## DEPARTMENT OF HEALTH AND HUMAN SERVICES

## CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: Y1RU

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY A	GENCY		Fac	cility ID: 00303
1. MEDICARE/MEDICAID PROVIDER N (L1) 245455 2.STATE VENDOR OR MEDICAID NO. (L2) 673342500	IO.	3. NAME AND AI (L3) <b>GOOD SAM</b> (L4) <b>601 WEST J</b> (L5) <b>JACKSON</b> ,	IARITAN SOO IACKSON		ACKSON (L6) 56	6143	<ol> <li>Initial</li> <li>Termin</li> <li>Validat</li> </ol>	nation tion	2. Recertification 4. CHOW 6. Complaint 9. Other
<ul><li>5. EFFECTIVE DATE CHANGE OF OWN (L9)</li><li>6. DATE OF SURVEY 09/10/2</li></ul>	NERSHIP 014 (L34)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	06 PRTF 10 NF		22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint  FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE			//31	DINE. (ESS)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	63 (L18) 63 (L17)	Complianc1. A  X B. Not in Con	nce With equirements e Based On: cceptable POC	gram	And/Or Approve	cal Personnel ur RN RN (Rural SN) afety Code	6. Sc 7. Mo 8. Pa	Requirement cope of Service edical Direct tient Room S eds/Room	ces Limit tor
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY ME	ETS			
18 SNF 18/19 SNF 63	19 SNF	ICF	IID		1861 (e) (1) or 1	861 (j) (1):	(L	L15)	
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMARK	S (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	EY AGENCY	APPROVAL		Date:
Joseph Garvey,, HFE NE II		1	0/21/2014	(L19)	Kamala Fiske-D	Downing, E	nforcemen	ıt Speciali	<u>ist</u> 10/27/2014 (L20
PART 1	II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	COFFICE OR	SINGLE ST	TATE AGE	NCY	
<ul><li>19. DETERMINATION OF ELIGIBILITY</li><li>_X 1. Facility is Eligible to Partic</li></ul>			IPLIANCE WITH HTS ACT:	H CIVIL	2. Ow		icial Solvency (F l Interest Disclo :	,	CFA-1513)
2. Facility is not Eligible	(L21)								
22. ORIGINAL DATE 23	3. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATI	ON ACTION:		(L3	30)
OF PARTICIPATION <b>04/01/1987</b>	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 01-Merger, Closur		- 0		eet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction 03-Risk of Involunt			06-Fail to Me	eet Agreement
25. LTC EXTENSION DATE: 27		VE SANCTIONS n of Admissions:	(T.44)		04-Other Reason fo	-	<u>(</u>	<u>OTHER</u> 07-Provider S 00-Active	Status Change
(L27)	B. Rescind St	uspension Date:	(L44)					70-Active	
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS				
		00140							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE					
	(L32)	09/05/2014		(L33)	DETERMINA	TION APPR	ROVAL		



#### 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, Program Specialist

Division of Compliance Monitoring

Kumala Fiske Downing

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

Good Samaritan Society - Jackson October 21, 2014 Page 2

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

Kumalu Fiske Downing

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

## 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 245455	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/15/2014
Name	e of Facility		Street Address, City, State, Zip Code	
GOOD SAMARITAN SOCIETY - JACKSON		SON	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	(Y4) Item	(Y5)	Date	(Y4)	Item	(	(Y5)	Date
		C	Correction			Correction					Correction
ID Prefix	F0312		ompleted 9/24/2014	ID Prefix		Completed		ID Prefix			Completed
	483.25(a)(3)					-		_			
				LSC		•		LSC			 
		C	Correction			Correction					Correction
			Completed			Completed					Completed
ID Prefix						-					_
Reg. # LSC				Reg. # LSC		-		Reg. # LSC			
		C	Correction			Correction					Correction
		C	Completed			Completed					Completed
						-					_
Reg. # LSC				Reg. # LSC		-		Reg. # LSC			_
								-			_
		C	Correction			Correction					Correction
ID Prefix		C	Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #				Dog #		=					
-				LSC		•		LSC			<u> </u>
		C	Correction			Correction					Correction
ID Drofiv			Completed	ID Drofiv		Completed		ID Brofiv			Completed
						-					
Reg. # LSC				Reg. # LSC		-		Reg. # LSC			<u> </u>
Reviewed E	By Re	eviewed E	Ву	Date:	Signature of Sur	veyor:				Date:	
State Agen		KS/I	KFD	10/21/2014	_	22113				10/	15/2014
Reviewed E	Ву Re	eviewed E	Ву	Date:	Signature of Sur	veyor:				Date:	
CMS RO											
Followup t	o Survey Compl				Check for any Unco	rrected Defi	cienci	es. Was a	Summary of		
	7/24/20	14			Uncorrected Defic	Hencies (CN	13-25	or) sent to	me racility?	YES	NO

## 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 245455	(Y2) Multiple Cons A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 9/25/2014
Name	e of Facility		Street Address, City, State, Zip Code	
GOOD SAMARITAN SOCIETY - JACKS		SON	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	(Y:	5) Date	(Y4) Item	(Y5	) Date	(Y4)	Item		(Y5)	Date
ID Prefix		Correction Completed 08/24/2014	ID Prefix		Correction Completed 09/24/2014		ID Prefix			Correction Completed 08/24/2014
•	NFPA 101		•	NFPA 101			Reg. #	NFPA 101		
LSC	K0029	_ 	LSC	K0056	<del>-</del> -		LSC	K0067		_
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed					Correction Completed
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed					Correction Completed
Reg. #			Reg. #				D "			
Reviewed E	By Reviewe	d By	Date:	Signature of Su	rveyor:				Date:	
State Agen	cy PS/KF	D	10/21/20	014	25	822				09/25/2014
Reviewed E	Reviewe	d By	Date:	Signature of Su	rveyor:				Date:	
Followup t	o Survey Completed o	n:		Check for any Unco Uncorrected Defi					YES	NO

# State Form: Revisit Report (Y1) Provider / Supplier / CLIA / Identification Number 00303 (Y2) Multiple Construction A. Building B. Wing 10/15/2014 Name of Facility Street Address, City, State, Zip Code 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
	Correction		Co	orrection			Correction
ID Prefix 2083	Completed <b>09/24/2014</b>	ID Prefix	Co	ompleted	ID Prefix		Completed
<del></del>	ile 4658.0520 Subp.	Reg. #			Reg. #		
	пе 4030.0320 Эшьр.						
	Correction		Co	orrection			Correction
ID Prefix	Completed	ID Prefix	Co	ompleted	ID Prefix		Completed
Reg. #							<del></del>
LSC					LSC		<u> </u>
	Correction			orrection			Correction
ID Prefix	Completed	ID Prefix	C	ompleted	ID Prefix		Completed
LSC		LSC			LSC		<u> </u>
	Correction		Co	orrection			Correction
ID Prefix	Completed	ID Prefix	Co	ompleted	ID Prefix		Completed
_		_					
		LSC			LSC		<u> </u>
	Correction		Co	orrection			Correction
ID Prefix	Completed	ID Prefix	Cc	ompleted	ID Prefix		Completed
Dog #		_					
		LSC			LSC		
Reviewed By	Reviewed By	Date:	Signature of Surve	-		Date:	10/15/2011
State Agency	KS/KFD	10/21/2014		22113			10/15/2014
Reviewed By — CMS RO	Reviewed By	Date:	Signature of Surve	yor:		Date:	
Followup to Surv	ey Completed on:	с	heck for any Uncorre Uncorrected Deficie				NO
STATE FORM: REV	/ISIT REPORT (5/99)	1	Page 1 of 1			Event ID: Y1RU1;	



#### 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

Kumalu Fiske Downing

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

	IAKI I-	TO BE COMIT	DETED DI 1	IIIE SIA	IE SURVET AGENCI		racinty iD. 00303
MEDICARE/MEDICAID PROVIDIO     (L1) 245455      STATE VENDOR OR MEDICAID N		3. NAME AND AI (L3) <b>GOOD SAM</b> (L4) <b>601 WEST J</b>	IARITAN SO			4. TYPE OF ACT  1. Initial  3. Termination	ION: _7(L8)  2. Recertification 4. CHOW
(L2) <b>673342500</b>		(L5) <b>JACKSON</b> ,	MN		(L6) <b>56143</b>	5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Af	9. Other iter Complaint
6. DATE OF SURVEY 09/1 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	<b>0/2014</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENI 12/31	DING DATE: (L35)
11LTC PERIOD OF CERTIFICATION	N.	10.THE FACILITY	/ IS CERTIFIED	AS:		-	
From (a):		X A. In Complia			And/Or Approved Waivers Of	f The Following Require	ements:
To (b):		Program R	equirements		2. Technical Personne		
.,	(1.10)	*	ee Based On:		3. 24 Hour RN	7. Medical I	
12.Total Facility Beds	<b>63</b> (L18)	I. A	cceptable POC		4. 7-Day RN (Rural SI 5. Life Safety Code	NF) 8. Patient Ro 9. Beds/Roo	
13.Total Certified Beds	<b>63</b> (L17)		npliance with Properts and/or Appli			(L12)	лі
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
63 (L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Kyla Einertson, HFI	E NE II	0	09/21/2014	(L19)	Kamala Fiske-Downing	, Enforcement Sp	ecialist 10/21/2014 (L20)
PAI	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	STATE AGENCY	
DETERMINATION OF ELIGIBIL      1. Facility is Eligible to F      2. Facility is not Eligible	articipate		IPLIANCE WITH	H CIVIL	21. 1. Statement of Fina 2. Ownership/Contr 3. Both of the Abov	rol Interest Disclosure Str	
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	Į:	(L30)
OF PARTICIPATION <b>04/01/1987</b>	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Closure		UNTARY to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail	to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-1 10V	ider Status Change
(L27)	B. Rescind St	uspension Date:	(L44) (L45)			00-Acti	ve
28. TERMINATION DATE:	29	). INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		00140					
	(L28)	00140		(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAI	LDATE			
	(L32)	09/05/2014		(L33)	DETERMINATION APP	'ROVAL	



#### 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

Kumalu Fiske Downing

Minnesota Department of Health

Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

## 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 245455	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/10/2014
Name	e of Facility		Street Address, City, State, Zip Code	
GOOD SAMARITAN SOCIETY - JACKSON		SON	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	(Y4) Item		(Y5)	Date	(Y4)	Item	(Y	5)	Date
ID Prefix	F0176	Correction Completed 08/25/2014	ID Prefix	F0276	C	Correction Completed 08/25/2014		ID Prefix	F0279		Correction Completed 08/25/2014
	483.10(n)			483.20(c)					483.20(d), 483.2		<u>)                                    </u>
		Correction				Correction					Correction
ID Prefix	F0315	Completed <b>08/25/2014</b>	ID Prefix	F0329		Completed <b>08/25/2014</b>		ID Prefix	F0463		Completed 08/25/2014
Reg. # LSC	483.25(d)		Reg. # LSC	483.25(I)				Reg. # LSC	483.70(f)		 
		Correction				Correction	·				Correction
ID Prefix		Completed	ID Prefix			Completed		ID Prefix			Completed
Reg. #			Reg. #					Б "			
ID Prefix		Correction Completed	ID Prefix		C	Correction Completed		ID Prefix			Correction Completed
Reg. # LSC			Reg. #								  
ID Prefix		Correction Completed	ID Prefix		C	Correction Completed		ID Prefix			Correction Completed
Reg. #			Reg. #								
	D. D.	unioused Dr.	Data	-							
State Agen		eviewed By GPN/KFD	Date: 09/21/201	_	re of Surv	-	221			Date:	09/10/2014
		eviewed By	Date:		re of Surv		221		I	Date:	09/10/2014
Followup t	to Survey Compl 7/24/20								Summary of the Facility?	YES	NO

