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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZTB2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00575

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245568**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **9/26/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 9/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 9/29/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245568

September 26, 2016

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

Dear Ms. Callahan:

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

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

Effective September 9, 2016 the above facility is certified for::

51 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 26, 2016

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

RE: Project Number S5569026

Dear Ms. Callahan:

On August 12, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 28, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On September 26, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 29, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 9, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 28, 2016, effective September 9, 2016 and therefore remedies outlined in our letter to you dated August 12, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245568 Y1	A. Building B. Wing Y2	9/26/2016 Y3

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

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0278	Correction	ID Prefix F0279	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.20(g) - (j)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed
LSC	09/09/2016	LSC	09/09/2016	LSC	09/09/2016
ID Prefix F0282	Correction	ID Prefix F0314	Correction	ID Prefix F0329	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(l)	Completed
LSC	09/09/2016	LSC	09/09/2016	LSC	09/09/2016
ID Prefix F0356	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.30(e)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/09/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KS/kfd	DATE 9/26/2016	SIGNATURE OF SURVEYOR 03048	DATE 9/26/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 7/28/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245568	A. Building 01 - MAIN BUILDING 01 B. Wing	8/29/2016

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

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 08/22/2016	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 08/22/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 9/26/2016	SIGNATURE OF SURVEYOR 25782	DATE 8/29/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 7/26/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZTB2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00575

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245568**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **07/28/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date : Susan Kalis, HFE NE II 08/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Health Program Representative 08/31/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 12, 2016

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

RE: Project Number S5569026

Dear Ms. Callahan:

On July 28, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233
Fax: (507) 537-7194

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 13, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

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

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 28, 2016 (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 28, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	07/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide timely and dignified services for 2 of 2 residents (R5, R36) reviewed who stated they waited long periods of time to have their call lights answered. Findings include: R5's quarterly Minimum Data Set (MDS) assessment dated 6/7/16, identified a Brief Interview for Mental Status (BIMS) score of 13 indicating mild cognitive impairment. The MDS further identified R5 had no behavior nor mood	F 241	F 241 Suggestion/Concern forms were initiated for R-5 and R-36 related to call light wait times. R-5's care plan was updated to meet toileting needs at night. A new process was created for answering call lights. All interview-able residents were asked about their call light wait times. Suggestion/Concern forms were initiated for any resident voicing concern. Based	9/9/16

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

Electronically Signed | 08/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	07/28/2016

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

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F 241	Continued From page 1 indicators. According to the MDS, R5 required extensive assist of one (1) staff with toileting, was frequently incontinent and had a scheduled toileting plan. When questioned whether staff treated R5 with dignity and respect on 7/25/16, at 4:21 p.m. R5 responded negatively because staff did not answer her call light in a timely manner during the night time shifts. The result of untimely staff response to her call light caused R5 to experience incontinence. R5 stated sometimes night staff would enter her room, turn the call light off, indicate they would return but would not come back. R5 stated she would have to activate her call light again. R5 stated it took staff twenty (20) minutes or more to answer her call light, which was too long. Consequently, R5 stated she was unable to control her bladder when waiting so long for staff to answer the light. R5 stated that when she was incontinent, it was belittling. R5's care plan, dated 6/6/16, identified R5 had bladder incontinence related to functional limitations evidenced by wetness with toileting. The care plan goal identified R5 would be continent seven (7) times per week by the next review date and would remain free from skin breakdown due to incontinence and brief use through the review date. The care plan interventions identified R5 would use incontinence products; be toileted at 4:00 a.m., 6:00 a.m., 10:00 a.m., 1:00 p.m., 4:00 p.m., 7:00 p.m., 10:00 p.m. and as needed. On 7/27/16, at 1:39 p.m. the social services (SS)-A representative was interviewed. SS-A stated R5 would be reliable with her memory of events. SS-A stated she was unaware of R5's	F 241	on suggestion/concern forms a new process was implemented for answering call lights. All staff was educated on the need to answer call lights in a memo dated 8/18/16. Education will be reviewed by the DNS in a staff meeting on 9/8/16 including new procedure for answering call lights. Audits will be conducted of three residents three times per week for four weeks and then three residents weekly for four weeks to ensure that their requests are addressed when utilizing there call light by the Licensed Social Worker or designee. Audit results will be reported to the QAPI Committee and Resident Council for review and recommendations. Completion date: September 9, 2016	

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F 241	Continued From page 2	F 241		

complaint but felt R5 would be able to identify timeliness. SS-A further confirmed that R5 was able to communicate whether or not it bothered her and/or whether it was a dignity issue.

