Electronically Delivered
August 25, 2021

Administrator
Good Samaritan Society - Comforcare
1201 17th Street Ne
Austin, MN 55912

RE: CCN: 245317
Cycle Start Date: June 29, 2021

Dear Administrator:

On August 23, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 25, 2021

Administrator
Good Samaritan Society - Comforcare
1201 17th Street Ne
Austin, MN 55912

Re: Reinspection Results
Event ID: BCTO12

Dear Administrator:

On August 23, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 29, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
July 19, 2021

Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, MN 55912

RE: CCN: 245317
Cycle Start Date: June 29, 2021

Dear Administrator:

On June 29, 2021, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 September 29, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by December 29, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/29/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5317030C (MN74080), with no defiencies, however, during the investigation deficiencies were identified and cited at at F561 and F713. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose	F 561		7/30/21

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

Electronically Signed | 07/29/2021

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F 561	Continued From page 1 activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to send a resdient to the emergency deportment per their request for 1 of 1 residents (R1) reviewed for choices. Findings include: Record review indicated R1's diagnosis list included acute and chronic respiratory failure with hypoxia, acute on chronic diastolic congestive heart failure, chronic obstructive Pulmonary disease, dependence on supplemental oxygen, obstructive sleep apnea and atrial fibrillation. R1's progress note on 6/15/21 at 9:18 a.m.,	F 561	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	

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F 561	Continued From page 2 indicated, R1 had oxygen saturation of 88% on 4 L nasal cannula. Respirations were unlabored, resident had a productive cough. R1 stated he is short of breath but not any more than usual. On 6/16/21 at 7:52 p.m., a progress note noted R1 had edema on both lower and upper extremities. Right hand was +3 and left hand was +2 edema noted. R1's weight on 6/14/21 R1's weight was documented as 256.4 pounds. On 6/18/21 R1's weight had increased to 262.6 pounds for a total of 6.2 pounds weight gain in 4 days. No notification of provider was documented in R1's electronic medical record. During an interview on 6/28/21, at 2:35 p.m. registered nurse (RN-A) stated she was the nurse that worked the evening shift the night before R1 went to the hospital. RN-A indicated at around 9:30 p.m. R1 was complaining of shortness of breath and was insistent he go to the hospital over in Rochester. RN-A stated at the time his oxygen saturations were 87%, indicated she could not get them to go over 90% before she realized that his oxygen tank was empty. RN-A stated after she administered 4 L of oxygen, R1's saturation went up to 90%, however R1 continued to report shortness of breath, and still wished to be transferred to the hospital. RN-A indicated family member (FM)-1 was at the facility visiting R1. RN-A stated FM-1 also wanted to send R1 to the hospital for further evaluation. RN-A stated she attempted to call the on-call physician three times to get an order to send R1 to the hospital. RN-A stated the first attempt was around 9:46 p.m. she left a message with the physician's answering service, then she called 15	F 561	F561 Self-Determination 1. R1 was transferred to the hospital on 6/18/21. 2. A review of hospital transfers was completed to ensure residents were transferred to the hospital in a timely manner per their request on 7/24/21. 3. Nurses will be re-educated on the resident's right to transfer to the hospital per GSS Resident Rights and Transfer/Discharge policy and procedure by the DNS or designee on 7/30/21. 4. Audits will be conducted by the Quality Assurance Coordinator or designee weekly x 4 and then monthly x 2 to ensure the transfer of residents requesting to go to the hospital occurred. Audit results will be brought to the monthly QA meeting for further recommendations. 5. 7/30/21	

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F 561	Continued From page 3	F 561		

minutes later and left another message, on the third attempt the answering service representative told her the physician had already been paged twice and there was nothing more that could be done. RN-A stated R1 could have been sent to the emergency room in an emergency, however, she did not feel R1's condition was an emergency because he was alert and orientated and did not demonstrate symptoms of shortness of breath. RN-A stated she reported to the overnight nurse the physician had not returned the phone call and both R1 and FM-1 wanted further evaluation in the emergency room. RN-A indicated an unawareness it was a resident right to choose the level of care and thought a physician order was required.

During an interview on 6/28/21, at 3:45 p.m. director of nursing (DON) indicated an unawareness the on-call 24-hour physician was not available on the evening shift and over night shift on 6/17 into 6/18/21. DON indicated a physician order was not required and R1 could have been sent in.

