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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: Y1RU
Facility ID: 00303

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245455**
2. STATE VENDOR OR MEDICAID NO.
(L2) **673342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - JACKSON**
(L4) **601 WEST JACKSON**
(L5) **JACKSON, MN** (L6) **56143**

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 **09/10/2014** (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 **63** (L18)
13.Total Certified Beds **63** (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: * Code: **B** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	63			
(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 :
Joseph Garvey,, HFE NE II 10/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/27/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/05/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245455

October 21, 2014

Mr. Daren Rife, Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, Minnesota 56143

Dear Mr. Rife:

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 September 24, 2014 the above facility is certified for:

63 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 63 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, Program Specialist
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

October 21, 2014

Mr. Daren Rife, Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, Minnesota 56143

RE: Project Number S5455025

Dear Mr. Rife:

On September 18, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective September 22, 2014. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 24, 2014. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on July 24, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on September 10, 2014. The most serious deficiencies at the time of the revisit 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 October 15, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on September 10, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 10, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on September 10, 2014, as of September 24, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 24, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of September 18, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 24, 2014, 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 October 24, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 24, 2014, is to be rescinded.

In our letter of September 18, 2014, 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 October 24, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 24, 2014, 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 visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245455	A. Building B. Wing	10/15/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - JACKSON	601 WEST JACKSON JACKSON, MN 56143

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**09/24/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KFD	10/21/2014	22113	10/15/2014
CMS RO				

Followup to Survey Completed on: 7/24/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245455	01 - MAIN BUILDING 01	9/25/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - JACKSON	601 WEST JACKSON JACKSON, MN 56143

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	08/24/2014	ID Prefix Reg. # NFPA 101 LSC K0056	09/24/2014	ID Prefix Reg. # NFPA 101 LSC K0067	08/24/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KFD	10/21/2014	25822	09/25/2014
CMS RO				

Followup to Survey Completed on: 7/24/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

AH Form Approved
10/28/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00303	A. Building B. Wing	10/15/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - JACKSON	601 WEST JACKSON JACKSON, MN 56143

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20835** Reg. # **MN Rule 4658.0520 Subp. :** LSC	Correction Completed **09/24/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KS/KFD	10/21/2014	22113	10/15/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/24/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Protecting, Maintaining and Improving the Health of Minnesotans

October 21, 2014

Mr. Daren Rife, Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, Minnesota 56143

Re: Enclosed Reinspection Results - Project Number S5455025

Dear Mr. Rife:

On October 15, 2014 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 October 15, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: Y1RU
Facility ID: 00303

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245455**

2. STATE VENDOR OR MEDICAID NO. (L2) **673342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - JACKSON**
(L4) **601 WEST JACKSON**
(L5) **JACKSON, MN** (L6) **56143**

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 **09/10/2014** (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 **63** (L18)

13.Total Certified Beds **63** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	63			
(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 :
Kyla Einertson, HFE NE II 09/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/21/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **04/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **09/05/2014** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

October 21, 2014

Mr. Daren Rife, Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, Minnesota 56143

Re: Enclosed Reinspection Results - Project Number S5455025

Dear Mr. Rife:

On October 15, 2014 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 October 15, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245455	A. Building B. Wing	9/10/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - JACKSON	601 WEST JACKSON JACKSON, MN 56143

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0176 Reg. # 483.10(n) LSC	08/25/2014	ID Prefix F0276 Reg. # 483.20(c) LSC	08/25/2014	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	08/25/2014
ID Prefix F0315 Reg. # 483.25(d) LSC	08/25/2014	ID Prefix F0329 Reg. # 483.25(l) LSC	08/25/2014	ID Prefix F0463 Reg. # 483.70(f) LSC	08/25/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/KFD	09/21/2014	31221	09/10/2014
CMS RO				

Followup to Survey Completed on: 7/24/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING ______ B. WING ______	R 09/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON** **JACKSON, MN 56143**

(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 An onsite resurvey was conducted by a surveyor of this department,on September 9, 10, 2014, to determine compliance with Federal deficiencies issued during a recertification survey exited on July 24, 2014. During this visit the following regulation was determined to be not corrected: F312.	{F 000}		
{F 312} SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with removal of facial hair for 2 of 3 residents (R7, R72) who were assessed to need assistance in completing activities of daily living skills (ADLs). This tag was issued at the certification survey exited on 7/24/14 and on this post certification survey (PCR) was again found not to be in compliance. Findings Include: R7 was observed on 9/9/14 at 10:52 a.m. and noted to have visible facial hair around her upper lip. R7 was observed on 9/9/14 at 3:07 p.m. and noted to have visible facial hair around her upper lip. R7 was observed on 9/10/14 at 8:30 a.m. and	{F 312}	F 312 Resident (R4) nails were cleaned and trimmed. Resident (R7) facial hair was removed by NA. All other residents who are unable to carry out nail care or facial hair were checked to assure they were clean and trimmed. Nurses and NA's received re-education on grooming and personal hygiene on 8/18/14 & 8/20/14. Licensed Nurses will be responsible to assure nail care and facial hair are removed unless there is a refusal by a resident. Observational audits will be completed weekly X2 nail & facial hair then X 1 month then reviewed by the quality committee for further recommendations	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING ______ B. WING ______	R 09/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON JACKSON, MN 56143**

(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 312}	Continued From page 1	{F 312}		

noted to have visible facial hair around her upper lip.
The quarterly Minimum Data Set (MDS) dated 7/23/14 indicated that R7 was unable to complete the Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment. The MDS dated 7/23/14 also indicated that R7 required extensive assist of one staff for personal hygiene.
R7's care plan dated 5/5/14 indicated that the resident was admitted on 8/29/13 and had diagnoses that included paralysis agitans, dementia and depressive disorder.
R7's care plan dated 5/5/14 indicated a problem ADLs self- care performance deficit and directed staff that R7 required assistance of one staff participation with personal hygiene.
During an interview on 9/10/14 at 9:45 a.m. registered nurse (RN)-A confirmed R7 had visible long facial hair around the corners of R7's upper lip. RN-A stated staff should have taken care of R7's facial hair on bath days and should look for facial hair daily as a part of morning cares as they are getting resident for the day. RN-A stated R7 had her scheduled bath on Tuesdays, which was yesterday (9/9/14 also the day surveyor entered facility) and stated there was no documentation that indicated R7 refused to allow staff to shave her facial hair.

R72 was observed on 9/9/14 at 8:40 a.m. and noted to have several short chin hairs across the bottom of her chin.

R72 was observed on 9/9/14 at 3:11 p.m. and was noted to have several short chin hairs across the bottom of her chin.

R72 was observed on 9/9/14 at 8:24 a.m. and was noted to have several short chin hairs across

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{F 312}	Continued From page 2 the bottom of her chin. R72's care plan dated 7/1/14 indicated R72 was admitted on 7/1/2014 and had diagnoses that included congestive heart failure, atrial fibrillation and anxiety state. The admission Minimum Data Set (MDS) dated 7/7/14 indicated R72 had a Brief Interview for Mental Status (BIMS) score of twelve which indicated moderate cognitive impairment. The MDS dated 7/7/14 also indicated that R7 required extensive assist of one staff for personal hygiene. R72's care plan dated 7/1/14 indicated a problem with ADLs self-care performance deficit and read, " PERSONAL HYGIENE: Encourage resident to do so independently while in the bathroom getting dressed for the day." During an interview on 9/10/14 at 9:50 a.m. RN-A confirmed R72 had visible facial hair along her chin and upper lip. RN-A stated staff should have taken care of R72's facial hair on bath days and should look for facial hair daily as a part of morning cares as they are getting resident for the day. RN-A stated R72 had her scheduled bath on Saturdays and stated there was no documentation that indicated R72 refused to allow staff to shave her facial hair. During an interview on 9/10/14 at 11:29 a.m. R72 stated, "Some of the staff offer to shave my facial hair and others don't." R72 stated staff did not offer to shave her facial hair on her bath days. R72 stated she used to shave her own facial hair, but did not have the equipment here to shave by herself. R72 stated she wanted staff to "shave her facial hair when they see it, as it does not look good to have facial hair." During an interview on 9/10/14 at 11:13 a.m. the	{F 312}		

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AH Form Approved
9/18/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00303	A. Building B. Wing	9/10/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - JACKSON	601 WEST JACKSON JACKSON, MN 56143