R36's quarterly MDS assessment dated 7/5/16, identified R36 with a BIMS of 15, indicating intact cognition. The MDS further identified that R36 had no long/short term memory problems, no behavioral issues, mild depression and required extensive assistance with transfers, toileting, dressing and bed mobility.

When questioned whether staff treated R5 with dignity and respect on 7/25/16, at 3:49 p.m. R36 responded by stating staff enter the room on the night shift when he activated his call light on, turn it off and indicate they would return. R36 explained that although staff indicated they would return, they would not. R36 stated that approximately a week ago, he was trying to remove some clothing because he was too hot so he utilized his call light for staff assistance. R36 stated staff entered the room after a long period, turned his call light off and explained they would return. R36 stated staff did not return for more than an hour. R36 stated night shift staff frequently take a long time to answer his call light. R36 expressed that it made him feel unimportant. R36 also stated it was undignified for staff to enter the room, turn the call light off and ignore his immediate request. R36's family member (F)-A who was present during the interview, verified R36 had expressed to her the concerns related to the long periods of wait time for night staff to respond to the call light and his needs addressed.

R36's care plan, dated 7/5/16, identified R36

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F 241	Continued From page 3 required assistance of staff to perform activities of daily living (ADL's). The care plan further identified R36 had an indwelling Foley catheter and required staff assistance to drain the catheter bag. When interviewed on 7/27/16, at 1:39 p.m. SS-A was questioned whether R36 would be reliable with his perception of events. SS-A stated R36 was reliable and indicated she was aware of the concern that R36 expressed related to the complaint that staff were not providing help in a timely manner. SS-A also stated that R36 had expressed this concern during his last care conference. SS-A verified R36 informed her about the incident when R36 wanted to take clothing off because he was hot and verified R36 stated it had taken staff more than one hour to assist him.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278		9/9/16

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F 278	Continued From page 4 false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to accurately assess 1 of 3 residents (R9) reviewed for dental status. Findings include: During observation on 7/25/16, at 4:09 p.m. R9 was observed to have approximately 5 worn front bottom teeth. Review of R9's Nursing Admit Re-Admit Data Collection dated 10/28/15, indicated R9 did not have her own teeth and had full upper and lower dentures. Review of R9's quarterly Minimum Data Set (MDS) dated 5/2/16, indicated no broken or loosely fitting denture. No mouth, facial pain or difficulty chewing. Review of R9's admission Care Area Assessment (CAA) dated 11/5/15, indicated resident had no natural teeth or tooth fragments (edentulous).	F 278	F 278 On 7/29/16 an Oral/Dental Assessment was completed on R-9 and the care plan was updated to accurately reflect dental status. Oral/Dental Assessments were completed by an RN on every resident. All care plans were updated to reflect the assessments. Education was provided to all licensed nurses on how to conduct the physical exam of the oral cavity through a memo posted 8/18/16. Education will be reviewed in a nursing staff meeting on 9/8/16. Audits will be conducted on each admission for four weeks and 50% of admissions for four weeks for accuracy of oral exams by the Director of Nursing or designee. Audits will be reported to the QAPI committee for review and recommendation.	