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION (X:		SURVEY PLETED
		245455	B. WING	i		F <b>09/1</b>	R 1 <b>0/2014</b>
	PROVIDER OR SUPPLIER	- JACKSON		6	STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	of this department, determine complia issued during a red July 24, 2014. Du	was conducted by a surveyor on September 9, 10, 2014, to nce with Federal deficiencies certification survey exited on ring this visit the following	{F 0	00}			
{F 312} SS=D	F312. 483.25(a)(3) ADL (DEPENDENT RES A resident who is udaily living receives	CARE PROVIDED FOR SIDENTS  nable to carry out activities of sthe necessary services to ition, grooming, and personal	{F 3	12}			
	by: Based on observareview, the facility of with removal of fact R72) who were assecompleting activities. This tag was issue exited on 7/24/14 assurvey (PCR) was compliance.  Findings Include: R7 was observed of noted to have visible lip. R7 was observed of noted to have visible lip.	NT is not met as evidenced tion, interview and document failed to provide assistance ial hair for 2 of 3 residents (R7, sessed to need assistance in as of daily living skills (ADLs). It is dat the certification survey and on this post certification again found not to be in on 9/9/14 at 10:52 a.m. and le facial hair around her upper on 9/9/14 at 3:07 p.m. and le facial hair around her upper on 9/10/14 at 8:30 a.m. and			F 312 Resident (R4) nails were clear and trimmed. Resident (R7) facial hai was removed by NA. All other residents who are unable to out nail care or facial hair were check assure they were clean and trimmed. Nurses and NA's received re-education 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 complete weekly X2 nail & facial hair then X 1 month then reviewed by the quality committee for further recommendation	carry ked to con on on on a	
ARODATOR		DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE S COMPLI	
		245455	B. WING				R 40/2044
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY		J	ST <b>60</b>	TREET ADDRESS, CITY, STATE, ZIP CODE O1 WEST JACKSON ACKSON, MN 56143	09/	10/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 312}	lip. The quarterly Minim 7/23/14 indicated the Brief Interview findicated severe condated 7/23/14 also extensive assist of R7's care plan date resident was admitted diagnoses that includementia and depre R7's care plan date ADLs self-care per staff that R7 require participation with per During an interview registered nurse (R long facial hair aroulip. RN-A stated star R7's facial hair on be facial hair daily as a are getting resident had her scheduled yesterday (9/9/14 a facility) and stated that indicated R7 reher facial hair.  R72 was observed noted to have seve bottom of her chin.  R72 was observed was noted to have seve the bottom of her chin.	e facial hair around her upper num Data Set (MDS) dated at R7 was unable to complete for Mental Status (BIMS) which agnitive impairment. The MDS indicated that R7 required one staff for personal hygiene. It does not be staff for a part of morning cares as they a for the day. RN-A stated R7 bath on Tuesdays, which was listed to allow staff to shave on 9/9/14 at 8:40 a.m. and ral short chin hairs across the several short chin hairs across	{F 3	12}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245455	B. WING				R 10/2014	
	PROVIDER OR SUPPLIER	L		ST <b>60</b>	STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		09/10/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
{F 312}	the bottom of her click R72's care plan data admitted on 7/1/20' included congestive and anxiety state.  The admission Min 7/7/14 indicated R7 Mental Status (BIM indicated moderate MDS dated 7/7/14 extensive assist of R72's care plan data with ADLs self-care PERSONAL HYG do so independently dressed for the day During an interview confirmed R72 had chin and upper lip. taken care of R72's should look for facing morning cares as the day. RN-A stated R Saturdays and state documentation that allow staff to shave During an interview stated, "Some of the hair and others donoffer to shave her far R72 stated she use but did not have the herself. R72 stated her facial hair where good to have facial	inin.  sed 7/1/14 indicated R72 was 14 and had diagnoses that 2 heart failure, atrial fibrillation imum Data Set (MDS) dated 12 had a Brief Interview for 15 score of twelve which cognitive impairment. The also indicated that R7 required one staff for personal hygiene. Sed 7/1/14 indicated a problem a performance deficit and read, IENE: Encourage resident to 15 y while in the bathroom getting 16 y while in the bathroom getting 17 on 9/10/14 at 9:50 a.m. RN-A 16 visible facial hair along her 17 RN-A stated staff should have 18 facial hair on bath days and 19	{F 3·	12}				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER	240400	1		REET ADDRESS, CITY, STATE, ZIP CODE	09/	10/2014	
	AMARITAN SOCIETY	- JACKSON		601	WEST JACKSON CKSON, MN 56143			
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{F 312}	director of nursing s facial hair was to be by staff and also on A policy titled Shavi directed staff on the resident. A policy ti revised on 10/2013 shave a resident. It	stated her expectation was e removed when it is noticed a bath day.  In prevised on 11/2013 e procedure of shaving a tled Routine Daily Practice had no guidelines on when to the did indicate that a resident shower per week and that skin	{F 3·	12}				

# State Form: Revisit Report (Y1) Provider / Supplier / CLIA / Identification Number 00303 (Y2) Multiple Construction A. Building B. Wing 9/10/2014 Name of Facility GOOD SAMARITAN SOCIETY - JACKSON State, Zip Code 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) D	ate
ID Prefix		Correction Completed 08/25/2014	ID Prefix		Correction Completed 08/25/2014		ID Prefix	•	Correction Completed 08/25/2014
	MN Rule 4658.040		Reg. # LSC	MN Rule 4658.0405 Su	-			MN Rule 4658.0525 Su	
ID Prefix Reg. # LSC	_21535 MN Rule4658.1315	Correction Completed 08/25/2014 5 Subp.1	ID Prefix Reg. # LSC	21565 MN Rule 4658.1325 Su	Correction Completed 08/25/2014 bp.		ID Prefix Reg. # LSC	MN St. Statute 144.651	Correction Completed 08/25/2014 Sul
	_23270 MN Rule 4658.551		Reg. #				Reg. #		
ID Prefix Reg. # LSC			Reg. #		Correction Completed				
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #		Correction Completed		ID Prefix		Correction Completed
Reviewed E State Agence Reviewed E	GP1	ewed By N/KFD ewed By	Date: 09/21/20 Date:	Signature of Sur	3	1221		Date:  Date:	9/10/2014
Followup to Survey Completed on: 7/24/2014				Check for any Unco Uncorrected Defice					NO

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00303		B. WING			R <b>10/2014</b>
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON	601 WES	DRESS, CITY, STACKSON N, MN 56143	STATE, ZIP CODE	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO	ICIES ) BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{2 000}	Initial Comments			{2 000}			
	****ATTEI	NTION*****					
	NH LICENSING	CORRECTION C	RDER				
	In accordance with 144A.10, this correspursuant to a surve found that the defic herein are not correspond to corrected shall with a schedule of the Minnesota Department.	ction order has be y. If, upon reinsp iency or deficience ected, a fine for ea be assessed in ac ines promulgated	een issued ection, it is ies cited ach violation ccordance by rule of				
	Determination of whe corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du corrected.	compliance with a rule provided at alle number indicans as several items, the items will be of Lack of compliany item of multi-p ment of a fine ever	all the tag ted below. failure to considered nce upon art rule will en if the item				
	You may request a that may result from orders provided that the Department with notice of assessment.	n non-compliance It a written reques hin 15 days of rec	with these at is made to beipt of a				
	INITIAL COMMENT An onsite follow-up September 9, 10, 2 was determined that order 4658.0520 St was NOT corrected remain in effect and onsite visit. Also ur	visit was complet 014. During this can at the following co ab. 2. A. (ACO nu l. This uncorrected will be reviewed	onsite visit it rrection mber 0835) d order will at the next				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00303		B. WING			R 1 <b>0/2014</b>
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 03/1	10/2014
GOOD S	AMARITAN SOCIETY	- JACKSON	601 WES	T JACKSON			
				N, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{2 000}	Continued From pa	ge 1		{2 000}			
	reviewed for possib	le penalty assess	ment.				
{2 835}	MN Rule 4658.0520 Proper Nursing Car		uate and	{2 835}			
	Subp. 2. Criteria for proper care. The cadequate and proper Evidence of adequate considerate treatmeter trespected and subpressions.	criteria for determi er care include: ate care and kind a ent at all times. F	ning and				
	This MN Requirements: Based on observation review, the facility fawith removal of facility fawith removal of facility fawith removal of facility with removal of facility facility with removal of f	on, interview and ailed to provide as al hair for 2 of 3 re essed to need ass of daily living skid at the certificationd on this post ce	document esistance esidents (R7, sistance in ills (ADLs). n survey rtification				
	Findings Include: R7 was observed o noted to have visibl lip. R7 was observed o noted to have visibl lip. R7 was observed o noted to have visibl lip. The quarterly Minim 7/23/14 indicated th the Brief Interview f indicated severe co	e facial hair aroun n 9/9/14 at 3:07 p e facial hair aroun n 9/10/14 at 8:30 e facial hair aroun num Data Set (ME nat R7 was unable or Mental Status (	ad her upper .m. and ad her upper a.m. and ad her upper OS) dated to complete (BIMS) which				

Minnesota Department of Health

STATE FORM Y1RU12 If continuation sheet 2 of 5

AND PLAN OF CORRECTION DENTIFICATION NOWBER. A. BUILDING:	ED
R	
00303 B. WING 09/10/20	014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD SAMARITAN SOCIETY - JACKSON  JACKSON, MN 56143	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) OMPLETE DATE
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 discorder. 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 (99/14/ 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 8:24 a.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 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 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.	

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Minnesota Department of Health STATE FORM

Y1RU12 If continuation sheet 3 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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				1 00/1	0/2014	
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE			
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PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
7/7/14 indicated R72 Mental Status (BIMS indicated moderate of MDS dated 7/7/14 al extensive assist of o R72's care plan date with ADLs self-care p " PERSONAL HYGIE do so independently dressed for the day." During an interview of confirmed R72 had of chin and upper lip. R taken care of R72's should look for facial morning cares as the day. RN-A stated R7 Saturdays and stated documentation that if allow staff to shave the During an interview of stated, "Some of the hair and others don't offer to shave her fac R72 stated she used but did not have the herself. R72 stated her facial hair when a good to have facial h  During an interview of director of nursing st facial hair was to be by staff and also on  A policy titled Shaving directed staff on the resident. A policy title	mum Data Set (MDS) dated 2 had a Brief Interview for 6) score of twelve which cognitive impairment. The Iso indicated that R7 required one staff for personal hygiene. Ed 7/1/14 indicated a problem performance deficit and read, ENE: Encourage resident to while in the bathroom getting on 9/10/14 at 9:50 a.m. RN-A visible facial hair along her RN-A stated staff should have facial hair on bath days and I hair daily as a part of ey are getting resident for the 72 had her scheduled bath on d there was no indicated R72 refused to her facial hair. on 9/10/14 at 11:29 a.m. R72 a staff offer to shave my facial t." R72 stated staff did not icial hair on her bath days. It to shave her own facial hair, equipment here to shave by she wanted staff to "shave they see it, as it does not look nair."	{2 835}				

Minnesota Department of Health

STATE FORM 6899 Y1RU12 If continuation sheet 4 of 5

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED		
		00303	B. WING		R 09/10	0/2014
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY,	STATE, ZIP CODE	1 00/11	0/2014
GOOD S	SAMARITAN SOCIETY	- IACKSON	T JACKSON			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	N, MN 56143	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
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{2 835}	Continued From pa	ige 4	{2 835}			
{2 835}	shave a resident. I	t did indicate that a resident shower per week and that skir				