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20550 Reg. # MN Rule 4658.0400 Subp. LSC	08/25/2014	ID Prefix 20560 Reg. # MN Rule 4658.0405 Subp. LSC	08/25/2014	ID Prefix 20910 Reg. # MN Rule 4658.0525 Subp. LSC	08/25/2014
ID Prefix 21535 Reg. # MN Rule4658.1315 Subp.1 LSC	08/25/2014	ID Prefix 21565 Reg. # MN Rule 4658.1325 Subp. LSC	08/25/2014	ID Prefix 21915 Reg. # MN St. Statute 144.651 Sul LSC	08/25/2014
ID Prefix 23270 Reg. # MN Rule 4658.5515 LSC	08/25/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GPN/KFD	09/21/2014	31221	09/10/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/24/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00303	A. BUILDING: ______ B. WING ______	R 09/10/2014

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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: An onsite follow-up visit was completed on September 9, 10, 2014. During this onsite visit it was determined that the following correction order 4658.0520 Sub. 2. A. (ACO number 0835) was NOT corrected. This uncorrected order will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order will be	{2 000}		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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{2 000}	Continued From page 1 reviewed for possible penalty assessment.	{2 000}		
{2 835}	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with removal of facial hair for 2 of 3 residents (R7, R72) who were assessed to need assistance in completing activities of daily living skills (ADLs). This tag was issued at the certification survey exited on 7/24/14 and on this post certification survey (PCR) was again found not to be in compliance. Findings Include: R7 was observed on 9/9/14 at 10:52 a.m. and noted to have visible facial hair around her upper lip. R7 was observed on 9/9/14 at 3:07 p.m. and noted to have visible facial hair around her upper lip. R7 was observed on 9/10/14 at 8:30 a.m. and noted to have visible facial hair around her upper lip. The quarterly Minimum Data Set (MDS) dated 7/23/14 indicated that R7 was unable to complete the Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment. The MDS	{2 835}		

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{2 835}	Continued From page 2	{2 835}		

dated 7/23/14 also indicated that R7 required extensive assist of one staff for personal hygiene.
R7's care plan dated 5/5/14 indicated that the resident was admitted on 8/29/13 and had diagnoses that included paralysis agitans, dementia and depressive disorder.
R7's care plan dated 5/5/14 indicated a problem ADLs self- care performance deficit and directed staff that R7 required assistance of one staff participation with personal hygiene.
During an interview on 9/10/14 at 9:45 a.m. registered nurse (RN)-A confirmed R7 had visible long facial hair around the corners of R7's upper lip. RN-A stated staff should have taken care of R7's facial hair on bath days and should look for facial hair daily as a part of morning cares as they are getting resident for the day. RN-A stated R7 had her scheduled bath on Tuesdays, which was yesterday (9/9/14 also the day surveyor entered facility) and stated there was no documentation that indicated R7 refused to allow staff to shave her facial hair.

R72 was observed on 9/9/14 at 8:40 a.m. and noted to have several short chin hairs across the bottom of her chin.

R72 was observed on 9/9/14 at 3:11 p.m. and was noted to have several short chin hairs across the bottom of her chin.

R72 was observed on 9/9/14 at 8:24 a.m. and was noted to have several short chin hairs across the bottom of her chin.

R72's care plan dated 7/1/14 indicated R72 was admitted on 7/1/2014 and had diagnoses that included congestive heart failure, atrial fibrillation and anxiety state.

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{2 835}	Continued From page 3 The admission Minimum Data Set (MDS) dated 7/7/14 indicated R72 had a Brief Interview for Mental Status (BIMS) score of twelve which indicated moderate cognitive impairment. The MDS dated 7/7/14 also indicated that R7 required extensive assist of one staff for personal hygiene. R72's care plan dated 7/1/14 indicated a problem with ADLs self-care performance deficit and read, " PERSONAL HYGIENE: Encourage resident to do so independently while in the bathroom getting dressed for the day." During an interview on 9/10/14 at 9:50 a.m. RN-A confirmed R72 had visible facial hair along her chin and upper lip. RN-A stated staff should have taken care of R72's facial hair on bath days and should look for facial hair daily as a part of morning cares as they are getting resident for the day. RN-A stated R72 had her scheduled bath on Saturdays and stated there was no documentation that indicated R72 refused to allow staff to shave her facial hair. During an interview on 9/10/14 at 11:29 a.m. R72 stated, "Some of the staff offer to shave my facial hair and others don't." R72 stated staff did not offer to shave her facial hair on her bath days. R72 stated she used to shave her own facial hair, but did not have the equipment here to shave by herself. R72 stated she wanted staff to "shave her facial hair when they see it, as it does not look good to have facial hair." During an interview on 9/10/14 at 11:13 a.m. the director of nursing stated her expectation was facial hair was to be removed when it is noticed by staff and also on bath day. A policy titled Shaving revised on 11/2013 directed staff on the procedure of shaving a resident. A policy titled Routine Daily Practice revised on 10/2013 had no guidelines on when to	{2 835}		

Minnesota Department of Health

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{2 835}	Continued From page 4 shave a resident. It did indicate that a resident would have a bath/shower per week and that skin was to be checked weekly.	{2 835}		

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

PRINTED: 09/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SEP 26 2014
MN Dept of Health
Rochester

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{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by a surveyor of this department,on September 9, 10, 2014, to determine compliance with Federal deficiencies issued during a recertification survey exited on July 24, 2014. During this visit the following regulation was determined to be not corrected: F312.	{F 000}	F 312 - Resident (R7) and (72) facial hair was removed by NA. NA and Charge nurses who worked on 9/6 & 9/9 were given coaching, counseling and re-education of importance of removing facial hair on those residents and any other dependent residents. All other residents who are dependent on staff to need assistance of daily living were checked to assure facial hair was removed unless there was a refusal by the resident. Nursing staff received re-education on 9/22 & 9/24 regarding dependent residents and removing facial hair including residents to be checked daily as some may need to be shaved more than on bath day, some daily. Daily audits have been instituted to assure facial hair is removed from residents who require assistance of daily living unless the resident has refused. Audits will be reviewed by DNS to assure compliance. Quality Assurance Coordinator will do random audits. All audits will be reviewed by Quality Team for further direction.	9/24/14
{F 312} SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with removal of facial hair for 2 of 3 residents (R7, R72) who were assessed to need assistance in completing activities of daily living skills (ADLs). This tag was issued at the certification survey exited on 7/24/14 and on this post certification survey (PCR) was again found not to be in compliance. Findings Include: R7 was observed on 9/9/14 at 10:52 a.m. and noted to have visible facial hair around her upper lip. R7 was observed on 9/9/14 at 3:07 p.m. and noted to have visible facial hair around her upper lip. R7 was observed on 9/10/14 at 8:30 a.m. and	{F 312} 9/26/14 GPM		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 9/23/14

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.

SEP 26 2014
MN Dept of Health
Rochester

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{F 312}	Continued From page 1 noted to have visible facial hair around her upper lip. The quarterly Minimum Data Set (MDS) dated 7/23/14 indicated that R7 was unable to complete the Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment. The MDS dated 7/23/14 also indicated that R7 required extensive assist of one staff for personal hygiene. R7's care plan dated 5/5/14 indicated that the resident was admitted on 8/29/13 and had diagnoses that included paralysis agitans, dementia and depressive disorder. R7's care plan dated 5/5/14 indicated a problem ADLs self- care performance deficit and directed staff that R7 required assistance of one staff participation with personal hygiene. During an interview on 9/10/14 at 9:45 a.m. registered nurse (RN)-A confirmed R7 had visible long facial hair around the corners of R7's upper lip. RN-A stated staff should have taken care of R7's facial hair on bath days and should look for facial hair daily as a part of morning cares as they are getting resident for the day. RN-A stated R7 had her scheduled bath on Tuesdays, which was yesterday (9/9/14 also the day surveyor entered facility) and stated there was no documentation that indicated R7 refused to allow staff to shave her facial hair. R72 was observed on 9/9/14 at 8:40 a.m. and noted to have several short chin hairs across the bottom of her chin. R72 was observed on 9/9/14 at 3:11 p.m. and was noted to have several short chin hairs across the bottom of her chin. R72 was observed on 9/9/14 at 8:24 a.m. and was noted to have several short chin hairs across	{F 312}		

SEP 2 6 2014
MN Dept of Health
Rochester

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

SEP 2 6 2014
MN Dept of Health
Rochester

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: Y1RU
Facility ID: 00303

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245455**
2.STATE VENDOR OR MEDICAID NO.
(L2) **673342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - JACKSON**
(L4) **601 WEST JACKSON**
(L5) **JACKSON, MN** (L6) **56143**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)
6. DATE OF SURVEY **07/24/2014** (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 **63** (L18)
13.Total Certified Beds **63** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	63			
(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 :
Danette Bakken, HFE II 09/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/04/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5545

August 5, 2014

Mr. Daren Rife, Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, Minnesota 56143

RE: Project Number S5455025

Dear Mr. Rife:

On July 24, 2014, 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (507) 206-2731
Fax: (507) 206-2711