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F 278	Continued From page 5 Review of R9's care plan dated 5/4/16, indicated R9 had potential oral/dental health problems related to dentures and specified resident had both upper and lower dentures. During interview on 7/26/16, at 11:27 a.m. R9 stated she wears a full upper denture and has "5 teeth left" on the bottom gum line. During interview on 7/26/16, at 1:44 p.m. nursing assistant (NA)-B stated "she has some teeth on the bottom" and wears a denture on top. During interview on 7/26/16 at 2:13 p.m. registered nurse (RN)-B confirmed R9 had some teeth on the lower gum line and verified the Nursing Admit Re-Admit Data Collection, CAA, and care plan did not accurately reflect this.	F 278	Completion Date: September 9, 2016	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		9/9/16

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F 279	Continued From page 6 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a comprehensive care plan related to the use of an antidepressant medication (Celexa) for 1 of 5 residents (R18) reviewed for unnecessary medications and 1 of 3 residents (R41) reviewed for non-pressure related skin condition. Findings include: R18's diagnoses included major depressive disorder (single episode), anxiety disorder, and dementia according to the facility face sheet. R18's quarterly Minimum Data Set (MDS) dated 6/16/16 included a diagnosis of depression. Review of the signed physician orders dated 6/9/16, included an order for Celexa 10 milligrams (mg) by mouth one time a day for depression with a start date of 2/12/16. The physician progress note dated 2/11/16 included: "For the complaint of depression and sadness we will start her on Celexa 10 mg daily if her [sic] okay with her family." R18's care plan dated 6/13/16, lacked an individualized comprehensive care plan for managing depression. When interviewed on 7/28/16, at 9:34 a.m.	F 279	F 279 A comprehensive care plan was developed for depression for R-18. A comprehensive care plan was developed for R-36 for impairment to skin integrity. All residents with a diagnosis of depression were reviewed for comprehensive care plan development. All residents with non-pressure related skin issues were reviewed for comprehensive care plan development. All licensed nurses were educated on care plan development for new skin issues and psychoactive medications through a memo issued 8/18/16. Education will be reviewed by the DNS in a nursing staff meeting on 9/8/16. Audits will be conducted for accurate care planning process in relevance to depression and skin integrity on three residents three times per week for four weeks and then three residents weekly for four weeks by the DNS or designee. Audit results will be reported to the QAPI committee for review and recommendation. Completion date: September 9, 2016	

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F 279	Continued From page 7	F 279		

registered nurse (RN)-B verified R18's diagnosis of depression and use of Celexa was not addressed on the care plan and should have been.

R41 was admitted with diagnoses of type 2 diabetes mellitus, rash and other nonspecific skin eruption.

During observation on 7/26/16, at 11:54 a.m. R41 was noted to have an approximately 1 centimeter (cm) scabbed area to left side of neck with 2 other approximately 1/2 cm scabs next to area. Some redness around the scabs was noted.

Review of R41's MDS dated 5/31/16, indicated R41 was receiving applications of ointments/medications other than to feet.

Review of R41's weekly Skin Observation records from 5/5/16-7/28/16 indicated R41 had small scabbed areas to bilateral arms and legs, neck, upper back, and forehead.

Review of current physician orders in electronic medication administration record (EMAR) included an order dated 9/16/14 for triamcinolone acetonide cream 0.1%, apply to affected area topically as needed for rash related to rash and other nonspecific skin eruption three times per day (TID) as needed (PRN)

Review of R41's treatment records show the triamcinolone acetonide cream 0.1% was used four times in May, six times in June, and three times in July.

During interview on 7/26/16, at 12:05 p.m. R41 stated area itched and staff apply salve to it.

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F 279	Continued From page 8 Further stated "maybe they should cover it" as resident was touching and itching area on left neck. During interview on 7/27/16, at 10:36 a.m. NA-A indicated R41 frequently has scabs on her face and arms. NA-A further indicated R41 will pick at them and has done this as long as she has been there. During interview on 7/28/16, at 8:00 a.m. RN-A indicated R41 has chronically picked and scratched at her skin stating "I can remember when she was admitted here, she had scabs and sores then" Further indicated R41 had a PRN order for triamcinolone cream, and usually allows application after her weekly bath. During interview on 7/28/16, at 8:37 a.m. RN-B indicated chronic skin problems should be identified on the care plan. RN-B further indicated a care plan had not been developed for skin problems and verified it should've been included.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow the plan of care which included monitoring for pressure ulcers for 1 of 3	F 282	F282 R-64 has discharged.	9/9/16