During an interview on 6/28/21, at 5:00 p.m. RN-B stated she worked the overnight shift of 6/17/21. RN-B stated RN-A had reported R1 wanted to be transferred to the emergency room for further evaluation and FM-1 wished for R1 to be transferred. RN-B stated she had attempted to reach the physician a couple of times on her shift, was not able to reach the physician, and could not recall what times she attempted. RN-B stated she did not send R1 to the hospital because she thought he was stable. RN-B indicated an unawareness it was a resident right to choose the level of care and thought a

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F 561	Continued From page 4 physician order was required. No related policies were provided by the facility.	F 561		
F 713 SS=F	Physician for Emergency Care Available 24 hrs CFR(s): 483.30(d) §483.30(d) Availability of physicians for emergency care The facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the on-call physician responded in a timely manner for residents with a change of condition for 1 of 1 resident (R1) reviewed for change in condition. Findings include: Record review indicated R1's diagnosis list included the following; acute and chronic respiratory failure with hypoxia, acute on chronic diastolic congestive heart failure, chronic obstructive Pulmonary disease, dependence on supplemental oxygen, obstructive sleep apnea and atrial fibrillation. R1's progress notes were reviewed and revealed the following: -6/16/21 at 7:52 p.m., Note Text: Document edema 2 x (times)/day of lower extremities two times a day related to congestive heart failure. Res has edema on both lower and upper extremities. Right hand was +3 and left hand was +2 edema noted."	F 713	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F713 Physician for Emergency Care Available 24 hrs 1. R1 was transferred to the hospital on 6/18/21. 2. All nurses were interviewed to determine if they had any lag time when contacting the on call physician on 6/17/21 and none were noted.	7/30/21

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F 713	Continued From page 5 -6/17/21 at 10:15 p.m., "Note text: Communication with family, Informed of condition and was in house when res and family decided for res to be transferred out to Rochester." -6/18/21 at 5:54 a.m., "Note text: Call placed to [name] hospital @ 2230 and again around 0300, talked to the operator but have not received call back yet from the hospital. Resident is alert and oriented X [times] 3, been using continuous positive air pressure (CPAP-used to treat sleep-related breathing disorders including sleep apnea) machine on and off, is currently resting quietly and comfortably in the wheelchair, vital signs taken and stable at this point. will keep monitoring resident." -6/18/21 at 7:15 a.m., "Note text: The Change In Condition (CIC)/s reported on this CIC Evaluation are/were: Edema (new or worsening) Functional decline (worsening function and/or mobility) Shortness of breath. Primary Care Provider responded with the following feedback: Send to ER for further evaluation" During an interview on 6/28/21, at 2:35 p.m. registered nurse (RN)-A stated she was the nurse that worked the evening shift the night before R1 went to the hospital. RN-A indicated at around 9:30 R1 was complaining of shortness of breath and was insistent he go to the hospital over in Rochester. RN-A stated at the time his oxygen saturations were 87%, indicated she could not get them to go over 90% before she realized that his oxygen tank was empty. RN-A stated after she administered 4 L of oxygen, R1's saturation went up to 90%, however R1	F 713	3. New process developed with Mayo Clinic Health Systems regarding on call physician services. All nurses will be educated on the new process by the DNS or designee on 7/30/21. Resident council meeting held on 7/26/21 and review of resident right to transfer to the hospital without a physician order was reviewed. All residents were given a written notice regarding resident rights and their right to transfer to the hospital without a physician order on 7/26/21. 4. Audits will be conducted by the Quality Assurance Coordinator or designee weekly x 4 and thenmonthly x 2 to ensure on call physicians are returning calls in a timely manner. Audit results will be brought to the monthly QA meeting for further recommendations. 5. 7/30/21	

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F 713	Continued From page 6	F 713		

continued to report shortness of breath, and still wished to be transferred to the hospital. RN-A indicated family member (FM)-1 was at the facility visiting R1. RN-A stated FM-1 also wanted to send R1 to the hospital for further evaluation. RN-A stated she attempted to call the on-call physician three times to get an order to send R1 to the hospital. RN-A stated the first attempt was around 9:46 p.m. she left a message with the physician's answering service, then she called 15 minutes later and left another message, on the third attempt the answering service representative told her the physician had already been paged twice and there was nothing more that could be done. RN-A stated R1 could have been sent to the emergency room in an emergency, however, she did not feel R1's condition was an emergency because he was alert and orientated and did not demonstrate symptoms of shortness of breath. RN-A stated she reported to the overnight nurse the physician had not returned the phone call and both R1 and FM-1 wanted further evaluation in the emergency room. RN-A indicated an unawareness it was a resident right to choose the level of care and thought a physician order was required.