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 2, 2014, 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 2, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,
- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 24, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of

payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 24, 2015 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING ______ B. WING ______	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	601 WEST JACKSON JACKSON, MN 56143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 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	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R67) was assessed to be safe to self-administer a nebulizer treatment. Findings include: R67 was admitted to the facility on May 2, 2014 and had no cognitive deficit according to the admission Minimum Data Set dated 5/9/2014. However, he had not been assessed for self-administration of medications as determined by the interdisciplinary committee. On 7/23/14, at 7:25 a.m. registered nurse (RN)-B	F 176 9/3/14 GPN	1. F 176 Resident (R67) has been assessed 7/29/14 for self-administration of nebulizer treatment by the interdisciplinary team. A physician order was obtained and care plan updated to reflect his request to self-administer nebulizer treatments. 2. All residents currently on nebulizer treatments were reviewed to ensure a self-administration of medication assessment had been completed by the interdisciplinary team and a physician order for self-administration completed if determined by the team and care plan updated to reflect this information. 3. All residents admitted to the center will have a self-administration of medication assessment completed by the interdisciplinary team and if determined to be able to self-administer a physician order will be obtained and care plan updated with this information. Licensed nurses have been re-educated if they receive an order for a resident to have nebulizer treatment a self-administration assessment and documentation of the assessment must be completed by the interdisciplinary team then the physician is notified for an order for the resident to self-administrate and care plan updated to reflect resident can self-administrate the nebulizer treatment.	8/25/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 8/20/14

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING ____ B. WING ____ AUG 25 2014	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	601 WEST JACKSON JACKSON, MN 56143

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F 176	Continued From page 1 was observed to administer a nebulizer treatment for R67 as ordered by his physician. RN-B set up the treatment and handed the device to R67 and walked out of the room. R67 was left alone in the room with the nebulizer treatment and machine running. After reviewing the physician's orders, it was noted there was not an order or any notation indicating R67 was able to self-administer the nebulizer treatment. On 7/23/14, at 1:50 p.m. an interview was conducted with RN-B. RN-B verified that R67 did not have an order or an assessment available indicating R67 was able to self-administer the nebulizer treatment. Based on the facility Resident Self-Administration of Medication policy dated 7/14 directed the interdisciplinary team must make a determination whether each resident who expresses a desire to self-administer medications can do this safely. The interdisciplinary team's determination that the resident can safely self-administer medications must be documented in the medical record, and a physician's order must be obtained prior to the resident self-administering medications.	F 176	4. Audits will be completed by the Staff Development Coordinator to ensure those residents observed self-administering their nebulizer treatments have been assessed by the interdisciplinary team and physician order obtained and care plan has this information. Any resident who receives a new order for nebulizer treatment will be audited to assure a self-administration assessment is completed by the interdisciplinary team, order received by physician and care planned. These audits will be done weekly for two months with results to QA for further recommendations.	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced	F 276	1. F 276 Resident (R4) bladder function was reassessed, evaluated and a quarterly MDS completed on 7/25/14. There were no changes to the residents' plan of care for resident's toileting plan. Nurses and nursing assistants have been re-educated on 8/18/14 & 8/20/18 to assure resident care plans are followed; all residents will have a nurse progress note and	8/25/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 276	Continued From page 2 by: Based on observation, interview and document review, the facility failed to reassess and evaluate bladder function during the most recent quarterly Minimum Data Set dated 4/12/14 for 1 of 2 residents (R4) reviewed for chronic urinary incontinence. Findings include: R4 had been admitted on 11/17/13. R4's admission record dated 7/24/14, identified but not limited to diagnosis of dementia. R4's quarterly Minimum Data Set (MDS) dated 4/12/14; identified R4 required extensive assist of one for toileting, scheduled toileting program, frequently incontinent of bladder and had moderate cognitive impairment. During observation on 7/21/14, at 7:40 p.m., R4 lay in bed, a visible wet urine stain had been seen on R4's shirt and there had been a strong urine odor in R4's room. R4 was yelling out "Help" this surveyor then alerted staff of R4 needing assistance. During observation on 7/23/14, at 8:46 a.m., R4 had been transferred by nursing assistant (NA)-A and NA-B from wheelchair to bed. Document review of R4's care plan dated 4/28/14, identified self- care performance deficit related to muscle weakness, neuro cognitive disorder with intervention of but not limited to toilet use: requires one staff participation to use toilet, will use toilet in room and urinal at bedside, toileting schedule: between five and seven a.m., after breakfast, before dinner, one to two times in the afternoon, after supper and HS (hour of	F 276	documentation of reassessment of bladder function quarterly and as appropriate. Audits will be conducted to assure all residents have documentation of reassessment and care plan is appropriate for the individual residents. DNS and Quality Assurance Committee will review monthly X 2 then as determined by the QAC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 276	Continued From page 3	F 276		

sleep) and check every two to three hours at night, transfers: requires one staff participation with pivot transfer and has bladder incontinence, pad product large brief.

R4's last completed bladder assessment dated 11/11/13, and identified R4 required one assist needed for transfer, one assist needed for ambulation, impaired balance, unsteady gait, impaired cognition and physical mobility to manage own clothing and own hygiene, urge and functional incontinence, toilet program: yes and proposed scheduled: between five and seven a.m., after breakfast, before dinner, one to two times in the afternoon, after supper and HS, check every two to three hours at night and toilet as needed. Reassessment of bladder function had not been completed for R4's quarterly review MDS dated 4/12/14. Further review of R4's interdisciplinary assessments and summary reviews and nurse progress notes lacked documentation of reassessment of bladder function for R4's quarterly review MDS dated 4/12/14.

R4's nursing assistant Kardex dated 7/23/14, identified toileting schedule: between five and seven a.m., after breakfast, before dinner, one to two times in the afternoon, after supper and HS and check every two to three hours at night. Toilet use: requires one staff participation to use toilet, will use toilet in room and urinal at bedside, pad product: large brief and transfer: requires one staff participation with pivot transfer.

During interview on 7/23/14, at 1:26 p.m., registered nurse (RN)-A verified no quarterly bladder assessment had been completed when completing the quarterly review of R4's bladder

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 276	Continued From page 4 function and had stated looking at the nursing assistant documentation during look back period for the quarterly assessment dated 4/12/14, R4 had no change from frequently incontinent, if no change we do not have to do a bladder assessment unless we see a change in voiding which is an increase or decrease in voiding. During interview on 7/24/14, at 11:18 a.m., RN-A verified R4's interdisciplinary assessments and summary reviews and nurse progress notes lacked documentation of reassessment of bladder function for R4's quarterly review MDS dated 4/12/14. During interview on 7/24/14, at 11:11 a.m., director of nursing had stated she would expect an analysis of R4's bladder function and an assessment to be completed for quarterly review of R4's bladder function. Document review of the facility Policy ASSESSMENT dated 9/12, read, "PURPOSE· To ensure resident assessments are completed and coordinated in compliance with appropriate regulations POLICY Review of assessments will be done every three (3) months and as appropriate. The comprehensive assessment will be revised to ensure accuracy."	F 276		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279		8/25/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING ______ B. WING ______ AUG 25 2014	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 5 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively care plan the risk for falls for 1 of 3 residents (R40) reviewed for accidents. Findings include: R40 was admitted on 5/29/14 for rehabilitation following a fall at home, polyneuropathy and Parkinson's disease according to the admission face sheet. The admission Minimum Data Set (MDS) dated 6/5/14, indicated R40 had a mild cognitive impairment and required extensive assist with transfers and gait. R40 was also at moderate risk for falls. The Falls Care Area Assessment (CAA) dated 6/5/14, indicated R40 was at risk for falls due to a fall history prior to admission. It was also noted	F 279	F 279 Resident (R40) on 7/20/14 RN completed Fall Risk Data Collection and was found to be a medium risk for falls; care plan was updated on 7/24/14. All residents who have had falls since the time of survey were reviewed to ensure that they had a Falls Risk Data Collection and Evaluation completed and care plan updated with fall interventions. Education was provided to nursing staff on this on 8/18 & 8/20/14.On admission all residents will have a Fall Risk Data Collection Tool completed and if determined to be at risk for falls or has a history of falls will be care planned. DNS will audit all new admissions and residents with falls to ensure that a Falls Risk Data Collection and Evaluation completed and care plan updated with fall interventions X 2 months, and then results will be sent to Quality Committee for further recommendations.	