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F 282	Continued From page 9 residents (R64) reviewed in the closed record sample and who had a pressure ulcer (PU). Findings include: R64 was admitted on 6/6/16, with diagnoses that included: end stage renal disease (ESRD) and Type 2 diabetes. Review of the resident's hospital discharge notes dated 6/6/16, included a summary that indicated R64 had an open sore on the coccyx. The current treatment was Mepilex sacral dressing to decrease friction and shear. The progress note revealed the ulcer measured 3.5 centimeters (CM) by 2.5 cm. The note further included the ulcer would be re-addressed weekly and to continue with the current treatment. Review of the initial admission data collection tool dated 6/6/16, identified R64 as having no skin concerns and and the resident was slightly limited in mobility. Review of the admission Minimum Data Set (MDS) dated 6/13/16, identified R64 as not being at risk for pressure ulcers and currently did not have a PU. Review of a fax by a facility nurse to the physician dated 6/20/16, included a note indicating R64 was found to have a large foam dressing on his coccyx area. The note further indicated the dressing had been on since admission on 6/6/16. The dressing was removed at this time and a 1.0 cm by 1.0 cm unstageable scabbed sore was found on the bony prominence (indicating it was most likely from pressure). The physician ordered a Mepilex dressing to the ulcer (the same order that was utilized to the area while in the hospital). Although R64 had a dressing on his coccyx it had	F 282	Skin checks were completed on all residents. A comprehensive care plan was developed for anyone with skin issues. The care plans for potential and actual skin integrity impairment are being followed. All nurses were educated on the process for completing a physical examination on admission and on the need to review all hospital paperwork with any admission through a memo posted 8/18/16. Education will be reviewed by the DNS in a nursing staff meeting on 9/8/16. Audits will be completed with each admission for accuracy of the skin examination and correlating care plan development and implementation for four weeks and then 50% of admission for four weeks by the DNS or designee. Audit results will be reported to the QAPI committee for review and recommendation. Completion date: September 9, 2016	

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F 282	Continued From page 10	F 282		

not been changed nor had the PU been monitored since admission on 6/6/16.

Review of R64's bathing schedule indicated the resident had been scheduled a bath weekly since admission. Further review of the bathing record indicated R64 received a bath on 6/7/16, 6/10/16 and 6/17/16. The skin observation documentation on these bath days indicated there were no skin conditions observed.

Review of the care plan identified R64 as having potential impairment of skin integrity related to end stage renal disease. Interventions listed: turn and reposition resident in bed and chair every shift and as needed, provide a pressure relieving device on bed and a Roho cushion on the wheelchair. The care plan further included staff to monitor and report any skin areas of breakdown, redness and blisters during weekly bathing or daily cares.

Interview with the director of nursing (DON) on 7/27/16, at 11:00 a.m. confirmed the facility staff had not followed the plan of care since admission for monitoring the residents skin. The DON also verified R64 was admitted with a PU and the staff had not observed the open area on any of the bath days listed above nor with resident cares until 6/20/16.

Review of the policy revised 4/16 and titled, Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements the following was noted: (12) When a pressure ulcer is present, daily monitoring (with accompanying documentation when a complication or change is identified) should include the following:
-an evaluation of the ulcer, if no dressing is

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F 282	Continued From page 11 present; an evaluation of the status of the dressing; if present (whether it is intact and whether draining, if present, is or is not leaking); -the status of the area surrounding the ulcer (that can be observed without removing the dressing); -the presence of possible complication, such as signs of increasing area of ulceration or soft tissue infection (for example, increased redness or swelling around the wound or increased drainage from the wound); and -whether pain, if present, is being adequately controlled. (14) The pressure ulcer should be assessed/evaluated at least weekly and documented on the Wound RN Assessment UDA.	F 282		
F 314 SS=D	.. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314		9/9/16