Minnesota Department of Health

STATE FORM 6899 Y1RU12 If continuation sheet 5 of 5

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LT DEECONS ROMAN	(X3) DATE SURVEY COMPLETED
		245455	B. WING		R
NAME OF	PROVIDER OR SUPPLIER	1	1	STREET ADDRESS, CITY, STATE, ZIP CODE	09/10/2014
GOOD S	AMARITAN SOCIETY	- JACKSON		601 WEST JACKSON JACKSON, MN 56143	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		LD BE COMPLETION
{F 312} SS=D	of this department, determine compliar issued during a rec July 24, 2014. Dur regulation was dete F312. 483.25(a)(3) ADL C DEPENDENT RESIDENT RESID	was conducted by a surveyor on September 9, 10, 2014, to not with Federal deficiencies ertification survey exited on ing this visit the following rmined to be not corrected:  ARE PROVIDED FOR	{F 0	was removed by NA. NA and nurses who worked on 9/6 & given coaching, counseling ar education of importance of refacial hair on those residents other dependent residents. All other residents who are destaff to need assistance of da were checked to assure facial removed unless there was a resident. Nursing staff received re-educe 9/22 & 9/24 regarding dependences and removing facial including residents to be checked.	Charge 9/9 were nd re- moving and any ependent ily living hair was efusal by ration on dent hair ked daily as
	by: Based on observation observation of facility of facility facility of facility	on, interview and document iled to provide assistance at hair for 2 of 3 residents (R7, essed to need assistance in of daily living skills (ADLs). at the certification survey d on this post certification gain found not to be in  9/9/14 at 10:52 a.m. and facial hair around her upper  9/9/14 at 3:07 p.m. and facial hair around her upper	1/26/ GPJ	some may need to be shaved on bath day, some daily. Daily audits have been institut assure facial hair is removed fresidents who require assistant living unless the resident has a Audits will be reviewed by DNs compliance. Quality Assurance Coordinator will do random au audits will be reviewed by Quality for further direction.	red to rom ce of daily refused. S to assure dits. All
OBATORY D	IBECTOR'S OR PROVIDE	 R/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	(X6) DATE

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE DING_	E CONSTRUCTION PER CONS	(X3) DATE SURVEY COMPLETED	
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{F 312}	lip. The quarterly Minim 7/23/14 indicated the Brief Interview findicated severe co dated 7/23/14 also in extensive assist of the R7's care plan dated resident was admitted diagnoses that includementia and depress and the R7's care plan dated ADLs self-care perstaff that R7 require participation with perpendicipation with perpen	e facial hair around her upper turn Data Set (MDS) dated at R7 was unable to complete or Mental Status (BIMS) which gnitive impairment. The MDS ndicated that R7 required one staff for personal hygiene. d 5/5/14 indicated that the ed on 8/29/13 and had ided paralysis agitans, essive disorder. d 5/5/14 indicated a problem formance deficit and directed d assistance of one staff rsonal hygiene. on 9/10/14 at 9:45 a.m. N)-A confirmed R7 had visible and the corners of R7's upper f should have taken care of ath days and should look for part of morning cares as they for the day. RN-A stated R7 bath on Tuesdays, which was so the day surveyor entered here was no documentation used to allow staff to shave	{F3	12}			

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION 2014 A. BUILDING No Dept of Health Rootnester			(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER		•	ε	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
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{F 312}	Continued From parthe bottom of her character R72's care plan data admitted on 7/1/201 included congestive and anxiety state.  The admission Minit 7/7/14 indicated R72 Mental Status (BIMS indicated moderate MDS dated 7/7/14 a extensive assist of R72's care plan data with ADLs self-care "PERSONAL HYGI do so independently dressed for the day. During an interview confirmed R72 had chin and upper lip. Faken care of R72's should look for facia morning cares as the day. RN-A stated R7 Saturdays and state documentation that allow staff to shave I During an interview stated, "Some of the hair and others don't	ge 2 nin.  ed 7/1/14 indicated R72 was 4 and had diagnoses that heart failure, atrial fibrillation mum Data Set (MDS) dated 2 had a Brief Interview for 6) score of twelve which cognitive impairment. The Iso indicated that R7 required one staff for personal hygiene. ed 7/1/14 indicated a problem performance deficit and read, ENE: Encourage resident to while in the bathroom getting on 9/10/14 at 9:50 a.m. RN-A visible facial hair along her RN-A stated staff should have facial hair on bath days and I hair daily as a part of ey are getting resident for the 1/2 had her scheduled bath on dithere was no indicated R72 refused to the facial hair.  on 9/10/14 at 11:29 a.m. R72 staff offer to shave my facial to the R72 stated staff did not	{F 3			NATE	
	R72 stated she used but did not have the herself. R72 stated her facial hair when good to have facial r	cial hair on her bath days. It to shave her own facial hair, equipment here to shave by she wanted staff to "shave they see it, as it does not look nair."  on 9/10/14 at 11:13 a.m. the					

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

CENTERS FOR MEDICARE & MEDICAID SERVICES			 SED 2 6 2014	OMB NO.	. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	E CONSTRUCTION  No Dept of Health		E SURVEY MPLETED
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{F 312}	Continued From pa director of nursing s facial hair was to be by staff and also on A policy titled Shavi directed staff on the resident. A policy ti revised on 10/2013 shave a resident.	age 3 stated her expectation was e removed when it is noticed n bath day.  ing revised on 11/2013 e procedure of shaving a itled Routine Daily Practice s had no guidelines on when to it did indicate that a resident shower per week and that skin	{F 3	DEFICIENCY)		
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Event ID:Y1RU12

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

## CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

					AND TRANSMITTAL		ID: Y1RU	
-	PART I -	TO BE COMPI	LETED BY T	HE STA	ATE SURVEY AGENCY	T	Facility ID: 00303	
MEDICARE/MEDICAID PROVIDER NO.     AASAASA		3. NAME AND ADDRESS OF FACILITY (L3) GOOD SAMARITAN SOCIETY - JACKSON				4. TYPE OF ACTION: <u>2 (</u> L8)		
(L1) <b>245455</b> 2.STATE VENDOR OR MEDICAID NO.		(L4) 601 WEST JACKSON			JACKSON	1. Initial	2. Recertification	
(L2) 673342500	(L5) JACKSON, MN		(L6) <b>56143</b>	3. Termination 5. Validation 7. On-Site Visit	4. CHOW 6. Complaint 9. Other			
5. EFFECTIVE DATE CHANGE OF OW	7. PROVIDER/SUPPLIER CATEGORY			<u>02</u> (L7)	8. Full Survey After Complaint			
(L9)	M	01 Hospital 05 HHA 09 ESRD				o. Full bulvey Alter Complaint		
6. DATE OF SURVEY 07/24/2	, ,	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF	10 NF	14 CORF	FISCAL YEAR END	DING DATE: (L35)	
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L10)	04 SNF	07 X-Ray 08 OPT/SP	11 ICF/II 12 RHC	ID 15 ASC 16 HOSPICE	12/31		
2 AOA 3 Other		04 SNF	00 OF 1/SF	12 KHC	10 HOSFICE	12/31		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	' IS CERTIFIED .	AS:				
From (a):		A. In Complian	nce With		And/Or Approved Waivers Of	The Following Require	ments:	
To (b):	Program Requirements			2. Technical Personnel6. Scope of Services Limit				
	(2 (110)	_	e Based On:		3. 24 Hour RN	7. Medical D		
12.Total Facility Beds	<b>63</b> (L18)	1. A	cceptable POC		<ul><li>4. 7-Day RN (Rural SN</li><li>5. Life Safety Code</li></ul>	(F) 8. Patient Ro 9. Beds/Roo		
13.Total Certified Beds	<b>63</b> (L17)	X B. Not in Corr Requirement	npliance with Prog ents and/or Appli			(L12)		
14. LTC CERTIFIED BED BREAKDOW	1				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
63								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):				
17. SURVEYOR SIGNATURE Date :					18. STATE SURVEY AGENCY APPROVAL Date:			
<u>Danette Bakken, HF</u>	09/03/2014 (L19)		Kamala Fiske-Downing, Enforcement Specialist 09/04/2014 (L20)					
PART	II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY		
19. DETERMINATION OF ELIGIBILIT	Y	20. COM	IPLIANCE WITH	H CIVIL	21. 1. Statement of Fina	ncial Solvency (HCFA-2:	572)	
1. Facility is Eligible to Part	RIGHTS ACT:			<ol> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol>				
Facility is not Eligible				5. Both of the Above	· · · · · · · · · · · · · · · · · · ·			
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:		(L30)	
OF PARTICIPATION	BEGINNING	G DATE	ENDING DAT	ГЕ	VOLUNTARY 00	INVOLU	JNTARY	
04/01/1987					01-Merger, Closure		Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement	
25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS			03-Risk of Involuntary Termination	on <u>OTHER</u>				
A. Suspension of Admissions:			04-Other Reason for Withdrawal 07-Provider Status Change					
(L27)			(L44)			00-Activ	re	
(22.7)	B. Rescind Si	uspension Date:	(L45)					
28. TERMINATION DATE:	20	). INTERMEDIARY/			30. REMARKS			
20. IEMMINITON DAIE.	25		CHRICIER NO.		50. KEMI KKIS			
00140								
(L28) (L31)				_				
31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE								

(L33)

DETERMINATION APPROVAL

(L32)



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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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,

Kumalu 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

cc: Licensing and Certification File

AUG 25 2014

PRINTED: 08/05/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION <sup>(1)</sup> A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245455	B. WING			07/	24/2014	
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 0.7.	- 1/2011	
GOOD S	SAMARITAN SOCIETY	- JACKSON			VEST JACKSON KSON, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 000	The facility's plan of as your allegation of Department's accept bottom of the first pube used as verificate.  Upon receipt of an accept of accept of an accept of accept of an accept of	f correction (POC) will serve f compliance upon the stance. Your signature at the age of the CMS-2567 form will	FC	000	Preparation and execution of this responsarious does not constitute an admiss by the provider of the truth of the facts conclusions set forth in the statement of plan of correction is prepared and/or explant of the statement of plant of correction is prepared and/or explant of the purposes of any alleged facility is not in substantial compliance requirements of participation, this responsarious constitutes the facility's alleged compliance in accordance with section of Operations Manual.	sion or agnalleged or feficienci ecuted sole of Federal ations that with Federal ation of	ies. The sly and the ral an of	
F 176 SS=D	validate that substate regulations has been your verification. 483.10(n) RESIDENDRUGS IF DEEMEDAN An individual resident the interdisciplinary §483.20(d)(2)(ii), has practice is safe.	ntial compliance with the n attained in accordance with IT SELF-ADMINISTER D SAFE  Int may self-administer drugs if team, as defined by s determined that this	F 1	76	1. F 176 Resident (R67) has bee 7/29/14 for self-administration of treatment by the interdisciplinar physician order was obtained an updated to reflect his request to administer nebulizer treatments.  2. All residents currently on neb treatments were reviewed to ensuadministration of medication ass been completed by the interdisciand a physician order for self-administration.	of nebulizy team. A d care pl self- ulizer ure a self essment plinary to	zer A an SSS/H F- had eam	
:	by: Based on observati review, the facility fa (R67) was assessed a nebulizer treatmen	on, interview and document iled to ensure 1 of 1 resident to be safe to self-administer at.	9/3//	14	completed if determined by the t plan updated to reflect this inform 3. All residents admitted to the co- have a self-administration of med assessment completed by the inte- team and if determined to be able administer a physician order will and care plan updated with this in Licensed nurses have been re-edu	eam and nation. enter wil dication erdisciplication be to self-be obtain formation	care I nary	
ABORATOR\	and had no cognitive admission Minimum However, he had no self-administration oby the interdisciplina On 7/23/14, at 7:25	o cognitive deficit according to the Minimum Data Set dated 5/9/2014. The had not been assessed for stration of medications as determined redisciplinary committee.  The had not been assessed for stration of medications as determined redisciplinary committee.  The had not been assessed for stration of the had not been assessed for the		7	they receive an order for a residen nebulizer treatment a self-administrate assessment and documentation of assessment must be completed by interdisciplinary team then the phy notified for an order for the resident administrate and care plan updated resident can self-administrate the negative services.		at to have stration the the ysician is nt to self- d to reflect	

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.