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F 279	Continued From page 6 that it would not be included in the care plan due to the facility's plan for strengthening. The plan of care did not include any information about R70's history of falls or fall risk. R70 was interviewed on 7/23/14, at 7:10 a.m. R70 verified a fall at home prior to admission as well as a fall in the facility on 7/20/14. R70 stated he lost his balance when he was up independently in his room. Registered nurse (RN)-A was interviewed on 7/24/14, at 11:00 a.m. RN-A stated the fall risk did not get placed on the care plan at admission because R70 was planned to get exercises for strengthening she did not feel R70 would be at risk for falls. RN-A verified the fall risk had not been care planned and agreed that since the fall on 7/20/14, it should have been added to the care plan.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure clean and trimmed nails for 1 of 3 residents (R4) and failed to provide assistance with removal of facial hair for 1 of 3 residents (R7) reviewed for activities of	F 312	F 312 Resident (R4) nails were cleaned and trimmed. Resident (R7) facial hair was removed by NA. All other residents who are unable to carry out nail care or facial hair were checked to assure they were clean and trimmed. Nurses and NA's received re-education on grooming and personal hygiene on 8/18/14 & 8/20/14. Licensed Nurses will be responsible to assure nail care and facial hair are removed unless there is a refusal by a resident.	8/25/14

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F 312	Continued From page 7 daily living. Findings include: R4's admission record dated 7/24/14, identified they were admitted on 11/17/13 and had a diagnosis of dementia. R4's quarterly Minimum Data Set (MDS) dated 4/12/14, identified R4 required extensive assist of one for personal hygiene. During observation on 7/21/14, at 7:31 p.m., R4 laid in bed resting. R4's fingernails on both hands were noted to be long, untrimmed and had black debris underneath fingernails. R4 had stated, "No" when asked if staff help to clean and trim fingernails. During observation on 7/22/14, at 1:45 p.m., R4 laid in bed resting. R4's fingernails remained long and untrimmed with black debris underneath nails. During observation on 7/23/14, at 7:22 a.m., R4 had been sitting in wheelchair at a table in the dining room waiting to be served breakfast. R4's fingernails remained long, untrimmed with black debris underneath nails. At 8:46 a.m., registered nurse (RN)-A had been in R4's room observed R4 ' s nails and verified some fingernails were long and had debris underneath some nails on both of R4's hands. R4's care plan dated 4/28/14, identified focus: activities of daily living self- care performance deficit related to muscle weakness, neuro cognitive disorder with interventions of but not limited to personal hygiene: requires one staff participation with personal hygiene and focus:	F 312	Observational audits will be completed weekly X2 nail & facial hair then X 1 month then reviewed by the quality committee for further recommendations	

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diabetes mellitus with intervention of but not limited to: diabetic nail care provided by licensed nurse.

Document review of the facility bath list and skin checks dated revised 7/17/14, identified R4's bath day on Wednesday days.

Document review of R4's nurse progress notes dated 6/25/14 through 7/18/14, had no documentation regarding nail care.

During interview on 7/23/14, at 10:13 a.m., RN-B had stated the nurse progress notes would be the only place to document nail care, under " skin care " on bath day.

During interview on 7/24/14, at 10:01 a.m., director of nursing had stated nail care is done on bath days or anytime it needs to be done. Director of nursing had stated if a resident with mood and behaviors refuses nail care and staff have gone in multiple times and resident continues to refuse, would expect staff to document resident has refused.
Document review of the facility Procedure NAIL CARE dated revised 11/13, read, "PURPOSE To keep nails clean and trimmed to promote well-being To observe nail condition To prevent nail discomfort PROCEDURE FOR FINGERNAILS 1. Licensed nurse should be notified to do nail care as needed for residents who are diabetic or are receiving anticoagulants who may tend to bleed easily. Never trim corns, callouses or blisters. 15. If documentation of nail care is desired, it should be set up in the care plan and documented in PCC - POC."
R7 was observed on 7/22/14 at 9:35 a.m. and noted to have visible facial hair around her mouth

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F 312	Continued From page 9 and chin. R7 was observed on 7/23/14 at 8:00 a.m. sitting in the day room and had visible facial hair that had not been removed. The licensed practical nurse (LPN)-A was interviewed on 7/23/14 at 8:00 a.m. and confirmed that R7 had facial hair and stated that the resident had a bath yesterday and that the staff should have shaved her. LPN-A indicated that the nursing assistants are to check each resident every day and shave them whenever necessary. R7's care plan dated 5/5/14 indicated that the resident was admitted on 8/29/13 and had diagnoses that included paralysis agitans, dementia and depressive disorder. R7's care plan dated 5/5/14 indicated a problem with activities of daily living (ADL) self- care performance deficit and directed staff that R7 required assistance of one staff participation with personal hygiene. The quarterly Minimum Data Set (MDS) dated 4/23/14 indicated that R7 was unable to complete the Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment. The MDS dated 4/23/14 also indicated that R7 required extensive assist of one staff for personal hygiene. Documentation indicated that R7 received a bath on 7/15/14 and also 7/22/14 with no documentation that facial hair removal was completed. The director of nursing (DON) was interviewed on 7/23/14 at 12:55 p.m. The DON indicated her expectations for female facial hair was that she would expect that it would be removed if noticed on the resident's bath day or any other day that it was noticed. A policy titled Shaving revised on 11/2013 directed staff on the procedure of shaving a resident. A policy titled Routine Daily Practice	F 312		

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F 312	Continued From page 10 revised on 10/2013 had no guidelines on when to shave a resident. It did indicate that a resident would have a bath/shower per week and that skin was to be checked weekly.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to reassess bladder function and failed to provide appropriate treatment and services to maintain or improve bladder function for 1 of 1 resident (R4) reviewed for urinary incontinence. Findings include: R4's admission record dated 7/24/14; identified R4 had been admitted on 11/17/13 and also included but not limited to diagnosis of dementia. R4's quarterly Minimum Data Set (MDS) dated 4/12/14; identified R4 required extensive assist of one for toileting, scheduled toileting program, frequently incontinent of bladder and had moderate cognitive impairment.	F 315	F 315 Resident (R4) bladder function was reassessed, evaluated and a quarterly MDS completed on 7/25/14. There were no changes to the residents' plan of care for resident's toileting plan. Nurses and nursing assistants have been re-educated on 8/18/14 & 8/20/18 to assure resident toileting care plans are followed; all residents will have a nurse progress note and documentation of reassessment of bladder function quarterly and as appropriate. Random resident Audits will be completed on following resident individual toileting program, assessing and re-evalauating the resident toileting programs monthly X 2 then as determined by Quality Team, DNS or designee responsible to complete audits.	8/25/14

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During observation on 7/21/14, at 7:40 p.m., R4 lay in bed, a visible wet urine stain had been seen on R4's shirt and there had been a strong urine odor in R4's room. R4 was yelling out "Help" this surveyor alerted staff of R4 needing assist.

During observation on 7/23/14, at 8:46 a.m., R4 had been transferred by nursing assistant (NA)-A and NA-B from wheelchair to bed. NA-A and NA-B were observed by surveyor to provide weight bearing assist when transferring R4 and R4 had been unsteady with maintaining balance and pivoting during transfer. NA-A and NA-B laid R4 down in bed, covered R4 with a blanket, placed call light in reach, turned off light to room and exited R4's room. NA-A and NA-B had not offered the toilet to R4 and had not checked R4's incontinent product, NA-A and NA-B verified at the time. NA-B had stated last time R4 had been toileted was 6:30 a.m. NA-A and NA-B had stated they did not know R4's toilet schedule. NA-A and NA-B had stated we can look up R4's toilet schedule in KIAS (computer system) and showed surveyor R4's toilet schedule. NA-A and NA-B verified R4's toilet schedule on the nursing assistant care sheets read R4 was to be toileted after breakfast.