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F 314	Continued From page 12 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to identify, assess and implement interventions to maintain skin integrity for 1 of 3 residents (R64) reviewed during closed record review and who was identified with a unstageable pressure ulcer (PU) to the coccyx. Findings include: R64 was admitted on 6/6/16, with diagnoses that included: end stage renal disease (ESRD) and Type 2 diabetes. Review of the R64's hospital discharge notes dated 6/6/16, included a summary that indicated R64 had an open sore on the coccyx. The current treatment was Mepilex sacral dressing to decrease friction and shear. The progress note revealed the ulcer measured 3.5 centimeters (CM) by 2.5 cm. The note further included the ulcer would be re-addressed weekly and to continue with the current treatment. Review of the initial admission data collection tool dated 6/6/16, identified R64 as having no skin concerns and and the resident was slightly limited in mobility. Review of the Braden scale dated 6/6/16, identifies R64 as having a score of "19" (meaning low risk for pressure ulcers).	F 314	F314 R64 discharged. Skin checks were completed on all residents. A comprehensive care plan was developed for anyone with skin issues. The care plans for potential and actual skin integrity impairment are being followed. All nurses were educated on the skin check procedure through a memo posted 8/18/16. . Education will be reviewed by the DNS in a nursing staff meeting on 9/8/16. Audits will be conducted for accuracy of skin checks on three residents three times per week for four weeks and then three residents weekly for four weeks by the DNS or designee. Audit results will be reported to the QAPI committee for review and recommendation. Completion date: September 9, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	07/28/2016

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

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F 314	Continued From page 13	F 314		

Review of the admission Minimum Data Set (MDS) assessment dated 6/13/16, identified R64 as not being at risk for pressure ulcers and currently did not have a PU.

Review of a fax by a facility nurse to the physician dated 6/20/16, included a note indicating R64 was found to have a large foam dressing on the coccyx area. The note further indicated the dressing had been on since admission on 6/6/16. The dressing was removed at this time and a 1.0 cm by 1.0 cm unstageable scabbed sore was found on the bony prominence (indicating it was most likely from pressure). The physician ordered a Mepilex dressing to the ulcer (the same order that was utilized to the area while in the hospital). Although R64 had a dressing on the coccyx it had not been changed nor had the PU been monitored since admission on 6/6/16.

Review of R64's bathing schedule revealed the resident had been scheduled a weekly bath since admission. Further review of the bathing record indicated R64 received a bath on 6/7/16, 6/10/16 and 6/17/16. The skin observation documentation on these bath days indicated there were no skin conditions observed.

Review of the current care plan identified R64 as having potential impairment of skin integrity related to ESRD. Interventions listed: turn and reposition resident on bed and chair every shift and as needed, provide a pressure relieving device on bed and a Roho cushion on the wheelchair. The care plan further included staff to monitor and report any skin areas of breakdown, redness and blisters during weekly bathing or daily cares.

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F 314	Continued From page 14 Interview with the director of nursing (DON) on 7/27/16, at 11:00 a.m. confirmed the staff should have identified R64's PU located on the coccyx when admitted to the facility. The DON also verified there had been no monitoring of the PU since admission on 6/6/16, and the wound dressing from the hospital remained in place until 6/20/16, when it had been removed. Review of the policy revised 4/16 and titled, Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements the following was noted: (12) When a pressure ulcer is present, daily monitoring (with accompanying documentation when a complication or change is identified) should include the following: -an evaluation of the ulcer, if no dressing is present; an evaluation of the status of the dressing; if present (whether it is intact and whether draining, if present, is or is not leaking); -the status of the area surrounding the ulcer (that can be observed without removing the dressing); -the presence of possible complication, such as signs of increasing area of ulceration or soft tissue infection (for example, increased redness or swelling around the wound or increased drainage from the wound); and -whether pain, if present, is being adequately controlled. (14) The pressure ulcer should be assessed/evaluated at least weekly and documented on the Wound RN Assessment UDA.	F 314		

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F 314	Continued From page 15	F 314		
F 329 SS=D	.. 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		9/9/16

