8/9/17 and the scheduling coordinator and all licensed nurses were educated on the policy for updating the nursing staff daily posting through a memo posted on 8/25/17, by the Director of Nursing. Education will be provided by Director of Nursing or designee, to all licensed nurses at the nursing staff meeting on 8/29/17. Audits will be performed weekly for four weeks and then monthly for two months, for accuracy of posted information, by the Director of Nursing or designee. The audit results will be reported to the QAPI committee for review and recommendations. Completion date: August 29, 2017	

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Electronically delivered
August 22, 2017

Ms. Elizabeth Callahan, Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5568027

Dear Ms. Callahan:

The above facility was surveyed on August 7, 2017 through August 10, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Kathryn Serie, Unit Supervisor at (507) 476-4233 or at kathryn.serie@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

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	00575	A. BUILDING: _____ B. WING _____	08/10/2017

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On August 7th, 8th, 9th and 10th, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00575	A. BUILDING: _____ B. WING _____	08/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a care plan was developed related to hemodialysis services for 1 of 1 resident (R5) reviewed who received ongoing dialysis treatments and for 1 of 2 residents (R62) reviewed for pain who was experiencing daily knee discomfort. Findings include: R5's face sheet, dated 8/10/17 listed current diagnoses of end stage renal disease and dependence on renal dialysis. R5's admission Minimum Data Set (MDS) assessment, dated 5/24/17 identified R5 was not yet receiving dialysis services upon admission.	2 560	Corrected. Completion Date: August 29, 2017	8/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 560	Continued From page 3 R5's current physician's orders, dated 7/21/17 listed an order for hemodialysis three times a week on Tuesdays, Thursdays and Saturdays. R5's current care plan, last updated 7/13/17, lacked any care plan focus or other care plan interventions related to hemodialysis. R5's treatment record, dated 8/17 lacked orders or treatments related to dialysis services. During observation and interview on 8/9/17, R5 was seated in his recliner in his room. R5 stated he went to dialysis three days per week, and nursing checked his vital signs before and after his treatments. R5 stated he had a central venous catheter (CVC) used for dialysis and that dialysis staff managed the flushing of his ports after dialysis treatment. He stated he was on a renal diet and needed to avoid things high in potassium, such as potatoes. During interview on 8/9/17, at 9:54 a.m., registered nurse (RN)-C stated she observed R5 for large fluctuations in his weight, and ensured his central catheter dressing was dry and intact post dialysis. During interview on 8/9/17, at 11:16 a.m. the director of nursing (DON) stated she was not sure whether dialysis interventions should be identified on the plan of care, but would check with RN-A, who primarily wrote the care plans for all of the residents. When interviewed on 8/9/17, at 1:18 p.m. RN-A stated the care plans were updated with the Minimum Data Set (MDS) assessments; however, any nurse could update the care plan when changes occurred between quarterly	2 560		

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2 560	Continued From page 4	2 560		

assessments. RN-A confirmed the dialysis interventions should have been identified on the care plan.

The facility policy entitled Dialysis Services, dated 9/16, indicated to care plan dialysis care specific to the resident; for example, unique nutritional needs or fluid restrictions.

R62's face sheet, dated 8/10/17, identified a knee sprain, with onset date of 7/20/17.

R62's admission MDS, dated 6/26/17, indicated she had not been experiencing significant discomfort upon admission to the facility.

R62's medication sheets, dated 7/17 and 8/17 identified R62 had experienced discomfort rated two (2) to (10) ten on a 10-point scale on a daily basis since 7/20/17. The medication sheets revealed R62 received multiple pain medications including tylenol, oxycodone (a narcotic) as well as topical ointment (Biofreeze).

R62's current care plan dated 8/9/17, lacked any interventions related to pain management or a care plan focus related to pain.

R62's eINTERACT assessment (a communication tool used to report changes in condition to a physician), dated 7/30/17, identified she was having pain rated a seven (7) on a 10-point scale in both the right and left knee, aggravated by movement and walking. Ice was listed as a helpful intervention, along with medications. The form indicated R62 was sent for steroid injections in the knee.

During observation and interview on 8/7/17, at 5:07 p.m. R62 stated she had been experiencing

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GOOD SAMARITAN SOCIETY - MARY JANE BR	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

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2 560	Continued From page 5	2 560		

pain in her left knee for at least a couple of weeks after a recent fall. R62 rated the discomfort as 10 on a 10-point scale at night. R62 was rubbing her knee during the interview.

During interview on 8/8/17, at 1:54 p.m. licensed practical nurse (LPN)-A stated R62 began experiencing knee discomfort on 7/20/17, after a fall and was still being reported at a moderate level. LPN-A stated she monitored R62's pain level after scheduled and as needed pain medications and documented the responses. LPN-A explained that several faxes had been sent to physicians related to R62's pain regimen and several order changes made. LPN-A stated R62's discomfort was worst at night.

During interview on 8/8/17, at 2:00 p.m. registered nurse (RN)-B stated R62's pain level varied on a daily basis, but was worst in the evenings. She stated ice and sometimes heat were helpful to control the discomfort, as well as narcotic pan medications and that the pain had been occurring since at least 7/21/17.

During observation and interview on 8/8/17, at 2:44 p.m. R62 stated she thought her pain was better today, a 6 or 7 on a 10-point scale. R62 did not demonstrate non-verbal signs of pain at this time.