R4's care plan dated 4/28/14, identified self- care performance deficit related to muscle weakness, neuro cognitive disorder with intervention of but not limited to toilet use: requires one staff participation to use toilet, will use toilet in room and urinal at bedside, toileting schedule: between five and seven a.m., after breakfast, before dinner, one to two times in the afternoon, after supper and HS (bedtime) and check every two to three hours at night, transfers: requires one staff

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F 315	Continued From page 12 participation with pivot transfer and has bladder incontinence, pad product large brief. R4's records identified last completed bladder assessment had been dated 11/11/13, and identified R4 required one assist needed for transfer, one assist needed for ambulation, impaired balance, unsteady gait, impaired cognition and physical mobility to manage own clothing and own hygiene, urge and functional incontinence, toilet program: yes and proposed scheduled: between five and seven a.m., after breakfast, before dinner, one to two times in the afternoon, after supper and HS (hour of sleep), check every two to three hours at night and toilet as needed. Reassessment of bladder function had not been completed for R4's quarterly review MDS dated 4/12/14. Further review of R4's interdisciplinary assessments and summary reviews and nurse progress notes lacked documentation of reassessment of bladder function for R4's quarterly review MDS dated 4/12/14. R4's nursing assistant Kardex dated 7/23/14, identified toileting schedule: between five and seven a.m., after breakfast, before dinner, one to two times in the afternoon, after supper and HS and check every two to three hours at night. Toilet use: requires one staff participation to use toilet, will use toilet in room and urinal at bedside, pad product: large brief and transfer: requires one staff participation with pivot transfer. During interview on 7/23/14, at 1:26 p.m., registered nurse (RN)-A verified no quarterly bladder assessment had been completed for quarterly review of R4's bladder function and had stated looking at the nursing assistant	F 315		

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F 315	Continued From page 13 documentation during look back period for the quarterly assessment dated 4/12/14, R4 had no change from frequently incontinent, if no change we do not have to do a bladder assessment unless we see a change in voiding which could be an increase or decrease in voiding. During interview on 7/24/14, at 11:18 a.m., RN-A verified R4's interdisciplinary assessments and summary reviews and nurse progress notes lacked documentation of reassessment of bladder function for R4's quarterly review MDS dated 4/12/14. During interview on 7/24/14, at 11:11 a.m., director of nursing had stated she would expect an analysis of R4's bladder function and an assessment to be completed for quarterly review of R4's bladder function. Document review of the facility Policy ASSESSMENT dated 9/12, read, "PURPOSE· To ensure resident assessments are completed and coordinated in compliance with appropriate regulations POLICY Review of assessments will be done every three (3) months and as appropriate. The comprehensive assessment will be revised to ensure accuracy."	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose	F 329	F 329 Resident (R4) Behavior team met on 8/1/14 and an assessment was completed, reviewed documentation, Updated care plan to reflect current targeted behaviors. Notification to physician 8/4/14 of findings and dose reduction is in place for ordered Risperdal. All residents identified as	8/25/14

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F 329	Continued From page 14 should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor target behaviors and adequately assess clinical indications to evaluate the effectiveness for continued use of psychotropic medications for 1 of 5 residents (R4) reviewed for unnecessary medications. Findings include: R4 had been admitted on 11/17/13 as found on the admission record dated 7/24/14, the record also identified but not limited to diagnosis of dementia. R4 ' s quarterly Minimum Data Set (MDS) dated 4/12/14, identified R4 had received antipsychotic medication, had behavior symptoms and had moderate cognitive impairment. Document review of R4's physician orders signed	F 329	receiving a psychotropic medication were re-assessed and targeted behaviors were reviewed and/or updated this was completed 8/1/14 All residents currently on a psychotropic medication are having their targeted behavior monitored and clinical indications are being evaluated for the effectiveness and continued use of psychotropic medications. Audits will be completed to determine if targeted behaviors are defined and non-pharmalogical interventions are appropriate. Behavior Committee will be responsible to randomly review residents monthly X 2 and report to Quality Committee Quarterly or as needed if concerns identified.	

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F 329	Continued From page 15 dated 6/12/14, revealed an order for Risperdal (an antipsychotic medication) 0.50 milligrams two times a day for dementia. Document review of the facility medication administration record print date 7/24/14, revealed R4 received Risperdal as ordered. Document review of R4's care plan print date 7/23/14, identified behavior symptom related to vascular dementia evidenced by takes oxygen off, yells, potential for elopement, poor judgment and insight with interventions of intervene as necessary to protect the rights and safety of others, approach and speak in calm manner, divert attention, remove from situation and take to alternative location as needed, provide opportunity for positive interaction, attention and minimize potential for resident's disruptive behaviors yelling by offering tasks which divert attention such as snacks and one to one visits. R4's nursing assistant Kardex print date 7/231/14, identified mood/behavior: intervene as necessary to protect the rights and safety of others, approach and speak in calm manner, divert attention, remove from situation and take to alternative location as needed, provide opportunity for positive interaction, attention, minimize potential for resident's disruptive behaviors yelling by offering tasks which divert attention such as snacks and one to one visits, non-pharmacological: attempt non-pharmacological interventions: simplify tasks: give instructions slowly and wait for a response. However R4's nursing assistant Kardex had not identified target behaviors of takes oxygen off, potential for elopement, poor judgment/insight and there had been no documentation in R4's record regarding monitoring of R4's target	F 329		

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behaviors except for yelling.

Document review of care conference note dated 4/29/14, revealed behaviors of yelling, getting angry and recently attempted to go outside. However there had been no documented analysis of R4's behaviors.

During interview on 7/23/14, at 10:39 a.m., registered nurse (RN)-C had stated behavior being documented on all residents is just general symptoms as found in the MDS. RN-C verified only one target behavior, yelling had been identified on the nursing assistant Kardex for the nursing assistants to document on the behavior if R4 had the behavior.

During interview on 7/24/14, at 9:00 a.m., director of nursing had stated social service is responsible to document review of behaviors. Director of nursing had stated we review behaviors with the physician and the physician documents an analysis of the behaviors. Surveyor requested documented analysis of behaviors, none had been provided.

During interview on 7/24/14, at 9:30 a.m., director of nursing verified only one target behavior, yelling had been identified on C4 ' s nursing assistant Kardex for the nursing assistants to document on the behavior if R4 had the behavior.

During interview on 7/24/14, at 10:01 a.m., director of nursing had stated she would expect target behaviors to be pulled over to the nursing assistant Kardex for the nursing assistants to know what they are and be able to document on them.

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F 463	Continued From page 17	F 463		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that a call light was in working condition for 1 of 30 residents (R47) and others to summons help if needed for R47. Findings include: R47 ' s call light located on the bedside on 7/21/14 at 6:27 p.m. was checked and found to not light up on the display outside of the room. R47 was in the dining room at that time eating supper. The call light is for resident, staff, and family use when assistance is needed. During an interview with the licensed practical nurse (LPN)-B on 7/21/14 at 6:53 p.m. it was confirmed that the call light was not functioning. LPN-B stated that it was a good thing the resident did not use his call light. R47's signed physician orders dated 6/12/14 indicated that R47 was admitted to the facility on 5/21/13 with a diagnosis including Alzheimer's disease. R47's annual Minimum Data Set (MDS) dated 4/23/14 indicated R47 was unable to complete the Brief Interview of Mental Status (BIMS) indicating R47 had severe cognitive impairment. When interviewed on 7/23/14 at 7:45 a.m. the director of maintenance (DM)-B indicated he was not aware that R47's call light was not	F 463	F 463 Resident (R47) call light was replaced on 7/23/14. All other resident call lights were checked and in good working order. Charge Nurses now have key to maintenance room to have access to call lights in case a call light needs replaced. Charge Nurses and NA's received education on replacing the call light or similar adaptive device 8/18/14 and 8/20/14.	8/25/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING ______ B. WING ______	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	601 WEST JACKSON JACKSON, MN 56143

(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 463	Continued From page 18	F 463		

functioning. DM-B stated that each unit of the facility had a maintenance book that is checked for needed repairs. DM-B stated that he had put in many new call lights since he had started at the facility. This particular call light was a double-cord and sometimes they get pulled apart. The maintenance book was checked with the DM-B and it was noted that on 7/21/14 that after surveyor notification the non-functioning call light issue was placed in the maintenance book. This was not noticed by maintenance until this time. DM-B stated that he tries to check the maintenance book daily. When a policy was requested for the maintenance of the call light system, DM-B stated that he did not know of a policy other than that staff was instructed to use the book for any maintenance concern. DM-B indicated that when he checked the call light after I interviewed him that sometimes it worked and sometimes it didn't, so he replaced it. A copy of the maintenance log and when it was received it was documented that the call light was repaired on 7/23/14.

On 7/23/14 at 9:15 a.m. the call light was functioning properly when checked.

During an interview with the director of nursing (DON) on 7/23/14 at 12:55 p.m., the DON indicated that if a call light was discovered not working that the expectation would be that the staff would notify maintenance and in the meantime make sure that the resident was safe.

The facility Call Light policy, dated 9/2012, read, "To ensure resident always has a method of calling for assistance. For residents unable to use call light, staff need to make frequent visits or provide an adaptive call light."

