Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 14, 2022

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

RE: CCN: 245568
Cycle Start Date: October 3, 2022

Dear Administrator:

On October 12, 2022, we notified you a remedy was imposed. On November 4, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 24, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 27, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 12, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 27, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 24, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 14, 2022

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

Re: Reinspection Results
Event ID: 580612

Dear Administrator:

On November 4, 2022 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 October 3, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
October 12, 2022

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

RE: CCN: 245568
Cycle Start Date: October 3, 2022

Dear Administrator:

On October 3, 2022, a survey was completed at your facility by the Minnesota Department of Health 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 constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 27, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 27, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 27, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 27, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Mary Jane Brown will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 27, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 April 3, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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,

Kamala Fiske-Downing

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

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 _____	C 10/03/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/30/2022 and 10/3/2022, 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: H55684808C (MN00087114), however due to the actions taken by the facility prior to survey, no deficiencies were cited: H55684752C (MN00086964), with a deficiency cited at F689. 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 that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		10/18/22

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

Electronically Signed | 10/18/2022

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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F 689	Continued From page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the resident care plan was updated to reflect the most recent comprehensive assessment to assure safe transfers for 1 of 5 residents (R1) reviewed for transfers. The facility's failures resulted in harm when R1 suffered a femur fracture after being inappropriately transferred. Findings include Facility Reported Incident (FRI) submitted to the State Agency on 9/20/22, identified nursing assistant (NA)-A had pivot transferred R1 to the sit on the toilet when R1 complained of pain in her left knee and could not stand to transfer off the toilet to the wheelchair. NA-A used a mechanical sit-to-stand lift to attempt to transfer her when R1's knee gave out and she was lowered to the floor. NA-A summoned a nurse to assess R1 which resulted in further evaluation at the emergency room. R2 was noted to have a fractured left leg. According to a follow-up report, R2 returned to the facility on 9/23/22 and died on 9/24/22. R1's face sheet dated 9/23/22, identified a diagnosis of Alzheimer's Disease, osteoporosis, and a history of a left femur (upper leg) fracture. R1's quarterly Minimum Data Set (MDS) dated 7/22/22, identified R1 had severe cognitive impairment and required two staff assist with transfers between surfaces and one staff assist	F 689	Good Samaritan Society- Mary Jane Brown 110 S Walnut Ave Luverne, MN 56156 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. F-689- Free of Accident Hazards/Supervision/Devices SS=G What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?	

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F 689	Continued From page 2 for transfers to the toilet. R1 did not walk and required use of a wheelchair for mobility. R1's most recent Sit-Stand-Walk Data Collection Tool dated 7/20/22, indicated R1 could not pull herself to a standing position and required the use of a sit-to-stand mechanical lift for transfers with a medium sized harness. The tool did not include the number of employees required to assist. R1's most recent MDS progress note dated 7/20/22, identified R2 required one (1) assist with mechanical sit-to-stand or total lift for transfers and toileting. R1's toileting care plan dated 8/10/21, gave staff a choice to either toilet with one (1) staff with mechanical sit-to-stand lift and medium harness or have R1 use the grab bars in bathroom to stand. R1's transfer care plan dated 8/24/16 directed staff to use the mechanical sit-to-stand and medium harness or two (2) staff assist with total lift and medium high back mesh sling when too weak or in pain. R1's care plan was not updated to reflect R1 required the sit-to-stand mechanical lift with one staff assist that was updated on 7/20/22, Sit-Stand-Walk Data Collection Tool. R1's nursing progress note dated, 9/19/20, identified the nurse was called to the room by NA-A. R1 was noted to be sitting on the floor leaning against the toilet with legs curled up. NA-A reported the resident became weak and was not able to complete the transfer properly resulting in resident to lose balance and fell to the ground. R1 complained of pain in her buttocks	F 689	DNS reviewed the incident and determined that the resident had been assessed in a timely manner but the Kardex and care plan had not been updated to match MDS assessment. The care plan gave unclear instructions for CNAs to determine transfer status modality. Staff were interviewed, and the resident's Care Plan was updated upon the time the resident returned to the facility on September 23, 2022. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Every resident has potential to be affected by the same deficient practice. All residents' care plans will be reviewed by 10/24/22 to reflect resident's specific care needs per the assessments. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur? Organization's policy on resident assessment, care planning and falls have been reviewed and is current. All licensed staff will be educated on resident specific assessment and care planning. In addition, all Staff will be re-educated on the related policies and procedures. How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice? Resident falls and the system for	