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245455	B. WING	AUG 25 2005	07/24/2014	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 176	was observed to ad for R67 as ordered the treatment and h walked out of the roroom with the neburunning.  After reviewing the noted there was not indicating R67 was nebulizer treatment  On 7/23/14, at 1:50 conducted with RN-not have an order of	Iminister a nebulizer treatment by his physician. RN-B set up anded the device to R67 and form. R67 was left alone in the dizer treatment and machine physician's orders, it was an order or any notation able to self-administer the p.m. an interview was B. RN-B verified that R67 did or an assessment available able to self-administer the	F 176	4. Audits will be completed by the Sta Development Coordinator to ensure the residents observed self-administering nebulizer treatments have been assess the interdisciplinary team and physical obtained and care plan has this inform. Any resident who receives a new orden nebulizer treatment will be audited to self-administration assessment is comby the interdisciplinary team, order reby physician and care planned. These audits will be done weekly for months with results to QA for further recommendations.	those their ed by an order nation. er for assure a pleted ceived	
F 276 SS=D	of Medication policy interdisciplinary teal whether each reside self-administer med. The interdisciplinary resident can safely must be documented physician's order maresident self-admini 483.20(c) QUARTE LEAST EVERY 3 M A facility must assess quarterly review instand approved by CN once every 3 month	ss a resident using the trument specified by the State MS not less frequently than	F 276	1. F 276 Resident (R4) bladder function reassessed, evaluated and a quarterly flower completed on 7/25/14. There were no changes to the residents' plan of care resident's toileting plan.  Nurses and nursing assistants have been educated on 8/18/14 & 8/20/18 to assure resident care plans are followed; all rewill have a nurse progress note and	MDS for  en re- ire	

#### PRINTED: 08/05/20 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVI STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-03 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 245455 B. WING NAME OF PROVIDER OR SUPPLIER 07/24/2014 STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - JACKSON **601 WEST JACKSON** JACKSON, MN 56143 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETIO TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 276 Continued From page 2 F 276 Based on observation, interview and document review, the facility failed to reassess and evaluate documentation of reassessment of bladder bladder function during the most recent quarterly function quarterly and as appropriate. Minimum Data Set dated 4/12/14 for 1 of 2 Audits will be conducted to assure all residents (R4) reviewed for chronic urinary residents have documentation of incontinence. reassessment and care plan is appropriate for the individual residents. Findings include: DNS and Quality Assurance Committee will review monthly X 2 then as determined by R4 had been admitted on 11/17/13. R4's the OAC. 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

	OF CORRECTION	IDENTIFICATION NUMBER:	1 .	ING	(X3) DATE SURVE	
		245455	B. WING		07	//24/2014
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP COL 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	HOULD BE	(X5) COMPLETION DATE
F 276	sleep) and check ev night, transfers: req	very two to three hours at uires one staff participation nd has bladder incontinence,	F 2	76		·
	11/11/13, and identineeded for transfer, ambulation, impaire impaired cognition a manage own clothin functional incontiner proposed scheduled a.m., after breakfastimes in the afternocheck every two to the as needed. Reasses had not been complimed and been complimed and the complex of the co	bladder assessment dated fied R4 required one assist one assist needed for d balance, unsteady gait, and physical mobility to g and own hygiene, urge and nce, toilet program: yes and it between five and seven t, before dinner, one to two on, after supper and HS, hree hours at night and toilet assment of bladder function eted for R4's quarterly review Further review of R4's essments and summary rogress notes lacked assessment of bladder arterly review MDS dated				
	identified toileting so seven a.m., after bro two times in the after and check every two use: requires one sta will use toilet in room	nt Kardex dated 7/23/14, hedule: between five and eakfast, before dinner, one to rnoon, after supper and HS to to three hours at night. Toilet aff participation to use toilet, and urinal at bedside, pad and transfer: requires one th pivot transfer.				
	registered nurse (RN bladder assessment	7/23/14, at 1:26 p.m., N)-A verified no quarterly had been completed when terly review of R4's bladder				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONST	RUCTION A.(3) /	3 2013		TE SURVEY MPLETED
		245455	B. WING		M. Losyi	energe -	07	//24/2014
	PROVIDER OR SUPPLIER  SAMARITAN SOCIETY	- JACKSON	·	601 WEST	DRESS, CITY, STA JACKSON N, MN 56143	TE, ZIP CODE	1 01	124120 [4
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (E	PROVIDER'S PLAN FACH CORRECTIVE DSS-REFERENCED DEFIC	ACTION SHOULD	D BE	(X5) COMPLETION DATE
F 276	function and had sassistant document for the quarterly asshad no change from change we do not hassessment unless which is an increase.  During interview on verified R4's interdissummary reviews at lacked documentation bladder function for dated 4/12/14.  During interview on director of nursing han analysis of R4's to	stated looking at the nursing ration during look back period sessment dated 4/12/14, R4 in frequently incontinent, if no ave to do a bladder we see a change in voiding or decrease in voiding.  7/24/14, at 11:18 a.m., RN-A sciplinary assessments and ind nurse progress notes on of reassessment of R4's quarterly review MDS  7/24/14, at 11:11 a.m., ad stated she would expect bladder function and an empleted for quarterly review	F 2	76				
F 279 SS=D	ensure resident asse coordinated in comp regulations POLICY be done every three appropriate. The corbe revised to ensure 483.20(d), 483.20(k) COMPREHENSIVE  A facility must use the to develop, review and comprehensive plan.	ed 9/12, read, "PURPOSE. To essments are completed and cliance with appropriate Review of assessments will (3) months and as accuracy."  (1) DEVELOP CARE PLANS  the results of the assessment and revise the resident's	F 27	9				8/25/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN	TPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED			
		245455	B. WING_	AUG 2 5 2014	07	/24/2014
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143	1 077	12412014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279		<u> </u>	F 27	9		
	objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.			F 279 Resident (R40) on 7/20/14 RN completed Fall Risk Data Collection a found to be a medium risk for falls; ca was updated on 7/24/14.	re plan	
	to be furnished to a highest practicable psychosocial well-b §483.25; and any se be required under § due to the resident's	tdescribe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided a exercise of rights under he right to refuse treatment.		All residents who have had falls since time of survey were reviewed to ensur they had a Falls Risk Data Collection Evaluation completed and care plan up with fall interventions.  Education was provided to nursing stath this on 8/18 & 8/20/14. On admission a residents will have a Fall Risk Data Collection Tool completed and if deter to be at risk for falls or has a history of	re that and odated  ff on all	
	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.			will be care planned.  DNS will audit all new admissions an residents with falls to ensure that a Fal Data Collection and Evaluation compland care plan updated with fall interve X 2 months, and then results will be se Quality Committee for further recommendations.	ls Risk eted ntions	
	following a fall at ho	n 5/29/14 for rehabilitation me, polyneuropathy and according to the admission				
	6/5/14, indicated R4 impairment and requ	mum Data Set (MDS) dated 0 had a mild cognitive uired extensive assist with R40 was also at moderate risk				
	6/5/14, indicated R4	Assessment (CAA) dated 0 was at risk for falls due to a dmission. It was also noted				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	NG	(X3) DATE SURVEY COMPLETED	
•		245455	B. WING	259 2 5 <u>2</u> 914	07/24/2014	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS; CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 312 SS=D	that it would not be to the facility's plan  The plan of care did about R70's history  R70 was interviewed R70 verified a fall a well as a fall in the he lost his balance independently in his Registered nurse (F7/24/14, at 11:00 a. did not get placed of because R70 was patrengthening she or risk for falls. RN-A been care planned on 7/20/14, it should plan.  483.25(a)(3) ADL CODEPENDENT RES  A resident who is undaily living receives maintain good nutritand oral hygiene.  This REQUIREMENT by:  Based on observative review, the facility for timmed nails for 1 to provide assistants.	included in the care plan due for strengthening.  If not include any information of falls or fall risk.  If on 7/23/14, at 7:10 a.m. thome prior to admission as facility on 7/20/14. R70 stated when he was up a room.  RN)-A was interviewed on m. RN-A stated the fall risk on the care plan at admission planned to get exercises for did not feel R70 would be at verified the fall risk had not and agreed that since the fall d have been added to the care	F 3		to re and tion on to	

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		E SURVEY IPLETED
		245455	B. WING			07/	24/2014
	PROVIDER OR SUPPLIER			60	REET ADDRESS, CITY, STATE, ZIP CODE 11 WEST JACKSON ACKSON, MN 56143	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	daily living.  Findings include:  R4's admission recthey were admitted diagnosis of demer Data Set (MDS) darequired extensive hygiene.  During observation laid in bed resting, were noted to be loaded by the laid of the late of the lat	cord dated 7/24/14, identified on 11/17/13 and had a ntia. R4's quarterly Minimum ated 4/12/14, identified R4 assist of one for personal on 7/21/14, at 7:31 p.m., R4 R4's fingernails on both hands ong, untrimmed and had black fingernails. R4 had stated, at staff help to clean and trim on 7/22/14, at 1:45 p.m., R4 R4's fingernails remained long helack debris underneath on 7/23/14, at 7:22 a.m., R4 wheelchair at a table in the group to be served breakfast. R4's ad long, untrimmed with black nails. At 8:46 a.m., registered been in R4's room observed rified some fingernails were s underneath some nails on	F3	112	Observational audits will be compl weekly X2 nail & facial hair then X month then reviewed by the qualit committee for further recommends	1 y	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION DING	(X3) DA	(X3) DATE SURVEY COMPLETED	
		245455	B. WING	)	0.	7/04/0044
	PROVIDER OR SUPPLIER  SAMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, 2 601 WEST JACKSON JACKSON, MN 56143	ZIP CODE	7/24/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	diabetes mellitus wi limited to: diabetic in nurse.  Document review of checks dated revise day on Wednesday  Document review of dated 6/25/14 throug documentation regated the nurse only place to docume care " on bath day.  During interview on had stated the nurse only place to docume care " on bath day.  During interview on director of nursing had stated the nurse of nursing had stated behaviors refuses namultiple times and rewould expect staff to refused.  Document review of CARE dated revised keep nails clean and well-being To observe nail discomfort PROFINGERNAILS 1. Lice notified to do nail car who are diabetic or a who may tend to blee callouses or blisters. care is desired, it shoplan and documented.	th intervention of but not ail care provided by licensed the facility bath list and skin d 7/17/14, identified R4's bath days.  R4's nurse progress notes gh 7/18/14, had no rding nail care.  7/23/14, at 10:13 a.m., RN-B progress notes would be the ent nail care, under "skin resident with mood and ail care and staff have gone in esident continues to refuse, document resident has the facility Procedure NAIL 11/13, read, "PURPOSE To trimmed to promote enail condition To prevent ocedure should be eas needed for residents re receiving anticoagulants and easily. Never trim corns, 15. If documentation of nail build be set up in the care	F3			