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F5455022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	601 WEST JACKSON JACKSON, MN 56143

(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
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, on August 7, 2013. At the time of this survey, Good Samaritan Society Jackson was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 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 Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	Please note that our signature and the response on the CMS – 2567L does not mean deficiency or the evidence presented to support any determination of non-compliance. We respond and provide a written plan of correction because law requires it. POC ok 8-25-14 	9/24/14

Dc: 9-2-14
EXIT: 7-24-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8/20/14

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
	245455	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON** **JACKSON, MN 56143**

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Jackson was constructed as follows: The original building was constructed in 1956, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type I(332) construction; The 1st Addition was constructed in 1965, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type I(332) construction; The 2nd Addition was constructed in 1976, is one-story, has a partial basement, is partially fire sprinklered protected and was determined to be of Type I(332) construction; The 3rd Addition was constructed in 1996, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type I(332) construction. The facility 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 63 beds and had a census of 56 at	K 000		

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	245455	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**07/24/2014**

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GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON** **JACKSON, MN 56143**

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K 000	Continued From page 2 time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 15 out of 56 residents. Findings include: On facility tour between 9:15 AM and 12:15 AM on 07/24/2014, observation revealed that the following was found: 1. The door to storage room # 3 (over 50 sq. ft.) does not have a self-closing device.	K 029	K 29 Self-closing devices will be added to the designated storage rooms (#3, #38) so that they will close at the appropriate times. The open penetration on the east wall around the duct work in the maintenance room (#40) will be fixed so that there are no open penetrations.	8/24/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**07/24/2014**

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GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON** **JACKSON, MN 56143**

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K 029	Continued From page 3 2. The door to storage room # 38 - (over 50 sq. ft.) does not have a self-closing device. 3. There is an open penetration in east wall, around old duct work opening, of the Maintenance Shop (#40). These deficient practices were confirmed by the Facility Maintenance Director (SH) at the time of discovery.	K 029		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide proper coverage of the fire sprinkler system as per 2000 NFPA 101 Chapter 19.3.5 and 9.7. The deficient practice could affect 15 out of 56 residents. FINDINGS INCLUDE: On facility tour between 9:15 AM and 12:15 AM	K 056	K 56 A working fire sprinkler system will be added to the vestibule of the main entrance attached to the skilled nursing facility.	9/24/14

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	245455	A. BUILDING **01 - MAIN BUILDING 01** B. WING	07/24/2014

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K 056	Continued From page 4 on 07/24/2014, observation revealed that in the 1976 addition, the main entrance vestibule does not have a fire sprinkler protection. This deficient practice was confirmed by the Facility Maintenance Director (SH) at the time of discovery.	K 056		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, that the facility's general ventilating and air conditioning system (HVAC) was not maintained in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 3-4.7. A noncompliant HVAC system could affect all 56 residents. Findings include: On facility tour between 9:15 AM and 12:15 AM on 07/24/2014, documentation review for fire damper testing for the past 4 years revealed, that the fire/smoke dampers have not been tested. Last documented test was on 7/17/07. This deficient practice was confirmed by the Facility Maintenance Director (SH) at the time of	K 067	K 67 All fire dampers will be inspected by a professional to make sure they are working properly. Any identified fire dampers that aren't working properly will be fixed or replaced.	8/24/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**07/24/2014**

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K 067	Continued From page 5 discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 067		

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5545

August 5, 2014

Mr.. Daren Rife, Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, Minnesota 56143

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5455025

Dear Mr.. Rife:

The above facility was surveyed on July 21, 2014 through July 24, 2014 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, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

When all orders are corrected, the order form should be signed and returned to:

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (507) 206-2731
Fax: (507) 206-2711

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 me.

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, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00303	A. BUILDING: ____ B. WING ____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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: On July 28, 29, 30, and 31, 2014, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature."	2 000	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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00303	A. BUILDING: ______ B. WING ______	07/24/2014

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2 000	Continued From page 1 Make a copy of these orders for your records and return the original to the address below: Minnesota Department of Health 18 Wood Lake Drive SE, Rochester, MN 55904 c/o Gary Nederhoff, Unit Supervisor	2 000	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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to reassess and evaluate	2 550		

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2 550	Continued From page 2	2 550		

bladder function during the most recent quarterly Minimum Data Set dated 4/12/14 for 1 of 2 residents (R4) reviewed for chronic urinary incontinence.

Findings include:

R4 had been admitted on 11/17/13. R4's admission record dated 7/24/14, identified but not limited to diagnosis of dementia. R4's quarterly Minimum Data Set (MDS) dated 4/12/14; identified R4 required extensive assist of one for toileting, scheduled toileting program, frequently incontinent of bladder and had moderate cognitive impairment.

During observation on 7/21/14, at 7:40 p.m., R4 lay in bed, a visible wet urine stain had been seen on R4's shirt and there had been a strong urine odor in R4's room. R4 was yelling out "Help" this surveyor then alerted staff of R4 needing assistance.

During observation on 7/23/14, at 8:46 a.m., R4 had been transferred by nursing assistant (NA)-A and NA-B from wheelchair to bed.

Document review of R4's care plan dated 4/28/14, identified self- care performance deficit related to muscle weakness, neuro cognitive disorder with intervention of but not limited to toilet use: requires one staff participation to use toilet, will use toilet in room and urinal at bedside, toileting schedule: between five and seven a.m., after breakfast, before dinner, one to two times in the afternoon, after supper and HS (hour of sleep) and check every two to three hours at night, transfers: requires one staff participation with pivot transfer and has bladder incontinence, pad product large brief.

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GOOD SAMARITAN SOCIETY - JACKSON	601 WEST JACKSON JACKSON, MN 56143

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2 550	Continued From page 3 R4's last completed bladder assessment dated 11/11/13, and identified R4 required one assist needed for transfer, one assist needed for ambulation, impaired balance, unsteady gait, impaired cognition and physical mobility to manage own clothing and own hygiene, urge and functional incontinence, toilet program: yes and proposed scheduled: between five and seven a.m., after breakfast, before dinner, one to two times in the afternoon, after supper and HS, check every two to three hours at night and toilet as needed. Reassessment of bladder function had not been completed for R4's quarterly review MDS dated 4/12/14. Further review of R4's interdisciplinary assessments and summary reviews and nurse progress notes lacked documentation of reassessment of bladder function for R4's quarterly review MDS dated 4/12/14. R4's nursing assistant Kardex dated 7/23/14, identified toileting schedule: between five and seven a.m., after breakfast, before dinner, one to two times in the afternoon, after supper and HS and check every two to three hours at night. Toilet use: requires one staff participation to use toilet, will use toilet in room and urinal at bedside, pad product: large brief and transfer: requires one staff participation with pivot transfer. During interview on 7/23/14, at 1:26 p.m., registered nurse (RN)-A verified no quarterly bladder assessment had been completed when completing the quarterly review of R4's bladder function and had stated looking at the nursing assistant documentation during look back period for the quarterly assessment dated 4/12/14, R4 had no change from frequently incontinent, if no change we do not have to do a bladder	2 550		

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2 550	Continued From page 4	2 550		

assessment unless we see a change in voiding which is an increase or decrease in voiding.

During interview on 7/24/14, at 11:18 a.m., RN-A verified R4's interdisciplinary assessments and summary reviews and nurse progress notes lacked documentation of reassessment of bladder function for R4's quarterly review MDS dated 4/12/14.

During interview on 7/24/14, at 11:11 a.m., director of nursing had stated she would expect an analysis of R4's bladder function and an assessment to be completed for quarterly review of R4's bladder function.

Document review of the facility Policy ASSESSMENT dated 9/12, read, "PURPOSE· To ensure resident assessments are completed and coordinated in compliance with appropriate regulations POLICY Review of assessments will be done every three (3) months and as appropriate. The comprehensive assessment will be revised to ensure accuracy."

SUGGESTED METHOD OF CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the revision and accuracy of the quarterly assessment process. The DON, or designee(s) could provide an in-service for all appropriate staff on these policies and procedures. The DON, or designee(s) could monitor to assure each resident with a quarterly assessment is accurate and revise.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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2 560	Continued From page 5	2 560		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively care plan the risk for falls for 1 of 3 residents (R40) reviewed for accidents. Findings include: R40 was admitted on 5/29/14 for rehabilitation following a fall at home, polyneuropathy and Parkinson's disease according to the admission face sheet. The admission Minimum Data Set (MDS) dated 6/5/14, indicated R40 had a mild cognitive impairment and required extensive assist with transfers and gait. R40 was also at moderate risk for falls. The Falls Care Area Assessment (CAA) dated 6/5/14, indicated R40 was at risk for falls due to a fall history prior to admission. It was also noted that it would not be included in the care plan due to the facility's plan for strengthening.	2 560		

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2 560	Continued From page 6 The plan of care did not include any information about R70's history of falls or fall risk. R70 was interviewed on 7/23/14, at 7:10 a.m. R70 verified a fall at home prior to admission as well as a fall in the facility on 7/20/14. R70 stated he lost his balance when he was up independently in his room. Registered nurse (RN)-A was interviewed on 7/24/14, at 11:00 a.m. RN-A stated the fall risk did not get placed on the care plan at admission because R70 was planned to get exercises for strengthening she did not feel R70 would be at risk for falls. RN-A verified the fall risk had not been care planned and agreed that since the fall on 7/20/14, it should have been added to the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service licensed staff to develop a care plan to include appropriate interventions for all identified care needs. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded.	2 835		

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2 835	Continued From page 7	2 835		

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure clean and trimmed nails for 1 of 3 residents (R4) and failed to provide assistance with removal of facial hair for 1 of 3 residents (R7) reviewed for activities of daily living.