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F 329	Continued From page 16 drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to identify parameters for use of as needed (PRN) anti-anxiety medication for 1 of 5 residents (R51) reviewed for unnecessary medications and who received PRN Ativan. Findings include: Review of the Diagnosis Report dated 7/28/16, identified R51 had diagnoses including: Major depressive disorder, recurrent, mild, restlessness and agitation and insomnia. Review of the annual Minimum Data Set (MDS) assessment dated 7/12/16, identified R51 had a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. Review of the medication administration record (MAR) identified R51 received the anti-anxiety medication Ativan 0.5 mg two times a day for anxiety disorder starting 4/20/16. The MAR also identified R51 had an order for Ativan 0.5 mg one half tablet (0.25 mg) three times daily PRN for agitation related to restlessness and agitation and 0.5 mg one tablet every 4 hours PRN for increased anxiety and agitation related to restlessness and agitation. It was difficult to determine when to administer the prescribed PRN Ativan. The MAR identified R51 received the following	F 329	F 329 An order for parameters for R-51's PRN Ativan order was received on 8/11/16. The PRN medications for all residents were reviewed for parameters for use. Parameters were requested from the primary care provider on any PRN medication missing parameters. Education was provided to all licensed nurses on the need for parameters with all PRN medication through a memo posted 8/18/16. Education will be reviewed by the DNS in a nursing staff meeting on 9/8/16. Audits will be conducted for parameters on all new orders for four weeks and 50% of new orders for four weeks by the DNS or designee. Audit results will be reported to the QAPI committee for review and recommendation. Completion date: September 9, 2016	

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F 329	Continued From page 17 PRN doses: (1) Ativan 0.25 mg: April-five (5) times, May- twice (2), June twice (2) and July once (1); and (2) Ativan 0.5 mg: April -three (3) times, May-seven (7), June-ten (10) times and July -fifteen (15) times. No parameters were identified to distinguish when Ativan 0.25 mg vs. Ativan 0.5 mg should be administered to R51. No clarification from the physician had been documented to verify whether two PRN Ativan orders were appropriate and/or necessary. During interview on 7/28/16, at 9:15 a.m. the director of nursing (DON) verified no parameters were identified for the use of the PRN Ativan 0.25 vs. Ativan 0.5 mg and it should have been identified. The DON agreed that clarification from the physician would be needed. A policy was requested for parameters for the use of PRN medication but none was provided.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data	F 356		9/9/16

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F 356	Continued From page 18 specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the required daily nurse staffing information included the actual hours worked by each category of nursing staff. This had the potential to affect all current residents in the facility, as well as family members, and the general public who may wish to review this information. Findings include: During the initial tour of the facility on 7/25/16, at 2:45 p.m. an observation was made of the posted daily nursing staffing hours. The posting included the current date, current census, total hours worked on the day, evening and night shifts for registered nurses (RN), licensed practical nurses (LPN), trained medication aide (TMA) and certified nursing assistants (CNA). The posting included the total hours for each shift but did not include shorter shifts worked within each 8 hour	F 356	F356 The format for posting the daily nursing staffing hours was revised to meet the regulation criteria. The scheduling coordinator and all licensed nurses were educated on the new form and when and how to update the daily nursing staff posting through a memo posted 8/18/16. Education will be reviewed by the DNS in a nursing staff meeting on 9/8/16. Audits will be conducted three times a week for four weeks and then weekly for four weeks at random times for accuracy of the posting compared to actual staff working by the Director of Nursing or Designee. The audit results will be reported to the QAPI Committee for	