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		245455	B. WING	abb 0.5 ggg	0	7/24/2014
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP COI 601 WEST JACKSON JACKSON, MN 56143	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	and chin. R7 was observed of in the day room and had not been remove nurse (LPN)-A was a.m. and confirmed stated that the resident that the staff should indicated that the nurse cach resident every whenever necessar R7's care plan dated resident was admitted diagnoses that includementia and depresident was admitted in activities of dail performance deficit required assistance personal hygiene. The quarterly Minim 4/23/14 indicated that the Brief Interview for indicated severe cognitive assist of on Documentation indicated that the director of nursing activities of nursing activities and also documentation that from pleted. The director of nursing activities are the director of nursing activities and the resident's battern that the resident's battern that the policy titled Shaving directed staff on the literature of the policy titled Shaving directed staff	in 7/23/14 at 8:00 a.m. sitting it had visible facial hair that wed. The licensed practical interviewed on 7/23/14 at 8:00 that R7 had facial hair and lent had a bath yesterday and have shaved her. LPN-A ursing assistants are to check day and shave them y. d 5/5/14 indicated that the ed on 8/29/13 and had ded paralysis agitans, essive disorder. d 5/5/14 indicated a problem y living (ADL) self- care and directed staff that R7 of one staff participation with um Data Set (MDS) dated at R7 was unable to complete or Mental Status (BIMS) which gnitive impairment. The MDS indicated that R7 required ne staff for personal hygiene, eated that R7 received a bath	F3	12		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		245455	B. WING		07/24/2014	
NAME OF I	PROVIDER OR SUPPLIER	4	1	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
GOOD S	AMARITAN SOCIETY	- JACKSON		601 WEST JACKSON JACKSON, MN 56143		
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F 312	Continued From pa	age 10	F 312			
	shave a resident. I would have a bath/swas to be checked					
F 315 SS=D	, ,	HETER, PREVENT UTI, DER	F 315	F 315 Resident (R4) bladder function versessessed, evaluated and a quarterly M		14
	assessment, the faresident who enters indwelling catheter resident's clinical or catheterization was who is incontinent of treatment and servi infections and to refunction as possible			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 educated on 8/18/14 & 8/20/18 to assur resident toileting care plans are follower residents will have a nurse progress not documentation of reassessment of blade function quarterly and as appropriate.  Random resident Audits will be completed following resident individual toileting program, assessing and re-evaluating to	or n re- re ed; all te and der	
	by: Based on observative review, the facility function and failed treatment and servi	NT is not met as evidenced tion, interview and document failed to reassess bladder to provide appropriate ices to maintain or improve r 1 of 1 resident (R4) reviewed ence.		resident toileting programs monthly X 2 as determined by Quality Team, DNS of designee responsible to complete audits	or	
	Findings include:		:			
	R4 had been admit included but not lim R4's quarterly Minir 4/12/14; identified F one for toileting, sci	cord dated 7/24/14; identified ted on 11/17/13 and also nited to diagnosis of dementia. mum Data Set (MDS) dated R4 required extensive assist of cheduled toileting program, ent of bladder and had impairment.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION .		DATE SURVEY COMPLETED	
		245455	B. WING			07/	24/2014	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		60	FREET ADDRESS, CITY, STATE, ZIP CODE D1 WEST JACKSON ACKSON, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 315	During observation lay in bed, a visible on R4's shirt and the odor in R4's room. Surveyor alerted state of the total participation had been transferred and NA-B from who NA-B were observed weight bearing assis R4 had been unstead pivoting during R4 down in bed, couplaced call light in reand exited R4's roo offered the toilet to incontinent product, the time. NA-B had toileted was 6:30 a. they did not know RNA-B had stated we schedule in KIAS (a surveyor R4's toilet verified R4's toilet verified R4's toilet verified R4's toilet sassistant care shee after breakfast.  R4's care plan date performance deficit neuro cognitive discont limited to toilet uparticipation to use and urinal at bedsid five and seven a.m. dinner, one to two the supper and HS (bedside)	on 7/21/14, at 7:40 p.m., R4 wet urine stain had been seen ere had been a strong urine R4 was yelling out "Help" this aff of R4 needing assist.  on 7/23/14, at 8:46 a.m., R4 ad by nursing assistant (NA)-A selchair to bed. NA-A and do by surveyor to provide st when transferring R4 and ady with maintaining balance transfer. NA-A and NA-B laid vered R4 with a blanket, each, turned off light to room m. NA-A and NA-B had not R4 and had not checked R4's NA-A and NA-B verified at stated last time R4 had been m. NA-A and NA-B had stated as toilet schedule. NA-A and Sechedule. NA-A and Sechedule. NA-A and Sechedule. NA-A and NA-B chedule on the nursing the read R4 was to be toileted at a stated to muscle weakness, order with intervention of but use: requires one staff toilet, will use toilet in room le, toileting schedule: between after breakfast, before imes in the afternoon, after dtime) and check every two to transfers: requires one staff toilet in room le, toileting schedule: between after breakfast, before imes in the afternoon, after dtime) and check every two to transfers: requires one staff	F3	315				

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	RIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245455	B. WING		07	//24/2014
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 315	participation with pi incontinence, pad participation with pi incontinence, pad participation with pi incontinence, pad participation and physicipation and physicipation and physicipation and physicipation and own hy incontinence, toilet scheduled: between breakfast, before diafternoon, after sup check every two to as needed. Reasse had not been comp MDS dated 4/12/14 interdisciplinary asserviews and nurse padocumentation of refunction for R4's quality 4/12/14.  R4's nursing assistation for R4's nursing assistation for R4's quality 12/14.  R4's nursing assistation for R4's quality 12/14.	vot transfer and has bladder product large brief.  fied last completed bladder pen dated 11/11/13, and ed one assist needed for needed for ambulation, unsteady gait, impaired cal mobility to manage own regione, urge and functional program: yes and proposed in five and seven a.m., after inner, one to two times in the oper and HS (hour of sleep), three hours at night and toilet issment of bladder function leted for R4's quarterly review. Further review of R4's ressments and summary progress notes lacked eassessment of bladder arterly review MDS dated  ant Kardex dated 7/23/14, chedule: between five and eakfast, before dinner, one to three hours at night. Toilet aff participation to use toilet, in and urinal at bedside, pad and transfer: requires one	F 3			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245455	B. WING_		07/24/2014	
	PROVIDER OR SUPPLIER  SAMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143	1 01/24/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETION	
F 315	documentation during quarterly assessment change from frequent we do not have to duriless we see a change increase or decrease.  During interview on verified R4's interdist summary reviews at lacked documentation bladder function for dated 4/12/14.  During interview on director of nursing han analysis of R4's lacked.	ng look back period for the ent dated 4/12/14, R4 had no ently incontinent, if no change to a bladder assessment ange in voiding which could be	F 31	5		
F 329 SS=D	of R4's bladder fund Document review of ASSESSMENT date ensure resident asso coordinated in comp regulations POLICY be done every three appropriate. The cor- be revised to ensure 483.25(I) DRUG RE- UNNECESSARY DF Each resident's drug unnecessary drugs. drug when used in e- duplicate therapy); o without adequate mo- indications for its use	the facility Policy ed 9/12, read, "PURPOSE: To essments are completed and bliance with appropriate Review of assessments will (3) months and as mprehensive assessment will e accuracy." GIMEN IS FREE FROM	F 329	F 329 Resident (R4) Behavior tear 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 direduction is in place for ordered Risperdal. All residents identified a	on, nt lose	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONST		(		E SURVEY IPLETED
		245455	B. WING				07/	24/2044
j	PROVIDER OR SUPPLIER	- JACKSON		601 WEST	DDRESS, CITY, STATE, ZIP ( T JACKSON DN, MN 56143	CODE	<u> </u>	24/2014
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F 329	should be reduced combinations of the Based on a compre resident, the facility who have not used given these drugs utherapy is necessar as diagnosed and drecord; and resident drugs receive gradu behavioral intervent contraindicated, in a drugs.  This REQUIREMEN by:	reasons above.  hensive assessment of a must ensure that residents antipsychotic drugs are not nless antipsychotic drug y to treat a specific condition ocumented in the clinical is who use antipsychotic al dose reductions, and ions, unless clinically in effort to discontinue these	F3	receivi re-asse review comple All reside medica behavio indicati effectiv psychot complete behavio pharma appropri respons monthly Committe	ing a psychotropic medessed and targeted be yed and/or updated this eted 8/1/14 idents currently on a pation are having their tor monitored and clinical ions are being evaluated yeness and continued ustropic medications. Authoris are defined and not alogical interventions a riate. Behavior Commits ible to randomly review X 2 and report to Quatee Quarterly or as new is identified.	ehaviors wis was esychotrop targeted cal eed for the use of udits will b rgeted on- are ttee will b	vere	
	facility failed to monicadequately assess of the effectiveness for psychotropic medicareviewed for unneces. Findings include:  R4 had been admitted the admission recordalso identified but not dementia. R4's qual (MDS) dated 4/12/14 antipsychotic medical and had moderate controlled.	ed on 11/17/13 as found on dated 7/24/14, the record t limited to diagnosis of rterly Minimum Data Set I, identified R4 had received atton, had behavior symptoms						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY IPLETED
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	PROVIDER OR SUPPLIE			60	REET ADDRESS, CITY, STATE, ZIP CODE 1 WEST JACKSON ACKSON, MN 56143		
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F 329	dated 6/12/14, reversions a day for detention such as a day for detention such as R4's nursing astention such as R4's nursing astention such as R4's nursing astention such as R4's nursing assis 7/23/14, identified and insight with in necessary to proto others, approach divert attention, realternative location opportunity for pominimize potential behaviors yelling attention such as R4's nursing assis 7/231/14, identified necessary to proto others, approach divert attention, realternative location opportunity for pominimize potential behaviors yelling attention such as non-pharmacology attention such as non-pharmacology in instructions sellowerer R4's nuridentified target by potential for elope and there had bear of the such as non-pharmacology and there had bear of the such as non-pharmacology and there had bear of the such as non-pharmacology attention such as non-pharmacology a	wealed an order for Risperdal medication) 0.50 milligrams two ementia. Document review of ation administration record print ealed R4 received Risperdal as of R4's care plan print date behavior symptom related to a evidenced by takes oxygen I for elopement, poor judgment aterventions of intervene as ect the rights and safety of and speak in calm manner, emove from situation and take to n as needed, provide sitive interaction, attention and I for resident's disruptive by offering tasks which divert snacks and one to one visits.  Stant Kardex print date and speak in calm manner, emove from situation and take to n as needed, provide sitive interaction, attention, and speak in calm manner, emove from situation and take to n as needed, provide sitive interaction, attention, I for resident's disruptive by offering tasks which divert snacks and one to one visits,		329			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		0	(X3) DATE SURVEY COMPLETED	
		245455	B. WING	4	[	07/2	24/2014
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP C 601 WEST JACKSON JACKSON, MN 56143	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE		(X5) COMPLETION DATE
F 329	behaviors except for Document review of 4/29/14, revealed by angry and recently and for R4's behaviors.  During interview on registered nurse (R being documented asymptoms as found only one target behaviors and the phase of nursing assistants to R4 had the behavior During interview on of nursing had stated to document review nursing had stated to physician and the phase of the behavior of nursing verified of yelling had been ideassistant Kardex for document on the beta document on the behaviors to be determined in the phase of the pha	f care conference note dated ehaviors of yelling, getting attempted to go outside. been no documented analysis  7/23/14, at 10:39 a.m., N)-C had stated behavior on all residents is just general in the MDS. RN-C verified avior, yelling had been sing assistant Kardex for the odocument on the behavior if	F 3	29			
		and be able to document on				A STATE OF THE STA	·

1	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		TE SURVEY MPLETED
		245455	B. WING		07.	/24/2014
ļ	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON	] (	STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143	1 011	TATILU ( T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 463 F 463 SS=D	483.70(f) RESIDEN ROOMS/TOILET/B The nurses' station resident calls through from resident rooms facilities.  This REQUIREMENT by: Based on observation review, the facility fawas in working condition (R47) and others to R47. Findings include: R47 's call light location facility fawas in the diningular to R47 was in the diningular family use when assoluting an interview nurse (LPN)-B on 7/c confirmed that the confirmed that the confirmed that R47 was in the did not use his call I R47's signed physic indicated that R47 was indicat	must be equipped to receive gh a communication system s; and toilet and bathing  IT is not met as evidenced ion, interview and document ailed to ensure that a call light dition for 1 of 30 residents summons help if needed for ated on the bedside on was checked and found to isplay outside of the room. In groom at that time eating the isfor resident, staff, and sistance is needed. With the licensed practical (21/14 at 6:53 p.m. it was all light was not functioning. was a good thing the resident ight. I iain orders dated 6/12/14 (vas admitted to the facility on losis including Alzheimer's ual Minimum Data Set (MDS) ated R47 was unable to onterview of Mental Status 47 had severe cognitive  In 7/23/14 at 7:45 a.m. the noce (DM)-B indicated he was	F 463		hecked to call laced.	8/25/14

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING		(X3) DATE S COMPL	
		245455	B. WING	<u> </u>		07/2/	1/2014
İ	PROVIDER OR SUPPLIER  SAMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, 2 601 WEST JACKSON JACKSON, MN 56143	ZIP CODE	01724	12014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD E THE APPROPRI	3E (	(X5) COMPLETION DATE
	functioning. DM-B facility had a mainter for needed repairs. in many new call lig facility. This particul double-cord and sood The maintenance by DM-B and it was not surveyor notification issue was placed in was not noticed by requested for the maintenance book or requested for the maintenance book or requested for the maintenance book for any maindicated that when I interviewed him the sometimes it didn't, the maintenance log was documented that on 7/23/14 at 9:15 a functioning properly  During an interview of (DON) on 7/23/14 at indicated that if a cal working that the expetting that the expetting that the expetting for assistance calling for assistance and the calling fo	stated that each unit of the enance book that is checked DM-B stated that he had put hits since he had started at the dar call light was a metimes they get pulled apart. book was checked with the ted that on 7/21/14 that after the non-functioning call light the maintenance book. This maintenance until this time. It tries to check the daily. When a policy was antenance of the call light did that he did not know of a staff was instructed to use intenance concern. DM-B he checked the call light after at sometimes it worked and so he replaced it. A copy of and when it was received it at the call light was repaired at the call light was repaired with the director of nursing 12:55 p.m., the DON light was discovered not ectation would be that the intenance and in the at that the resident was safe.	F 4	163			