Findings include:

R4's admission record dated 7/24/14, identified they were admitted on 11/17/13 and had a diagnosis of dementia. R4's quarterly Minimum Data Set (MDS) dated 4/12/14, identified R4 required extensive assist of one for personal hygiene.

During observation on 7/21/14, at 7:31 p.m., R4 laid in bed resting. R4's fingernails on both hands were noted to be long, untrimmed and had black debris underneath fingernails. R4 had stated, "No" when asked if staff help to clean and trim fingernails.

During observation on 7/22/14, at 1:45 p.m., R4 laid in bed resting. R4's fingernails remained long and untrimmed with black debris underneath nails.

During observation on 7/23/14, at 7:22 a.m., R4 had been sitting in wheelchair at a table in the dining room waiting to be served breakfast. R4's fingernails remained long, untrimmed with black debris underneath nails. At 8:46 a.m., registered nurse (RN)-A had been in R4's room observed R4 ' s nails and verified some fingernails were long and had debris underneath some nails on both of R4's hands.

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2 835	Continued From page 8	2 835		

R4's care plan dated 4/28/14, identified focus: activities of daily living self- care performance deficit related to muscle weakness, neuro cognitive disorder with interventions of but not limited to personal hygiene: requires one staff participation with personal hygiene and focus: diabetes mellitus with intervention of but not limited to: diabetic nail care provided by licensed nurse.

Document review of the facility bath list and skin checks dated revised 7/17/14, identified R4's bath day on Wednesday days.

Document review of R4's nurse progress notes dated 6/25/14 through 7/18/14, had no documentation regarding nail care.

During interview on 7/23/14, at 10:13 a.m., RN-B had stated the nurse progress notes would be the only place to document nail care, under " skin care " on bath day.

During interview on 7/24/14, at 10:01 a.m., director of nursing had stated nail care is done on bath days or anytime it needs to be done. Director of nursing had stated if a resident with mood and behaviors refuses nail care and staff have gone in multiple times and resident continues to refuse, would expect staff to document resident has refused.
Document review of the facility Procedure NAIL CARE dated revised 11/13, read, "PURPOSE To keep nails clean and trimmed to promote well-being To observe nail condition To prevent nail discomfort PROCEDURE FOR FINGERNAILS 1. Licensed nurse should be notified to do nail care as needed for residents who are diabetic or are receiving anticoagulants

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2 835	Continued From page 9	2 835		

who may tend to bleed easily. Never trim corns, callouses or blisters. 15. If documentation of nail care is desired, it should be set up in the care plan and documented in PCC - POC."

R7 was observed on 7/22/14 at 9:35 a.m. and noted to have visible facial hair around her mouth and chin.
R7 was observed on 7/23/14 at 8:00 a.m. sitting in the day room and had visible facial hair that had not been removed. The licensed practical nurse (LPN)-A was interviewed on 7/23/14 at 8:00 a.m. and confirmed that R7 had facial hair and stated that the resident had a bath yesterday and that the staff should have shaved her. LPN-A indicated that the nursing assistants are to check each resident every day and shave them whenever necessary.
R7's care plan dated 5/5/14 indicated that the resident was admitted on 8/29/13 and had diagnoses that included paralysis agitans, dementia and depressive disorder.
R7's care plan dated 5/5/14 indicated a problem with activities of daily living (ADL) self- care performance deficit and directed staff that R7 required assistance of one staff participation with personal hygiene.
The quarterly Minimum Data Set (MDS) dated 4/23/14 indicated that R7 was unable to complete the Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment. The MDS dated 4/23/14 also indicated that R7 required extensive assist of one staff for personal hygiene.
Documentation indicated that R7 received a bath on 7/15/14 and also 7/22/14 with no documentation that facial hair removal was completed.
The director of nursing (DON) was interviewed on 7/23/14 at 12:55 p.m. The DON indicated her expectations for female facial hair was that she

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2 835	Continued From page 10 would expect that it would be removed if noticed on the resident's bath day or any other day that it was noticed. A policy titled Shaving revised on 11/2013 directed staff on the procedure of shaving a resident. A policy titled Routine Daily Practice revised on 10/2013 had no guidelines on when to shave a resident. It did indicate that a resident would have a bath/shower per week and that skin was to be checked weekly. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff responsible for meeting personal grooming for residents the need to keep nails trimmed and clean and facial hair for women trimmed if the woman had identified this as important to them. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 835		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	2 910		

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2 910	Continued From page 11	2 910		

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to reassess bladder function and failed to provide appropriate treatment and services to maintain or improve bladder function for 1 of 1 resident (R4) reviewed for urinary incontinence.

Findings include:

R4's admission record dated 7/24/14; identified R4 had been admitted on 11/17/13 and also included but not limited to diagnosis of dementia. R4's quarterly Minimum Data Set (MDS) dated 4/12/14; identified R4 required extensive assist of one for toileting, scheduled toileting program, frequently incontinent of bladder and had moderate cognitive impairment.

During observation on 7/21/14, at 7:40 p.m., R4 lay in bed, a visible wet urine stain had been seen on R4's shirt and there had been a strong urine odor in R4's room. R4 was yelling out "Help" this surveyor alerted staff of R4 needing assist.

During observation on 7/23/14, at 8:46 a.m., R4 had been transferred by nursing assistant (NA)-A and NA-B from wheelchair to bed. NA-A and NA-B were observed by surveyor to provide weight bearing assist when transferring R4 and R4 had been unsteady with maintaining balance and pivoting during transfer. NA-A and NA-B laid R4 down in bed, covered R4 with a blanket, placed call light in reach, turned off light to room and exited R4's room. NA-A and NA-B had not offered the toilet to R4 and had not checked R4's

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2 910	Continued From page 12 incontinent product, NA-A and NA-B verified at the time. NA-B had stated last time R4 had been toileted was 6:30 a.m. NA-A and NA-B had stated they did not know R4's toilet schedule. NA-A and NA-B had stated we can look up R4's toilet schedule in KIAS (computer system) and showed surveyor R4's toilet schedule. NA-A and NA-B verified R4's toilet schedule on the nursing assistant care sheets read R4 was to be toileted after breakfast. R4's care plan dated 4/28/14, identified self- care performance deficit related to muscle weakness, neuro cognitive disorder with intervention of but not limited to toilet use: requires one staff participation to use toilet, will use toilet in room and urinal at bedside, toileting schedule: between five and seven a.m., after breakfast, before dinner, one to two times in the afternoon, after supper and HS (bedtime) and check every two to three hours at night, transfers: requires one staff participation with pivot transfer and has bladder incontinence, pad product large brief. R4's records identified last completed bladder assessment had been dated 11/11/13, and identified R4 required one assist needed for transfer, one assist needed for ambulation, impaired balance, unsteady gait, impaired cognition and physical mobility to manage own clothing and own hygiene, urge and functional incontinence, toilet program: yes and proposed scheduled: between five and seven a.m., after breakfast, before dinner, one to two times in the afternoon, after supper and HS (hour of sleep), check every two to three hours at night and toilet as needed. Reassessment of bladder function had not been completed for R4's quarterly review MDS dated 4/12/14. Further review of R4's interdisciplinary assessments and summary	2 910		

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2 910	Continued From page 13	2 910		

reviews and nurse progress notes lacked documentation of reassessment of bladder function for R4's quarterly review MDS dated 4/12/14.

R4's nursing assistant Kardex dated 7/23/14, identified toileting schedule: between five and seven a.m., after breakfast, before dinner, one to two times in the afternoon, after supper and HS and check every two to three hours at night. Toilet use: requires one staff participation to use toilet, will use toilet in room and urinal at bedside, pad product: large brief and transfer: requires one staff participation with pivot transfer.

During interview on 7/23/14, at 1:26 p.m., registered nurse (RN)-A verified no quarterly bladder assessment had been completed for quarterly review of R4's bladder function and had stated looking at the nursing assistant documentation during look back period for the quarterly assessment dated 4/12/14, R4 had no change from frequently incontinent, if no change we do not have to do a bladder assessment unless we see a change in voiding which could be an increase or decrease in voiding.

During interview on 7/24/14, at 11:18 a.m., RN-A verified R4's interdisciplinary assessments and summary reviews and nurse progress notes lacked documentation of reassessment of bladder function for R4's quarterly review MDS dated 4/12/14.

During interview on 7/24/14, at 11:11 a.m., director of nursing had stated she would expect an analysis of R4's bladder function and an assessment to be completed for quarterly review of R4's bladder function.