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F 689	Continued From page 3 and top of left knee. The nurse's assessment identified R1 had swelling and bruising above left knee and R1 was complaining of severe pain. R1 was transferred to the emergency room by ambulance. A follow up progress note dated 9/20/22, indicated R1 was admitted to the hospital for a diagnosis of severe distal femur fracture. A progress note dated 9/23/22, included R1 was not a candidate for surgery and was readmitted to the facility on hospice/palliative cares. Progress dated 9/24/22, indicated R1 died. During an interview on 9/30/22, at 12:25 p.m. NA-B indicated she provided cares for R1 and always used the sit-to-stand mechanical lift for transfers. During an interview on 9/30/22, at 1:50 p.m. NA-C stated she always used a sit-to-stand lift to transfer R1. She further stated although the care plan said you can pivot transfer or use the lift; it had been a long time since she had seen R1 transferred by pivot transfer. During an interview on 9/30/22, at 2:15p.m. licensed practical nurse (LPN)-A indicated she was working the night of R1's fall and responded to NA-A's request for help. She indicated the sit-to-stand lift was in R1's room with the sling attached to it and R1 was on the bathroom floor. R1's left knee began to swell quickly and sent her to the emergency room. LPN-A stated NA-A had pivot transferred from her wheelchair to the toilet in the bathroom. Stated there were a lot of new NAs. NA's were supposed to follow the resident's Kardex (abbreviated care plan used by direct care staff) or the flow sheet with resident's transfer status on it for quick reference. LPN-A	F 689	evaluating consistent implementation of policies to ensure that the corrective action is monitored and the deficient practice is being corrected will be discussed during At-Risk/Fall meetings. For every resident discussed during an At-Risk meeting, the assessment, Kardex, and Careplan will be evaluated to ensure consistent and matching implementation of policies. A random resident care observation and care plan audit will be conducted 3x/week for 4 weeks, then weekly for 4 months and as needed. The findings will be shared with the QAPI committee monthly x5 months for input on the need to increase, decrease or discontinue audits. The date for correction and the title of the person responsible for correction of deficiency. The date of correction will be 10/24/22 DNS or designee will be responsible for the correction of the deficiency.	

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F 689	Continued From page 4 reviewed and verified R1's transfer status on the flow sheet was pivot transfer or sit-to-stand mechanical lift. LPN-A indicated the transfer flow sheet and Kardex did not reflect the most recent transfer assessment on 7/20/22. During an interview on 10/3/22, at 10:35 a.m. NA-D indicated the resident transfer ability was communicated on the computer Kardex; NA's had a printed sheet for quick reference. NA-D indicated R1 always transferred to the toilet with the sit-to-stand lift. R1 could not pivot transfer because even with the use of the sit-to-stand, R1's knees would "creak and crack". During an interview on 10/3/22, at 10:40 a.m. NA-E stated staff followed the resident's Kardex. The Kardex told them how residents were supposed to be transferred according to the care plan. NA-E explained R1 always used the sit-to-stand lift and did not know if R1 would have been able to pivot transfer. During an interview on 10/3/22, at 10:45 a.m. LPN-B indicated R1 was a sit-to-stand transfer and the NAs were to refer to the resident Kardex for the care planned transfer method. During an interview on 10/4/22, at 7:15 a.m. NA-A stated she assisted R1 at the time of the incident. NA-A indicated she was employed by a staffing agency but had worked at the facility for a couple months. NA-A explained she had pivot transferred R1 to the toilet and did not use a mechanical lift. However, when it was time to stand up R1 could not stand because her knees hurt. The attempted to stand R1 using the sit-to-stand lift. When she was lifting R1 up, R1's knee gave out so she lowered R1 to the floor. NA-A then took the	F 689		