#### FRINTED. VOIUDIZU14 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING\_ B. WING 245455 07/24/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **601 WEST JACKSON GOOD SAMARITAN SOCIETY - JACKSON** JACKSON, MN 56143 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (X5) COMPLETION DATE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)

F3455022

PRINTED: 08/05/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245455 B. WING 07/24/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **601 WEST JACKSON** GOOD SAMARITAN SOCIETY - JACKSON JACKSON, MN 56143 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) **INITIAL COMMENTS** K 000 | K 000 Please note that our signature and the response on the CMS - 2567L does not FIRE SAFETY mean deficiency or the evidence THE FACILITY'S POC WILL SERVE AS YOUR presented to support any determination ALLEGATION OF COMPLIANCE UPON THE of non-compliance. We respond and DEPARTMENT'S ACCEPTANCE. YOUR provide a written plan of correction SIGNATURE AT THE BOTTOM OF THE FIRST because law requires it. PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. 10 C ok 8-25-14 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. AUG 2 5 2014 PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or 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.

dunnahatar

8/20114

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  9 01 - MAIN BUILDING 01		E SURVEY MPLETED
		245455	B. WING			07/	24/2014
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		•	STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	THE PLAN OF CONDEFICIENCY MUSTOLLOWING INFO.  1. A description of vito correct the deficiency.  2. The actual, or proceed and a responsible for correct the deficiency.  3. The name and/or responsible for corrected are reoccurred.  Good Samaritan Socconstructed as followed as followed and the protected and was constructed and	RRECTION FOR EACH TINCLUDE ALL OF THE DRMATION:  what has been, or will be, done ency.  poposed, completion date.  title of the person ection and monitoring to nace of the deficiency.  poiety Jackson was ws:  g was constructed in 1956, is assement, is fully fire sprinkler determined to be of Type  as constructed in 1965, is assement, is fully fire sprinkler determined to be of Type  as constructed in 1976, is assement, is partially fire and was determined to be	K	)000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245455	B. WING_		07/24/2014	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	١
K 000	time of the survey.  The requirement at	42 CFR, Subpart 483.70(a) is	K 00	00		
K 029 SS=D	NOT MET as evided NFPA 101 LIFE SAI One hour fire rated fire-rated doors) or extinguishing system and/or 19.3.5.4 proto the approved automoption is used, the approved automoption is used, the atomic spaces by sm doors. Doors are sefield-applied protect 48 inches from the lapermitted. 19.3.2.  This STANDARD is Based on observatifacility failed to main	construction (with ¾ hour an approved automatic fire in accordance with 8.4.1 ects hazardous areas. When ratic fire extinguishing system areas are separated from oke resisting partitions and elf-closing and non-rated or ive plates that do not exceed bottom of the door are 1	K 02	Self-closing devices will be added to designated storage rooms (#3, #38 that they will close at the appropriatimes. The open penetration on the wall around the duct work in the maintenance room (#40) will be fix that there are no open penetrations	B) so te east ed so	4
	following requirement Section 19.3.2.1. The affect 15 out of 56 reference Findings include:  On facility tour between 07/24/2014, observed following was found:	een 9:15 AM and 12:15 AM ervation revealed that the ge room # 3 (over 50 sq. ft.)		K		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		MPLETED
		245455	B. WING		07/	24/2014
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILITION DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 056 SS=D	2. The door to store ft.) does not have a 3. There is an oper around old duct wor Maintenance Shop  These deficient practically Maintenance discovery.  NFPA 101 LIFE SAI  If there is an automainstalled in accordation the Installation oprovide complete cobuilding. The system accordance with NF Inspection, Testing, Water-Based Fire Psupervised. There is an operation of the Installation oprovide complete cobuilding.	age room # 38 - (over 50 sq. self-closing device. n penetration in east wall, k opening, of the	K 0			9/24/19
	systems are equipp switches, which are building fire alarm so the building fire alarm so the system of the sprinkler system of the sprinkler system of the s	ed with water flow and tamper electrically connected to the ystem. 19.3.5  not met as evidenced by: on and staff interview, the ide proper coverage of the as per 2000 NFPA 101 9.7. The deficient practice of 56 residents.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG <b>01 - Main Building 01</b>		E SURVEY IPLETED
	a	245455	B. WING_		07/	24/2014
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 056	on 07/24/2014, obs 1976 addition, the r not have a fire sprir	ervation revealed that in the nain entrance vestibule does akler protection.	K 08	56		
K 067 SS=F	Facility Maintenance discovery. NFPA 101 LIFE SAI Heating, ventilating, with the provisions on accordance with	ce was confirmed by the e Director (SH) at the time of FETY CODE STANDARD and air conditioning comply of section 9.2 and are installed the manufacturer's 9.5.2.1, 9.2, NFPA 90A,	K 06	K 67  All fire dampers will be inspected by professional to make sure they are working properly. Any identified fire dampers that aren't working properly be fixed or replaced.	e	8/24/14
	Based on documer interview, that the fa air conditioning syst maintained in accor 19.5.2.1 and NFPA	s not met as evidenced by: ntation review and staff acility's general ventilating and tem (HVAC) was not dance with the LSC, Section 90A, Section 3-4.7. A C system could affect all 56				
	on 07/24/2014, doc damper testing for t the fire/smoke dam Last documented te This deficient practi	reen 9:15 AM and 12:15 AM umentation review for fire he past 4 years revealed, that pers have not been tested. est was on 7/17/07.  ce was confirmed by the e Director (SH) at the time of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			COMPLETED		
		245455	B. WING		07/24/2014
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON		STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE COMPLETION
K 067	Continued From pa discovery.	ge 5	K	067	
	*TEAM COMPOSIT Gary Schroeder, Lif		1		



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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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.

Good Samaritan Society - Jackson August 5, 2014 Page 2

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

Kumalu Fishe Downing

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

Good Samaritan Society - Jackson August 5, 2014 Page 3

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00303	B. WING		07/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	JACKSON I, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTENTION*****					
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre pursuant to a surve found that the defic herein are not correnot corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag le number indicated below. It is several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result fron orders provided tha the Department wit	hearing on any assessments non-compliance with these to a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	this Department's s and the following lid When corrections a date on the bottom marked with "Labor	and 31, 2014, surveyors of taff visited the above provider censing orders were issued. The completed, please sign and of the first page in the line		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. I to	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00303	B. WING		07/24/201	4
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	ΓJACKSON N, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMF	(5) PLETE TE
2 000	Continued From pa	ge 1	2 000			
	return the original to Minnesota Departm	e SE, Rochester, MN 55904		The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule out of complisted in the "Summary Statement Deficiencies" column and replaces Comply" portion of the correction of This column also includes the find which are in violation of the state is after the statement, "This Rule is r as evidence by." Following the surfindings are the Suggested Method Correction and Time period for Correction and Time period for Correction and Time period for Correction." THIS APPLIEST FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION OF CORRECTIONS OF MINNESOTA ST	rag." iance is of the "To order. ings statute not met veyors d of rrection. DING OF THIS	
2 550	Subp. 4. Review of home must examing quarterly and must comprehensive ass	O Subp. 4 Comprehensive ent; Review  assessments. A nursing e each resident at least revise the resident's essment to ensure the y of the assessment.	2 550	STATUTES/RULES.		
	This MN Requirements by: Based on observati	ent is not met as evidenced on, interview and document ailed to reassess and evaluate				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		DED.	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00303		B. WING		07/	24/2014
NAME OF	PROVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	601 WEST	JACKSON			
	AMARTAN GOOLTT	DAOROON	JACKSON,	MN 56143			T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 550	Continued From pa	ge 2		2 550			
	Minimum Data Set	ring the most recent of dated 4/12/14 for 1 of ewed for chronic urina	2				
	Findings include:						
	admission record d limited to diagnosis Minimum Data Set identified R4 require toileting, scheduled	ted on 11/17/13. R4's ated 7/24/14, identifie of dementia. R4's quantifie (MDS) dated 4/12/14; ed extensive assist of toileting program, freder and had moderate ont.	one for				
	lay in bed, a visible on R4's shirt and th odor in R4's room.	on 7/21/14, at 7:40 p. wet urine stain had be ere had been a strong R4 was yelling out "Heed staff of R4 needing	een seen g urine				
		on 7/23/14, at 8:46 a. ed by nursing assistan eelchair to bed.					
	4/28/14, identified s related to muscle w disorder with interve toilet use: requires of toilet, will use toilet toileting schedule: bafter breakfast, befor the afternoon, after sleep) and check en night, transfers: req	f R4's care plan dated self- care performance reakness, neuro cognition of but not limite one staff participation in room and urinal at least even five and seven ore dinner, one to two supper and HS (hour very two to three hour luires one staff participand has bladder incontrief.	deficit tive d to to use pedside, n a.m., times in of s at				

Minnesota Department of Health

STATE FORM 6899 Y1RU11 If continuation sheet 3 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00303		B. WING		07/	24/2014
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON		T JACKSON			
	T			N, MN 56143			T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI / MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 550	Continued From pa	ge 3		2 550			
	R4's last completed 11/11/13, and identing needed for transfer ambulation, impaired impaired cognition amanage own clothing functional incontine proposed schedules a.m., after breakfast times in the afternorcheck every two to as needed. Reassen had not been comp MDS dated 4/12/14 interdisciplinary asserviews and nurse placementation of refunction for R4's quality 4/12/14.	ified R4 required on, one assist needed balance, unstead and physical mobiliting and own hygiene nee, toilet programs of between five and three hours at nights sament of bladder a leted for R4's quart are Further review of sessments and sumprogress notes lacked assessment of blade assessment as a let a	ne assist If for Idy gait, Ity to Ie, urge and If seven Ie to two Id HS, It and toilet If function Iterly review If the service of the servic				
	R4's nursing assistated identified toileting solven a.m., after by two times in the after and check every two use: requires one solven will use toilet in root product: large brief staff participation with the solven as the sol	chedule: between fireakfast, before din ernoon, after suppe to three hours at taff participation to m and urinal at bed and transfer: require	ive and ner, one to or and HS night. Toilet use toilet, side, pad				
	During interview on registered nurse (R bladder assessmer completing the quafunction and had sassistant document for the quarterly asshad no change fron change we do not h	N)-A verified no quant had been comple arterly review of R4' stated looking at the tation during look basessment dated 4/1 in frequently inconting.	arterly ted when s bladder e nursing ack period 2/14, R4 nent, if no				

Minnesota Department of Health

STATE FORM 6899 Y1RU11 If continuation sheet 4 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00303		B. WING		07/	24/2014
	PROVIDER OR SUPPLIER			DRESS, CITY, S	STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- JACKSON		N, MN 56143	}		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 550	assessment unless which is an increase which is an increase During interview on verified R4's interdissummary reviews a lacked documentation bladder function for dated 4/12/14.  During interview on director of nursing han analysis of R4's assessment to be of R4's bladder function for the document review of R4's bladder function of R4's bladder functions. POLICY be done every three appropriate. The configurations POLICY be done every three appropriate. The configuration of designee (signecessary the policity of the revision and account assessment process could provide an instaff on these policity or designee (signeces) could resident with a quarant revise.	we see a change in e or decrease in voide or decrease	m., RN-A ents and notes to of ew MDS  m., d expect d an entry review  POSE- To pleted and riate ments will sment will  TION: The evise as regarding rly ignee(s) opriate The DON, each accurate	2 550			