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F 356	Continued From page 19 shift, and did not match the actual hours worked by staff. Review of the daily nurse staffing posted for the dates 7/25, 7/26, 7/27, and 7/28 identified the following staff hours and times: (1) 1 LPN/LVN (licensed vocational nurse) worked (10 p.m.-6:30 a.m.) = 8 total hours, (2) 2 CNA worked (10:30 p.m.-7 a.m.) = 16 total hours, (3) 1 RN worked (6 a.m.-2:30 p.m.) = 8 total hours, (4) 2 TMA/LPN worked (6 a.m.-2:30 p.m.) =16 total hours, (5) 5 CNA worked (6 a.m.-2:30 p.m.) = 36 total hours, (6) 1 RA (resident assistant) worked (5:30 a.m.-2:00 p.m.) = 8 total hours, (7) 1 RN worked (2 p.m.-10:30 p.m.) = 8 total hours, (8) 2 TMA/LPN worked (2 p.m. -10:30 p.m.) = 16 total hours, and (9) 5 CNA worked (2:15 p.m.-10:45 p.m.) = 36 total hours. However, review of the daily staffing assignments for 7/25/16, 7/26, 7/27 and 7/28 identified the following shifts: (1) 2 licensed nurses-(6 a.m.-2:30 p.m.); (6 a.m.-6 p.m.); or (10 a.m. -10:30 p.m.) (2) 1 TMA-(10:15 a.m.- 6:45 p.m.) (3) 3 or 4 CNA- (6:00 a.m.-2:30 p.m.); or (6 a.m.-10:00 p.m.) (4) 1 CNA- (6:00 a.m.-12 p.m.) or (6 a.m.-10:00 a.m.) (5) 2 licensed nurses-(2 p.m.-6 p.m.); (10 a.m.-10:30 p.m.) or (6 p.m.-10:30 p.m.) (6) 2 CNA- (2:15 p.m.-10:45 p.m.) (7) 2 CNA-(4 p.m.-10 p.m.)	F 356	review and recommendations. Completion date: September 9, 2016	

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F 356	Continued From page 20 (8) 1 CNA-(2:15 p.m.-4 p.m.) and (9) 1 CNA- (5 p.m.-7 p.m. or until 9 p.m.) shift. The only daily nursing staffing hours posted for 7/25/16 thru 7/28/16, that were accurate were for the night shift (10:30 p.m.- 7:00 a.m.) During interview on 7/28/16, at 9:15 a.m. the director of nursing (DON) verified the posted daily nursing staffing hours did not match the actual shifts worked. The shortened shifts were not reflected on the posted hours of work.	F 356		

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	245568	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/26/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 26, 2016. At the time of this survey, Building 01 of Good Samaritan Society Mary J. Brown was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145 Facsimile: 651-215-0525, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/22/2016

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Good Samaritan Society Mary J. Brown was constructed as follows: The original building was constructed in 1959, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1965, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1987, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 3rd Addition was constructed in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire	K 000		

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K 000	Continued From page 2 department notification. The facility has a capacity of 51 beds and had a census of 49 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 FINDINGS INCLUDE: During Facility Inspection on July 26, 2016, between 11:00 AM and 1:00 PM, observation during the inspection revealed the door on the Kitchen Storage Room was observed not to self close and latch into door frame.	K 029	The facility, installed an automatic door closer for the Kitchen Storage Room on 7-27-16. The current door now has an automatic door closer that will latch appropriately into the door frame, and will be compliant with fire rating requirements. The installation of the new door closer was done under the direction of the Facility Director of Maintenance, Don Weinkauf.	8/22/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 This deficient practice was observed by the Facility Maintenance Director.	K 029		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 FINDINGS INCLUDE: During Facility Inspection on July 26, 2016, between 11:00 AM and 1:00 PM, the following deficiency was observed related to the fire sprinkler system: 01.) An additional fire sprinkler head is needed in the Activities Storage Room (205).	K 056	The Facility, by coordination with contractor, Building Sprinkler Incorporated, installed a new fire sprinkler head in the Activity Storage Room on 8-11-16. This installation was completed under the direction of the Facility Director of Maintenance, Don Weinkauf.	8/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/26/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 4 This deficient practice was verfied by the Maintenance Supervisor.	K 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**07/26/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 26, 2016. At the time of this survey, Good Samaritan Society Mary J. Brown, Building 02 was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies.. Building 02 of Good Samaritan Society Mary J. Brown consists of the 2011 building addition, which includes a new main entrance, offices, conference room and beauty shop. Building 02 is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II (111) construction. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 51 beds and had a census of 49 at time of the survey.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/22/2016

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.