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2 910	Continued From page 14 Document review of the facility Policy ASSESSMENT dated 9/12, read, "PURPOSE· To ensure resident assessments are completed and coordinated in compliance with appropriate regulations POLICY Review of assessments will be done every three (3) months and as appropriate. The comprehensive assessment will be revised to ensure accuracy." SUGGESTED METHOD OF CORRECTION: The Director of Nursing could inservice staff to complete quarterly urinary assessments and to provide toileting assistance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services,	21535		

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Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to monitor target behaviors and adequately assess clinical indications to evaluate the effectiveness for continued use of psychotropic medications for 1 of 5 residents (R4) reviewed for unnecessary medications.

Findings include:

R4 had been admitted on 11/17/13 as found on the admission record dated 7/24/14, the record also identified but not limited to diagnosis of dementia. R4 ' s quarterly Minimum Data Set (MDS) dated 4/12/14, identified R4 had received antipsychotic medication, had behavior symptoms and had moderate cognitive impairment.

Document review of R4's physician orders signed dated 6/12/14, revealed an order for Risperdal (an antipsychotic medication) 0.50 milligrams two times a day for dementia. Document review of the facility medication administration record print date 7/24/14, revealed R4 received Risperdal as ordered.

Document review of R4's care plan print date 7/23/14, identified behavior symptom related to vascular dementia evidenced by takes oxygen off, yells, potential for elopement, poor judgment and insight with interventions of intervene as necessary to protect the rights and safety of

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others, approach and speak in calm manner, divert attention, remove from situation and take to alternative location as needed, provide opportunity for positive interaction, attention and minimize potential for resident's disruptive behaviors yelling by offering tasks which divert attention such as snacks and one to one visits.

R4's nursing assistant Kardex print date 7/231/14, identified mood/behavior: intervene as necessary to protect the rights and safety of others, approach and speak in calm manner, divert attention, remove from situation and take to alternative location as needed, provide opportunity for positive interaction, attention, minimize potential for resident's disruptive behaviors yelling by offering tasks which divert attention such as snacks and one to one visits, non-pharmacological: attempt non-pharmacological interventions: simplify tasks: give instructions slowly and wait for a response. However R4's nursing assistant Kardex had not identified target behaviors of takes oxygen off, potential for elopement, poor judgment/insight and there had been no documentation in R4's record regarding monitoring of R4's target behaviors except for yelling.

Document review of care conference note dated 4/29/14, revealed behaviors of yelling, getting angry and recently attempted to go outside. However there had been no documented analysis of R4's behaviors.

During interview on 7/23/14, at 10:39 a.m., registered nurse (RN)-C had stated behavior being documented on all residents is just general symptoms as found in the MDS. RN-C verified only one target behavior, yelling had been identified on the nursing assistant Kardex for the

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21535	Continued From page 17 nursing assistants to document on the behavior if R4 had the behavior. During interview on 7/24/14, at 9:00 a.m., director of nursing had stated social service is responsible to document review of behaviors. Director of nursing had stated we review behaviors with the physician and the physician documents an analysis of the behaviors. Surveyor requested documented analysis of behaviors, none had been provided. During interview on 7/24/14, at 9:30 a.m., director of nursing verified only one target behavior, yelling had been identified on C4 ' s nursing assistant Kardex for the nursing assistants to document on the behavior if R4 had the behavior. During interview on 7/24/14, at 10:01 a.m., director of nursing had stated she would expect target behaviors to be pulled over to the nursing assistant Kardex for the nursing assistants to know what they are and be able to document on them. SUGGESTED METHOD OF CORRECTION: The director of nursing or pharmacist could in-service all employees responsible for assessment and monitoring of psychoactive medications educates these employees on the need to monitor behaviors to determine if the medication is effective to treat behaviors. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin	21565		

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Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R67) was assessed to be safe to self-administer a nebulizer treatment.

Findings include:

R67 was admitted to the facility on May 2, 2014 and had no cognitive deficit according to the admission Minimum Data Set dated 5/9/2014. However, he had not been assessed for self-administration of medications as determined by the interdisciplinary committee.

On 7/23/14, at 7:25 a.m. registered nurse (RN)-B was observed to administer a nebulizer treatment for R67 as ordered by his physician. RN-B set up the treatment and handed the device to R67 and walked out of the room. R67 was left alone in the room with the nebulizer treatment and machine running.

After reviewing the physician's orders, it was noted there was not an order or any notation indicating R67 was able to self-administer the nebulizer treatment.

On 7/23/14, at 1:50 p.m. an interview was conducted with RN-B. RN-B verified that R67 did not have an order or an assessment available indicating R67 was able to self-administer the

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21565	Continued From page 19 nebulizer treatment. Based on the facility Resident Self-Administration of Medication policy dated 7/14 directed the interdisciplinary team must make a determination whether each resident who expresses a desire to self-administer medications can do this safely. The interdisciplinary team's determination that the resident can safely self-administer medications must be documented in the medical record, and a physician's order must be obtained prior to the resident self-administering medications. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could monitor to assure that residents may self-administer medications if the comprehensive resident assessment and comprehensive plan of care indicates the practice is safe and there is a written order from the attending physician. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations	21915		

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21915	Continued From page 20 regarding facility policies. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to attempt to organize a family council on at least an annual basis. On 7/24/14, at 9:00 a.m., licensed social worker (LSW)-A was interviewed about family council. LSW-A indicated they had offered community education with guest speakers on Alzheimer's disease the past couple of years, with the most recent meeting on 7/22/14. LSW denied any discussion at the meetings that related to any cares or concerns within the facility. LSW denied having a current family council where family members were able to discuss their concerns. LSW further denied any attempts were made in developing a family council or organizing a family meeting other than quarterly care conferences. SUGGESTED METHOD OF CORRECTION: The Administrator and Social Worker could develop policies to include an attempt to organize family council on at least a yearly basis. The Quality Assurance Committee could develop a system to monitor the attempts made at forming a family council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21915		
23270	MN Rule 4658.5515 Nurse Call System; Existing Construction A communication system must be provided in a nursing home. It must register a call from the resident at the nursing station and activate a	23270		

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23270	Continued From page 21 signal light by the bedroom door. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that a call light was in working condition for 1 of 30 residents (R47) and others to summons help if needed for R47. Findings include: R47 ' s call light located on the bedside on 7/21/14 at 6:27 p.m. was checked and found to not light up on the display outside of the room. R47 was in the dining room at that time eating supper. The call light is for resident, staff, and family use when assistance is needed. During an interview with the licensed practical nurse (LPN)-B on 7/21/14 at 6:53 p.m. it was confirmed that the call light was not functioning. LPN-B stated that it was a good thing the resident did not use his call light. R47's signed physician orders dated 6/12/14 indicated that R47 was admitted to the facility on 5/21/13 with a diagnosis including Alzheimer's disease. R47's annual Minimum Data Set (MDS) dated 4/23/14 indicated R47 was unable to complete the Brief Interview of Mental Status (BIMS) indicating R47 had severe cognitive impairment. When interviewed on 7/23/14 at 7:45 a.m. the director of maintenance (DM)-B indicated he was not aware that R47's call light was not functioning. DM-B stated that each unit of the facility had a maintenance book that is checked for needed repairs. DM-B stated that he had put in many new call lights since he had started at the facility. This particular call light was a double-cord and sometimes they get pulled apart. The maintenance book was checked with the	23270		

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DM-B and it was noted that on 7/21/14 that after surveyor notification the non-functioning call light issue was placed in the maintenance book. This was not noticed by maintenance until this time. DM-B stated that he tries to check the maintenance book daily. When a policy was requested for the maintenance of the call light system, DM-B stated that he did not know of a policy other than that staff was instructed to use the book for any maintenance concern. DM-B indicated that when he checked the call light after I interviewed him that sometimes it worked and sometimes it didn't, so he replaced it. A copy of the maintenance log and when it was received it was documented that the call light was repaired on 7/23/14.

On 7/23/14 at 9:15 a.m. the call light was functioning properly when checked.

During an interview with the director of nursing (DON) on 7/23/14 at 12:55 p.m., the DON indicated that if a call light was discovered not working that the expectation would be that the staff would notify maintenance and in the meantime make sure that the resident was safe.

The facility Call Light policy, dated 9/2012, read, "To ensure resident always has a method of calling for assistance. For residents unable to use call light, staff need to make frequent visits or provide an adaptive call light."

SUGGESTED METHOD OF CORRECTION:
The facility could devise a process whereby the call light system is checked for all residents on a periodic basis, e.g. when a new resident is admitted or moved to a different room.

TIME PERIOD FOR CORRECTION: Seven (7)

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23270	Continued From page 23 days.	23270		