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00303		B. WING		07/2	24/2014
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- JACKSON 6	01 WEST	DRESS, CITY, S F JACKSON I, MN 56143	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 5		2 560			
2 560	Plan of Care; Contents comprehensive plan objectives and time long- and short-term and mental and psylidentified in the compassessment. The compassessment include the increquired by Minness subdivision 14, para This MN Requirements. Based on interview	of plan of care. The n of care must list mea tables to meet the resin goals for medical, nuychosocial needs that an prehensive resident comprehensive plan of dividual abuse preventiota Statutes, section 62 agraph (b).	surable dent's irsing, are care ion plan 26.557, enced the	2 560			
	facility failed to comprehensively care plan the risk for falls for 1 of 3 residents (R40) reviewed for accidents.  Findings include:						
	following a fall at ho	on 5/29/14 for rehabilitatione, polyneuropathy are according to the adm	nd				
	6/5/14, indicated R4 impairment and req	imum Data Set (MDS) 40 had a mild cognitive juired extensive assist R40 was also at mode	with				
	6/5/14, indicated R4 fall history prior to a	a Assessment (CAA) days at risk for falls of admission. It was also included in the care plays for strengthening.	due to a noted				

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Minnesota Department of Health STATE FORM

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7.1. 20.23.110.			
		00303	B. WING		07/2	4/2014
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S <b>T JACKSON</b>	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	I, MN 56143	<b>;</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 6	2 560			
	The plan of care did about R70's history	d not include any information of falls or fall risk.				
	R70 verified a fall a					
	7/24/14, at 11:00 a. did not get placed of because R70 was partengthening she or risk for falls. RN-A been care planned	RN)-A was interviewed on m. RN-A stated the fall risk on the care plan at admission planned to get exercises for did not feel R70 would be at verified the fall risk had not and agreed that since the fall d have been added to the care				
	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 (21) days.	R CORRECTION: Twenty-one				
2 835	MN Rule 4658.0520 Proper Nursing Car	O Subp. 2 A Adequate and re; Criteria	2 835			
	proper care. The cadequate and proper Evidence of adequate	ate care and kind and ent at all times. Privacy must				

Minnesota Department of Health

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00303		B. WING		07/24/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	「JACKSON I, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 835	Continued From pa	ge 7	2 835			
	by: Based on observative review, the facility for trimmed nails for 1 to provide assistant	ent is not met as evidenced on, interview and document ailed to ensure clean and of 3 residents (R4) and failed be with removal of facial hair (R7) reviewed for activities of				
	Findings include:					
	they were admitted diagnosis of demer Data Set (MDS) da	ord dated 7/24/14, identified on 11/17/13 and had a itia. R4's quarterly Minimum ted 4/12/14, identified R4 assist of one for personal				
	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.					
	had been sitting in dining room waiting fingernails remaine debris underneath nurse (RN)-A had b R4's nails and ver	on 7/23/14, at 7:22 a.m., R4 wheelchair at a table in the to be served breakfast. R4's d long, untrimmed with black hails. At 8:46 a.m., registered been in R4's room observed ified some fingernails were a underneath some nails on				

Minnesota Department of Health

STATE FORM 6899 Y1RU11 If continuation sheet 8 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00303		B. WING		07/	24/2014
PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			, ,	,		
SAMARITAN SOCIETY	- JACKSON	JACKSON	N, MN 56143			
(EACH DEFICIENCY	MUST BE PRECEDED BY	Y FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Continued From pa	ge 8		2 835			
activities of daily livideficit related to mucognitive disorder vilimited to personal participation with pediabetes mellitus will	ing self- care perfor uscle weakness, new with interventions of hygiene: requires or ersonal hygiene and ith intervention of bu	mance uro but not ne staff focus: ut not				
Document review of the facility bath list and skin checks dated revised 7/17/14, identified R4's bath day on Wednesday days.						
dated 6/25/14 throu	igh 7/18/14, had no	ss notes				
had stated the nurs only place to docum	e progress notes we nent nail care, unde	ould be the				
director of nursing hath days or anytime of nursing had state behaviors refuses remultiple times and a would expect staff to refused.  Document review of CARE dated revise keep nails clean and well-being To observail discomfort PR FINGERNAILS 1. L	nad stated nail care ne it needs to be doned if a resident with nail care and staff have sident continues to document resident of the facility Procedud 11/13, read, "PUR of trimmed to promotive nail condition To COCEDURE FOR Licensed nurse should the document of the facility procedud 11/13, read, "PUR of trimmed to promotive nail condition To COCEDURE FOR Licensed nurse should be done to be something to be should	is done on ne. Director mood and ave gone in o refuse, at has ure NAIL POSE To te prevent				
	PROVIDER OR SUPPLIER  SAMARITAN SOCIETY  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From pa  R4's care plan date activities of daily liv deficit related to mu cognitive disorder v limited to personal participation with pe diabetes mellitus w limited to: diabetic r nurse.  Document review of checks dated revise day on Wednesday  Document review of dated 6/25/14 throut documentation regal  During interview on had stated the nurs only place to docum care " on bath day.  During interview on director of nursing h bath days or anytim of nursing had state behaviors refuses r multiple times and r would expect staff t refused. Document review of CARE dated revise keep nails clean an well-being To obser nail discomfort PR FINGERNAILS 1. L	PROVIDER OR SUPPLIER  SAMARITAN SOCIETY - JACKSON  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM  Continued From page 8  R4's care plan dated 4/28/14, identified activities of daily living self- care perford deficit related to muscle weakness, net cognitive disorder with interventions of limited to personal hygiene: requires or participation with personal hygiene and diabetes mellitus with intervention of bulimited to: diabetic nail care provided by nurse.  Document review of the facility bath list checks dated revised 7/17/14, identified day on Wednesday days.  Document review of R4's nurse progrest dated 6/25/14 through 7/18/14, had no documentation regarding nail care.  During interview on 7/23/14, at 10:13 a had stated the nurse progress notes we only place to document nail care, under care " on bath day.  During interview on 7/24/14, at 10:01 a director of nursing had stated if a resident with behaviors refuses nail care and staff hamultiple times and resident continues to would expect staff to document resider refused.  Document review of the facility Proceduc CARE dated revised 11/13, read, "PUR keep nails clean and trimmed to promo well-being To observe nail condition To nail discomfort PROCEDURE FOR FINGERNAILS 1. Licensed nurse should a state of the saciety of the saciety of the facility Proceduces of the	PROVIDER OR SUPPLIER  SAMARITAN SOCIETY - JACKSON  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  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	PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, S  AMARITAN SOCIETY - JACKSON  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  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.  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Licensed nurse should be	PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  601 WEST JACKSON JACKSON, MN 56143  SUMMARY STATEMENT OF DEFICIENCIES (EXCH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 8  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 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	DENTIFICATION NUMBER:    ABUILDING:   COM

Minnesota Department of Health

STATE FORM 6899 Y1RU11 If continuation sheet 9 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00202	B WING		07/0	4/204.4
		00303	D. WING		0712	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	「JACKSON I, MN 56143			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
2 835	Continued From pa	ge 9	2 835			
	callouses or blisters	eed easily. Never trim corns, s. 15. If documentation of nail hould be set up in the care ed in PCC - POC."				
	noted to have visible and chin.	n 7/22/14 at 9:35 a.m. and e facial hair around her mouth				
	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					
	a.m. and confirmed	interviewed on 7/23/14 at 8:00 that R7 had facial hair and dent had a bath yesterday and				
	that the staff should	I have shaved her. LPN-A ursing assistants are to check				
	whenever necessar					
	resident was admit	d 5/5/14 indicated that the ted on 8/29/13 and had				
	dementia and depre	uded paralysis agitans, essive disorder.				
	R7's care plan date with activities of da	d 5/5/14 indicated a problem ily living (ADL) self- care				
		and directed staff that R7 of one staff participation with				
	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.					
	on 7/15/14 and also	cated that R7 received a bath o 7/22/14 with no 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					

Minnesota Department of Health

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00303	B. WING		07/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	TJACKSON N, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 835	would expect that it on the resident's bat was noticed. A policy titled Shav directed staff on the resident. A policy trevised on 10/2013 shave a resident. I would have a bath/was to be checked SUGGESTED MET The director of nurs responsible for mer residents the need clean and facial ha woman had identifit	t would be removed if noticed ath day or any other day that it ing revised on 11/2013 e procedure of shaving a itled Routine Daily Practice had no guidelines on when to t did indicate that a resident shower per week and that skin	2 835			
2 910	Subp. 5. Incontine have a continuous management to recunnecessary use o comprehensive reshome must ensure  A. a resident without an indwellir unless the resident that catheterization  B. a resident wireceives appropriate prevent urinary trace	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the sident assessment, a nursing that: The enters a nursing home and catheter is not catheterized so clinical condition indicates was necessary; and the is incontinent of bladder the treatment and services to cot infections and to restore as the function as possible.	2 910			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00303	B. WING		07/	24/2014
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- IACKSON 601 WE	ST JACKSON			
GOOD 3	AWARTAN SOCIETT	JACKS	ON, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 11	2 910			
	by: Based on observati review, the facility for function and failed to treatment and servi bladder function for for urinary incontine Findings include: R4's admission recorded had been admitt included but not lim R4's quarterly Minin 4/12/14; identified Fone for toileting, scl frequently incontine moderate cognitive	ord dated 7/24/14; identified ted on 11/17/13 and also ited to diagnosis of dementianum Data Set (MDS) dated R4 required extensive assist oneduled toileting program, ent of bladder and had impairment.				
	lay in bed, a visible on R4's shirt and th odor in R4's room.	on 7/21/14, at 7:40 p.m., R4 wet urine stain had been see ere had been a strong urine R4 was yelling out "Help" this aff of R4 needing assist.				
	had been transferred and NA-B from when NA-B were observed weight bearing assist R4 had been unstead and pivoting during R4 down in bed, couplaced call light in reand exited R4's room	on 7/23/14, at 8:46 a.m., R4 ed by nursing assistant (NA)-/eelchair to bed. NA-A and ed by surveyor to provide st when transferring R4 and ady with maintaining balance transfer. NA-A and NA-B laid vered R4 with a blanket, each, turned off light to room m. NA-A and NA-B had not R4 and had not checked R4's	d			

Minnesota Department of Health

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STATEMENT OF C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00303	B. WING		07/2	4/2014
NAME OF PRO\	VIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
		601 WEST	JACKSON			
GOOD SAMA	ARITAN SOCIETY	- JACKSON JACKSON	I, MN 56143	<b>:</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
ince the toil the NA school survey assigned and five din support the toil	et time. NA-B had leted was 6:30 a. leted was 6:30 a. leted was 6:30 a. leted was 6:30 a. leted was 6:40 a. leted was 6:40 a. leted was 6:40 a. leted was hedule in KIAS (conveyor R4's toilet sistant care sheeter breakfast.  It's care plan date afformance deficit buro cognitive discontinuous deficit buro cognitive discontinuous deficit leted was end seven a.m. anner, one to two tipper and HS (become hours at night articipation with pix continence, pad pottinence, pad pottinence, one assist paired balance, ungnition and physicontinence, toilet pheduled: between eakfast, before disternoon, after supper lete leternoon, after supper leternoon, after supper leternoon was leternoon and physicontinence, toilet pheduled: between leternoon, after supper leternoon, after supper leternoon was leternoon after supper leternoon was leternoon after supper leternoon after suppe	NA-A and NA-B verified at stated last time R4 had been m. NA-A and NA-B had stated A's toilet schedule. NA-A and e can look up R4's toilet computer system) and showed schedule. NA-A and NA-B chedule on the nursing ts read R4 was to be toileted d 4/28/14, identified self- care related to muscle weakness, order with intervention of but use: requires one staff toilet, will use toilet in room le, toileting schedule: between le, after breakfast, before mes in the afternoon, after of time) and check every two to let transfer and has bladder roduct large brief.  Ited last completed bladder rendated 11/11/13, and led one assist needed for needed for ambulation, unsteady gait, impaired cal mobility to manage own regiene, urge and functional program: yes and proposed in five and seven a.m., after nner, one to two times in the per and HS (hour of sleep), three hours at night and toilet ssment of bladder function leted for R4's quarterly review. Further review of R4's essments and summary	2 910			