When interviewed on 8/9/17, at 1:18 p.m. RN-A, who typically updated the care plans, stated all nursing staff could update the care plan and would have expected R62's pain and the implemented interventions to have been a part of the comprehensive plan of care. She indicated since the issue with knee pain had occurred between MDS assessment timeframe's, she had not yet developed a care plan related to this

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GOOD SAMARITAN SOCIETY - MARY JANE BF	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

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2 560	Continued From page 6 problem since it was not a problem upon R62's admission to the facility. The facility policy entitled Pain Management, last revised 5/17 indicated the interdisciplinary team will develop both pharmacological and non-pharmacological approaches on care plans for residents experiencing pain. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to the development of the care plan. The DON or designee, could provide training for all nursing staff related to care plan development. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		8/29/17

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2 830	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow manufacturer's instructions during the administration of insulin for 1 of 2 residents (R21) observed who received insulin via an insulin pen. Findings include: On 8/7/17, at 7:21 p.m. registered nurse (RN)-B was observed preparing and administering insulin to R21 via a Lantus SoloStar pen. RN-B removed the cap from the pen and then attached a disposable needle to the rubber stopper located at end of the pen. After attaching the needle to the SoloStar pen, RN-B dialed-up 74 units and administered the insulin into R21's stomach. RN-B did not prime the SoloStar pen prior to dialing up and administering the prescribed insulin dose. When interviewed at this time, RN-B confirmed she had not primed the SoloStar pen prior to dialing the prescribed insulin dosage. RN-B further indicated she had never primed an insulin pen nor been instructed to do so prior to dialing the prescribed dose. When interviewed on 8/8/17, at 4:14 p.m. licensed practical nurse (LPN)-B stated there is no need to prime an insulin pen nor waste 2 units prior to dialing up the dose and subsequent administration. LPN-B further indicated the insulin pens "self prime" after applying the needle. When interviewed on 8/9/17, at 9:43 a.m. the director of nursing (DON) explained she would apply the needle, dial the prescribed dose on the insulin pen and then administer to the resident. The DON indicated she would not waste nor	2 830	Corrected. Completion Date: August 29, 2017	

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2 830	Continued From page 8 prime the insulin pen prior, confirming she had not been taught to implement this step. When interviewed on 8/10/17, at 10:23 a.m. the pharmacist from Lewis Drug stated insulin pens should be used according to manufacturer's guidelines when administering insulin via an insulin pen. The Lantus SoloStar pen manufacturer's Instructions included: Always perform the safety test before each injection. This ensures you get an accurate dose by ensuring that pen and needle work properly and removes air bubbles. Select a dose of 2 units by turning the dosage selector. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. Hold the pen with the needle pointing upwards. Tap the insulin reservoir so that any air bubbles rise up towards the needle. Press the injection button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety test several times before insulin is seen. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice licensed staff related to the appropriate insulin administration and procedure as recommended by the manufacturer of the insulin pen. The director could conduct random audits to ensure the appropriate use of the insulin pen was implemented by staff and report the findings to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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	245568	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/09/2017**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society Mary J. Brown was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145 Facsimile: 651-215-0525, or	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/25/2017

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

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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us
<mailto:Marian.Whitney@state.mn.us> and
Angela.Kappenman@state.mn.us
<mailto:Angela.Kappenman@state.mn.us>

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Building 01 of Good Samaritan Society Mary J. Brown was constructed as follows:
The original building was constructed in 1959, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction;
The 1st Addition was constructed in 1965, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction;
The 2nd Addition was constructed in 1987, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction;
The 3rd Addition was constructed in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction.
The 4th Addition was constructed in 2011, is a new main entrance, offices, conference room and beauty shop, is one-story in height, has no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/09/2017**

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K 000	Continued From page 2 basement, is fully fire sprinkler protected and was determined to be of Type II (111) construction. These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 51 beds and had a census of 50 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 362 SS=F	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at	K 362		8/9/17

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	245568	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/09/2017**

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K 362	Continued From page 3 the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This STANDARD is not met as evidenced by: Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7. This deficient practice could effect 50 of the 50 residents. FINDINGS INCLUDE: During the Facility Inspection on August 09, 2017, between 11:00 AM and 2:00 PM, observation during the inspection revealed the self-closing Dining Room Hall Corridor Door connected to the fire alarm does not positively latch into the door frame. This deficient practice was observed by the Facility Maintenance Director.	K 362	The facility adjusted tension on the door closer on the Dining Room Hall Corridor door on 8-9-17. The door was adjusted to compensate for increased air movement in the corridor. The adjusted door tension allows the door to latch appropriately into the door frame, and is compliant with Life Safety Code requirements. The adjustment of the door tension was completed by Facility Director of Maintenance. The doors will be checked on a regular basis by the Director of Maintenance, for continued compliance. Results of the audits will be reviewed by the QAPI committee.	

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K 911 SS=F	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This STANDARD is not met as evidenced by: Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 08/09/2017, the following electrical issues were noted during the inspection: 1.) A surface mounted electrical box in the 129 A Soiled Utility Room does not have a cover installed. 2.) The therapy oven/stove needs a positive lock-out device installed to prevent residents from turning this device on without staff approval. This deficient practice was verified by the Facility Maintenance Director.	K 911	1)The facility re-installed the surface mounted electrical box in the 129A Soiled Utility room on 8-10-17. The installation of the electrical box was completed by Facility Director of Maintenance. Monitoring of electrical boxes will be performed on a regular basis by the Director of Maintenance, for continued compliance. Results of the audits will be reviewed by the QAPI committee. 2)The facility purchased a positive lock-out device and installed it over the therapy oven power switch on 8-10-17. A key for the positive lock-out device is locked in a cabinet within the activity room, out of resident's reach. The installation of the positive lock-out device was completed by Facility Director of Maintenance. Monitoring of lock-out devices will be performed on a regular basis by the Director of Maintenance, for continued compliance. Results of the audits will be reviewed by the QAPI committee.	8/10/17