During an interview on 6/28/21 at 2:48 p.m., nurse practitioner (NP-A) stated that if a resident wants to be seen in the emergency department (ED) and a provider cannot be reached staff should bring this to the attention of the administrative personnel within the facility. The ED has stated that they will not refuse to treat a patient without an order from the physician. NP-A stated she knew the facility has had issues in the past with this and not getting a hold of providers so part of their plan should be to alert their

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F 713	Continued From page 7	F 713		

administrator that they are experiencing this.

During an interview on 6/28/21, at 3:45 p.m. director of nursing (DON) indicated an unawareness the on-call 24-hour physician was not available on the evening shift and over night shift on 6/17 into 6/18/21. DON indicated R1 should have been transferred to the emergency room per his request.

During an interview on 6/28/21, at 5:00 p.m. registered nurse (RN)-B stated she worked the overnight shift of 6/17/21. RN-B stated RN-A had reported R1 wanted to be transferred to the emergency room for further evaluation and FM-1 wished for R1 to be transferred. RN-B stated she had attempted to reach the physician a couple of times on her shift, was not able to reach the physician, and could not recall what times she attempted. RN-B stated she did not send R1 to the hospital because she thought he was stable. RN-B indicated an unawareness it was a resident right to choose the level of care and thought a physician order was required.

During an interview on 6/29/21, at 11:11 a.m. FM-1 stated a little after 9:00 p.m. she had received a call from a family friend that there was something wrong with R1. FM-1 stated she had arrived at the facility shortly after the phone call and found R1 sitting in his wheelchair in the middle of his doorway. FM-1 stated compared to what he looked like only two days ago he looked horrible. FM-1 stated he was slouched down in his wheelchair and obviously short of breath, seemed like he was a little delirious, and had horrible swelling in his right hand that had not been there two days ago. FM-1 told her he

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F 713	Continued From page 8 thought he was filling with fluid again and wanted to go to the emergency room. FM-1 stated the nurse took his oxygen saturations and they were only 88%, the oxygen tank was empty, even after she changed the tank out, R1 continued to complain it was hard to breath and he looked uncomfortable. FM-1 stated the nurse told her she was going to go call the doctor to get an order to send him to the emergency room. FM-1 stated R1 did not want to lay down because he could not breath laying down and wanted to sit up and wait for the ambulance. FM-1 stated the nurse came back around 10:30 p.m. and said she had called the doctor three times and would be send R1 to the hospital as soon as they got a call back from the doctor. FM-1 stated at 11:15 p.m. she left the facility. FM-1 stated the next morning at 5:30 a.m. she called the local hospital and they told FM-1 that R1 had not been transported there and suggested calling another hospital. FM-1 stated she called that hospital and R1 had not been transferred there either. FM-1 stated she then called the facility, the nurse who answered the phone told her that he had not been transferred and continued to sleep in his wheelchair in the doorway of his room. No related policies were provided by the facility.	F 713		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 19, 2021

Administrator
Good Samaritan Society - Comforcare
1201 17th Street Ne
Austin, MN 55912

Re: State Nursing Home Licensing Orders
Event ID: BCTO11

Dear Administrator:

The above facility was surveyed on June 29, 2021 through June 29, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: _____ B. WING _____	C 06/29/2021

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GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted on 6/29/21, to investigate complaint H5317030C (MN74080). As a result the following was identified: The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5317030C (MN74080), during the investigation licensing orders were identified and issued. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		
21265	MN Rule 4658.0705 Subp. 2 A MedicalCare&Treatment; Availablity -emergency Subp. 2. Availability of physicians for emergency and advisory care. A. A nursing home must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency, and to act in an advisory capacity. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the on-call physician responded in a timely manner for residents with a change of condition for 1 of 1 resident (R1) reviewed for change in condition. Findings include: Record review indicated R1's diagnosis list included the following; acute and chronic respiratory failure with hypoxia, acute on chronic diastolic congestive heart failure, chronic obstructive Pulmonary disease, dependence on	21265	Corrected.	7/30/21