STATEMENT OF DEF	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00303	B. WING		07/2	4/2014
NAME OF PROVIDER	R OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD SAMARIT	AN SOCIETY	- JACKSON	ΓJACKSON N, MN 56143			
	ACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
review docum function 4/12/14  R4's n identifit seven two time and changer register bladder quarter than standocum quarter changer we do unless an increase an increase an increase an increase and complex standocum quarter changer we do unless an increase an increase and complex summal lacked bladder dated an analysis and complex summal lacked bladder dated and	ursing assistated toileting sa.m., after brines in the after eck every two equires one satisfication with the experience of the experience	progress notes lacked eassessment of bladder earterly review MDS dated ant Kardex dated 7/23/14, chedule: between five and reakfast, before dinner, one to ernoon, after supper and HS to to three hours at night. Toilet taff participation to use toilet, and urinal at bedside, pad and transfer: requires one with pivot transfer.  7/23/14, at 1:26 p.m., N)-A verified no quarterly thad been completed for R4's bladder function and at the nursing assistant ing look back period for the ent dated 4/12/14, R4 had no ently incontinent, if no change do a bladder assessment ange in voiding.  7/24/14, at 11:18 a.m., RN-A sciplinary assessments and and nurse progress notes ion of reassessment of R4's quarterly review MDS  7/24/14, at 11:11 a.m., and stated she would expect bladder function and an completed for quarterly review		DEFICIENCY)		

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPP IDENTIFICATION			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				A. BOILDING.			
		00303		B. WING		07/2	24/2014
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON		「JACKSON N, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENC MUST BE PRECEDED  SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 910	Continued From particles of ASSESSMENT data ensure resident associated in commendations POLICY be done every three appropriate. The complete done every three appropriates are suggested to ensure SUGGESTED MET Director of Nursing complete quarterly provide toileting associated associate	of the facility Policy ed 9/12, read, "PU sessments are conpliance with approper (a) months and a symprehensive asset a cacuracy."  THOD OF CORRECT COULD inservice staurinary assessments assets ance.	npleted and priate sments will as essment will CTION: The aff to nts and to	2 910			
21535	therapy; B. for excessiv C. without ade	ral  al. A resident's dru unnecessary drugs is any drug when u idose, including du e duration; quate indications for nce of adverse cor dose should be red rug regimen review e nursing home more ne Interpretive Guid egulations, title 42 Appendix P of the ideal of the control of the ideal of the ideal of the control of the ideal of the ideal of the control of the id	or regimen  An sed: uplicate drug  or its use; or nsequences luced or  v required in ust comply delines for section State reyors for by the	21535			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00303	B. WING		07/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	「JACKSON I, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 15	21535			
	This standard is incavailable through the	cing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan te Law Library. It is not 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.					
	dated 6/12/14, reve (an antipsychotic m times a day for den the facility medicati	of R4's physician orders signed called an order for Risperdal dedication) 0.50 milligrams two mentia. Document review of on administration record printialed R4 received Risperdal as				
	7/23/14, identified to vascular dementia off, yells, potential f and insight with inte	of R4's care plan print date behavior symptom related to evidenced by takes oxygen for elopement, poor judgment erventions of intervene as cot the rights and safety of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00303	B. WING		07/	24/2014
	PROVIDER OR SUPPLIER	- JACKSON 601 WES	DDRESS, CITY, S T JACKSON N, MN 56143	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21535	others, approach ar divert attention, remalternative location opportunity for posiminimize potential function behaviors yelling by attention such as six 7/231/14, identified necessary to protect others, approach a divert attention, remalternative location opportunity for posiminimize potential function such as six non-pharmacologic give instructions sloth However R4's nursified target behaviors except for Document review of 4/29/14, revealed by angry and recently However there had of R4's behaviors.  During interview on registered nurse (R being documented symptoms as found only one target behaviors except behaviors as found only one target behaviors except for the symptoms as found only one target behaviors except for the symptoms as found only one target behaviors.	and speak in calm manner, nove from situation and take to as needed, provide tive interaction, attention and or resident's disruptive offering tasks which divert nacks and one to one visits.  The control of the rights and safety of and speak in calm manner, nove from situation and take to as needed, provide tive interaction, attention, or resident's disruptive offering tasks which divert nacks and one to one visits, al: attempt al interventions: simplify tasks: only and wait for a response. In assistant Kardex had not naviors of takes oxygen off, nent, poor judgment/insight on documentation in R4's onitoring of R4's target				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00303	B. WING		07/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	JACKSON I, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21535	nursing assistants to R4 had the behavior During interview on of nursing had stated to document review nursing had stated physician and the panalysis of the behadocumented analysis been provided.  During interview on of nursing verified of yelling had been ideassistant Kardex for document on the beautiful to the panalysis of the behadocument on the beautiful to the panalysis of the panalysis of the beautiful to the panalysis of the beautiful to the panalysis of the beautiful to the panalysis of the panalysis of the beautiful to the panalysis of	o document on the behavior if or.  7/24/14, at 9:00 a.m., director ed social service is responsible of behaviors. Director of we review behaviors with the hysician documents an aviors. Surveyor requested sis of behaviors, none had  7/24/14, at 9:30 a.m., director only one target behavior, entified on C4's nursing rethe nursing assistants to ehavior if R4 had the behavior.  7/24/14, at 10:01 a.m., had stated she would expect be pulled over to the nursing rethe nursing assistants to and be able to document on and be able to document on the presence on sible for assessment and to active medications educates in the need to monitor hine if the medication is	21535			
21565	MN Rule 4658.1329 Medications Self Ad	5 Subp. 4 Administration of dmin	21565			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00303	B. WING		07/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	「JACKSON I, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21565	self-administer med resident assessmer care as required in 4658.0405 indicate is a written order from This MN Requirements.  This MN Requirements assessed on observation review, the facility for (R67) was assessed a nebulizer treatment and had no cognitive admission Minimum However, he had no self-administration by the interdisciplin.  On 7/23/14, at 7:25 was observed to accompany to the reatment and he walked out of the reatment and he walked	inistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.  ent is not met as evidenced ion, interview and document ailed to ensure 1 of 1 resident ailed to be safe to self-administer ent.  to the facility on May 2, 2014 we deficit according to the n Data Set dated 5/9/2014. The proof of medications as determined ary committee.  In a.m. registered nurse (RN)-B diminister a nebulizer treatment by his physician. RN-B set up handed the device to R67 and from. R67 was left alone in the lizer treatment and machine the physician's orders, it was that an order or any notation able to self-administer the interval of the self-administer the i	21565			
	conducted with RN not have an order of	p.m. an interview was -B. RN-B verified that R67 did or an assessment available able to self-administer the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUF			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				A. BOILDING.			
		00303		B. WING		07/2	4/2014
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON		「JACKSON I, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE MUST BE PRECEDEI SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21565	Continued From pa	ge 19		21565			
	nebulizer treatment						
	Based on the facilit of Medication policy interdisciplinary tea whether each resid self-administer med The interdisciplinary resident can safely must be documented physician's order magnetic resident self-administer medicates the puritten order from to the control of the properties of the puritten order from the control of the properties of the puritten order from the control of the properties of the puritten order from the control of the properties of the puritten order from the control of the properties of the puritten order from the control of the properties of the puritten order from the control of the properties of the puritten order from the control of the properties of the propert	r dated 7/14 direct m must make a content who expressed dications can do to the property team's determinister med in the medical ust be obtained pristering medication. THOD OF CORRISING and/or designat residents may dications if the content and comprehe oractice is safe arthe attending physical material management.	cted the determination desire to this safely. In that the nedications record, and a prior to the pons.  ECTION: In the could of the pons of the nedications record and a prior to the pons.				
21915	MN St. Statute 144 Residents of HC Fa		atients &	21915			
	Subd. 27. Advisor their families shall he maintain, and partic family councils. Ear assistance and sparetings shall be a visitors attending or invitation. A staff peresponsibility of progresponding to writte council meetings. I shall be encourage	nave the right to oblipate in resident ch facility shall proceed for meetings. Ifforded privacy, which will be deviding this assistant requests which resident and family and family upon the courters on shall be deviding this assistant and family and fam	organize, advisory and rovide Council with staff or noil's signated the ance and n result from nily councils				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00303		B. WING		07/	24/2014
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON		TJACKSON I, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INFO	NCIES D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21915	Continued From pa	ge 20		21915			
	regarding facility policies.						
	This MN Requirement by: Based on interview failed to attempt to least an annual base	and record revie organize a family	w the facility				
	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 MET Administrator and S policies to include a council on at least a Assurance Commit monitor the attempt council.	Social Worker co in attempt to orga a yearly basis. T tee could develo	uld develop anize family he Quality p a system to				
	TIME PERIOD FOR (21) days.	R CORRECTION	: Twenty-one				
23270	MN Rule 4658.5518 Construction	5 Nurse Call Sys	tem; Existing	23270			
	A communication synursing home. It m resident at the nurs	ust register a cal	ll from the				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. BUILDING:			
		00303	B. WING		07/2	24/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- JACKSON	T JACKSON N, MN 56143			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
23270	Continued From pa	age 21	23270			
	•					
	signal light by the bedroom door.					
	by: Based on observat review, the facility f was in working con (R47) and others to R47. Findings include: R47 's call light loc 7/21/14 at 6:27 p.m not light up on the o R47 was in the dini supper. The call lig family use when as During an interview nurse (LPN)-B on 7 confirmed that the LPN-B stated that i did not use his call R47's signed physi indicated that R47 5/21/13 with a diag disease. R47's and dated 4/23/14 indic complete the Brief (BIMS) indicating R impairment. When interviewed of director of mainten not aware that R47	cian orders dated 6/12/14 was admitted to the facility on nosis including Alzheimer's nual Minimum Data Set (MDS) rated R47 was unable to Interview of Mental Status R47 had severe cognitive on 7/23/14 at 7:45 a.m. the ance (DM)-B indicated he was "s call light was not				
	facility had a mainted for needed repairs. in many new call light facility. This particulation and so	s stated that each unit of the enance book that is checked DM-B stated that he had put ghts since he had started at the ular call light was a pretimes they get pulled apart. book was checked with the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED						
		00303		B. WING		07/	07/24/2014						
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
GOOD SAMARITAN SOCIETY - JACKSON  GOOD SAMARITAN SOCIETY - 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	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETI DATE							
23270	DM-B and it was no surveyor notification issue was placed in was not noticed by DM-B stated that he maintenance book requested for the maintenance book requested for the maintenance book for any maindicated that when I interviewed him the sometimes it didn't, the maintenance lowas documented the on 7/23/14.  On 7/23/14 at 9:15 functioning properly During an interviewe (DON) on 7/23/14 aindicated that if a caworking that the existaff would notify maintenance make sure call light, staff reprovide an adaptive SUGGESTED MET The facility could decall light system is a periodic basis, e.g. admitted or moved	oted that on 7/21/2 the het non-function in the maintenance untile tries to check the daily. When a polarintenance of the ed that he did not at staff was instructional transport of the ed that he did not at staff was instructional transport of the checked the contact sometimes it was not be replaced it go and when it was not the call light was at the call light was at 12:55 p.m., the all light was discorpectation would be aintenance and in the policy, dated 9/2 that the resident the resident of the call light."  THOD OF CORRECT or residents need to make free ed to make free ed to a different roor when a new resident of a different roor of the call fight.	aing call light book. This I this time. The icy was example call light know of a more than the call light after worked and and and a copy of a received it as repaired was of nursing DON wered not exthat the call the call light after worked and as repaired was as a copy of a received it as repaired was as a copy of	23270									
TIME PERIOD FOR CORRECTION: Seven (7)			Ĩ										

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
		00303	B. WING	B. WING		07/24/2014						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
GOOD SAMARITAN SOCIETY - JACKSON  GOOD SAMARITAN SOCIETY - JACKSON  JACKSON, MN 56143												
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5) COMPLETE DATE							
23270	Continued From pa	age 23	23270									