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21265	Continued From page 2 supplemental oxygen, obstructive sleep apnea and atrial fibrillation. R1's progress notes were reviewed and revealed the following: -6/16/21 at 7:52 p.m., Note Text: Document edema 2 x (times)/day of lower extremities two times a day related to congestive heart failure. Res has edema on both lower and upper extremities. Right hand was +3 and left hand was +2 edema noted." -6/17/21 at 10:15 p.m., "Note text: Communication with family, Informed of condition and was in house when res and family decided for res to be transferred out to Rochester." -6/18/21 at 5:54 a.m., "Note text: Call placed to [name] hospital @ 2230 and again around 0300, talked to the operator but have not received call back yet from the hospital. Resident is alert and oriented X [times] 3, been using continuous positive air pressure (CPAP-used to treat sleep-related breathing disorders including sleep apnea) machine on and off, is currently resting quietly and comfortably in the wheelchair, vital signs taken and stable at this point. will keep monitoring resident." -6/18/21 at 7:15 a.m., "Note text: The Change In Condition (CIC)/s reported on this CIC Evaluation are/were: Edema (new or worsening) Functional decline (worsening function and/or mobility) Shortness of breath. Primary Care Provider responded with the following feedback: Send to ER for further evaluation" During an interview on 6/28/21, at 2:35 p.m.	21265		

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21265	Continued From page 3 registered nurse (RN)-A stated she was the nurse that worked the evening shift the night before R1 went to the hospital. RN-A indicated at around 9:30 R1 was complaining of shortness of breath and was insistent he go to the hospital over in Rochester. RN-A stated at the time his oxygen saturations were 87%, indicated she could not get them to go over 90% before she realized that his oxygen tank was empty. RN-A stated after she administered 4 L of oxygen, R1's saturation went up to 90%, however R1 continued to report shortness of breath, and still wished to be transferred to the hospital. RN-A indicated family member (FM)-1 was at the facility visiting R1. RN-A stated FM-1 also wanted to send R1 to the hospital for further evaluation. RN-A stated she attempted to call the on-call physician three times to get an order to send R1 to the hospital. RN-A stated the first attempt was around 9:46 p.m. she left a message with the physician's answering service, then she called 15 minutes later and left another message, on the third attempt the answering service representative told her the physician had already been paged twice and there was nothing more that could be done. RN-A stated R1 could have been sent to the emergency room in an emergency, however, she did not feel R1's condition was an emergency because he was alert and orientated and did not demonstrate symptoms of shortness of breath. RN-A stated she reported to the overnight nurse the physician had not returned the phone call and both R1 and FM-1 wanted further evaluation in the emergency room. RN-A indicated an unawareness it was a resident right to choose the level of care and thought a physician order was required. During an interview on 6/28/21 at 2:48 p.m.,	21265		

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21265	Continued From page 4	21265		

nurse practitioner (NP-A) stated that if a resident wants to be seen in the emergency department (ED) and a provider cannot be reached staff should bring this to the attention of the administrative personnel within the facility. The ED has stated that they will not refuse to treat a patient without an order from the physician. NP-A stated she knew the facility has had issues in the past with this and not getting a hold of providers so part of their plan should be to alert their administrator that they are experiencing this.

During an interview on 6/28/21, at 3:45 p.m. director of nursing (DON) indicated an unawareness the on-call 24-hour physician was not available on the evening shift and over night shift on 6/17 into 6/18/21. DON indicated R1 should have been transferred to the emergency room per his request.

During an interview on 6/28/21, at 5:00 p.m. registered nurse (RN)-B stated she worked the overnight shift of 6/17/21. RN-B stated RN-A had reported R1 wanted to be transferred to the emergency room for further evaluation and FM-1 wished for R1 to be transferred. RN-B stated she had attempted to reach the physician a couple of times on her shift, was not able to reach the physician, and could not recall what times she attempted. RN-B stated she did not send R1 to the hospital because she thought he was stable. RN-B indicated an unawareness it was a resident right to choose the level of care and thought a physician order was required.

During an interview on 6/29/21, at 11:11 a.m. FM-1 stated a little after 9:00 p.m. she had received a call from a family friend that there was something wrong with R1. FM-1 stated she had

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21265	Continued From page 5	21265		

arrived at the facility shortly after the phone call and found R1 sitting in his wheelchair in the middle of his doorway. FM-1 stated compared to what he looked like only two days ago he looked horrible. FM-1 stated he was slouched down in his wheelchair and obviously short of breath, seemed like he was a little delirious, and had horrible swelling in his right hand that had not been there two days ago. FM-1 told her he thought he was filling with fluid again and wanted to go to the emergency room. FM-1 stated the nurse took his oxygen saturations and they were only 88%, the oxygen tank was empty, even after she changed the tank out, R1 continued to complain it was hard to breath and he looked uncomfortable. FM-1 stated the nurse told her she was going to go call the doctor to get an order to send him to the emergency room. FM-1 stated R1 did not want to lay down because he could not breath laying down and wanted to sit up and wait for the ambulance. FM-1 stated the nurse came back around 10:30 p.m. and said she had called the doctor three times and would be send R1 to the hospital as soon as they got a call back from the doctor. FM-1 stated at 11:15 p.m. she left the facility. FM-1 stated the next morning at 5:30 a.m. she called the local hospital and they told FM-1 that R1 had not been transported there and suggested calling another hospital. FM-1 stated she called that hospital and R1 had not been transferred there either. FM-1 stated she then called the facility, the nurse who answered the phone told her that he had not been transferred and continued to sleep in his wheelchair in the doorway of his room.

No related policies were provided by the facility.
SUGGESTED METHOD OF CORRECTION: The administrator, medical director, and/or director of

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21265	Continued From page 6 nursing (DON) could review the facility's agreement/contract for 24/7 on call physician and develop new procedures in the event the on-call physician service in the event the contracted service is not available or review the facility's expectations with the contracted service provider and request the provider supply the facility with a performance improvement plan. Based on what the facility determines to be the best to ensure quality of care for the residents, provide the staff with education on process and protocols. The facility could then develop and implement an auditing system as part of the quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21265		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable	21830		7/30/21

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21830	Continued From page 7 efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the	21830		

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21830	Continued From page 8 family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to send a resdient to the emergency deportment per their request for 1 of 1 residents (R1) reviewed for choices. Findings include:	21830	Corrected.	

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21830	Continued From page 9 Record review indicated R1's diagnosis list included acute and chronic respiratory failure with hypoxia, acute on chronic diastolic congestive heart failure, chronic obstructive Pulmonary disease, dependence on supplemental oxygen, obstructive sleep apnea and atrial fibrillation. R1's progress note on 6/15/21 at 9:18 a.m., indicated, R1 had oxygen saturation of 88% on 4 L nasal cannula. Respirations were unlabored, resident had a productive cough. R1 stated he is short of breath but not any more than usual. On 6/16/21 at 7:52 p.m., a progress note noted R1 had edema on both lower and upper extremities. Right hand was +3 and left hand was +2 edema noted. R1's weight on 6/14/21 R1's weight was documented as 256.4 pounds. On 6/18/21 R1's weight had increased to 262.6 pounds for a total of 6.2 pounds weight gain in 4 days. No notification of provider was documented in R1's electronic medical record. During an interview on 6/28/21, at 2:35 p.m. registered nurse (RN-A) stated she was the nurse that worked the evening shift the night before R1 went to the hospital. RN-A indicated at around 9:30 p.m. R1 was complaining of shortness of breath and was insistent he go to the hospital over in Rochester. RN-A stated at the time his oxygen saturations were 87%, indicated she could not get them to go over 90% before she realized that his oxygen tank was empty. RN-A stated after she administered 4 L of oxygen, R1's saturation went up to 90%, however R1 continued to report shortness of breath, and still wished to be transferred to the hospital. RN-A	21830		

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21830	Continued From page 10	21830		

indicated family member (FM)-1 was at the facility visiting R1. RN-A stated FM-1 also wanted to send R1 to the hospital for further evaluation. RN-A stated she attempted to call the on-call physician three times to get an order to send R1 to the hospital. RN-A stated the first attempt was around 9:46 p.m. she left a message with the physician's answering service, then she called 15 minutes later and left another message, on the third attempt the answering service representative told her the physician had already been paged twice and there was nothing more that could be done. RN-A stated R1 could have been sent to the emergency room in an emergency, however, she did not feel R1's condition was an emergency because he was alert and orientated and did not demonstrate symptoms of shortness of breath. RN-A stated she reported to the overnight nurse the physician had not returned the phone call and both R1 and FM-1 wanted further evaluation in the emergency room. RN-A indicated an unawareness it was a resident right to choose the level of care and thought a physician order was required.

During an interview on 6/28/21, at 3:45 p.m. director of nursing (DON) indicated an unawareness the on-call 24-hour physician was not available on the evening shift and over night shift on 6/17 into 6/18/21. DON indicated a physician order was not required and R1 could have been sent in.

During an interview on 6/28/21, at 5:00 p.m. RN-B stated she worked the overnight shift of 6/17/21. RN-B stated RN-A had reported R1 wanted to be transferred to the emergency room for further evaluation and FM-1 wished for R1 to be transferred. RN-B stated she had attempted to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00967	A. BUILDING: _____ B. WING _____	C 06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 11 reach the physician a couple of times on her shift, was not able to reach the physician, and could not recall what times she attempted. RN-B stated she did not send R1 to the hospital because she thought he was stable. RN-B indicated an unawareness it was a resident right to choose the level of care and thought a physician order was required. No related policies were provided by the facility. SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident choices and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then aduit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		