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F 689	Continued From page 5 sit-to-stand sling off, removed the lift from the bathroom, and called the nurse. NA-A indicated she had been trained to transfer R1. NA-A stated she was following the Kardex and R1 could pivot transfer or use the sit-to-stand lift in the bathroom. During an interview on 9/30/22, at 12:50 p.m. the director of nursing (DON) indicated she did not complete the resident assessments and did not know if the sit/stand/walk assessment determined if a resident could pivot transfer. DON reviewed R1's functional ability assessment and verified the assessment did not identify R1's ability to pivot transfer. Further verified the Kardex was what the NAs would reference to determine how to transfer a resident as the Kardex reflects what the care planned interventions were. DON indicated the facility's incident investigation identified R1 was care planned for either a pivot transfer or a sit-to-stand "depending on how she was doing" and did not identify the lack of revision to R1's care plan with results from the 7/20/22 assessment. DON indicated R1's care plan should have been revised after the assessment was completed. The facility did not provide a policy for updating the care plan or mechanical lift transfers.	F 689		

Electronically delivered
October 12, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: 580611

Dear Administrator:

The above facility was surveyed on September 30, 2022 through October 3, 2022 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00575	A. BUILDING: _____ B. WING _____	C 10/03/2022

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/30/2022 and 10/3/2022, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: HH55684808C (MN00087114), however NO licensing orders were issued due to actions taken by the facility prior to survey. The following complaint was found to be SUBSTANTIATED: HH55684752C (MN00086964), with a licensing order issued at 0830. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box	2 000		

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2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the resident care plan was updated to reflect the most recent comprehensive assessment to assure safe transfers for 1 of 5	2 830	Corrected.	10/18/22

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2 830	Continued From page 3 residents (R1) reviewed for transfers. The facility's failures resulted in harm when R1 suffered a femur fracture after being inappropriately transferred. Findings include Facility Reported Incident (FRI) submitted to the State Agency on 9/20/22, identified nursing assistant (NA)-A had pivot transferred R1 to the sit on the toilet when R1 complained of pain in her left knee and could not stand to transfer off the toilet to the wheelchair. NA-A used a mechanical sit-to-stand lift to attempt to transfer her when R1's knee gave out and she was lowered to the floor. NA-A summoned a nurse to assess R1 which resulted in further evaluation at the emergency room. R2 was noted to have a fractured left leg. According to a follow-up report, R2 returned to the facility on 9/23/22 and died on 9/24/22. R1's face sheet dated 9/23/22, identified a diagnosis of Alzheimer's Disease, osteoporosis, and a history of a left femur (upper leg) fracture. R1's quarterly Minimum Data Set (MDS) dated 7/22/22, identified R1 had severe cognitive impairment and required two staff assist with transfers between surfaces and one staff assist for transfers to the toilet. R1 did not walk and required use of a wheelchair for mobility. R1's most recent Sit-Stand-Walk Data Collection Tool dated 7/20/22, indicated R1 could not pull herself to a standing position and required the use of a sit-to-stand mechanical lift for transfers with a medium sized harness. The tool did not include the number of employees required to assist.	2 830		

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2 830	Continued From page 4 R1's most recent MDS progress note dated 7/20/22, identified R2 required one (1) assist with mechanical sit-to-stand or total lift for transfers and toileting. R1's toileting care plan dated 8/10/21, gave staff a choice to either toilet with one (1) staff with mechanical sit-to-stand lift and medium harness or have R1 use the grab bars in bathroom to stand. R1's transfer care plan dated 8/24/16 directed staff to use the mechanical sit-to-stand and medium harness or two (2) staff assist with total lift and medium high back mesh sling when too weak or in pain. R1's care plan was not updated to reflect R1 required the sit-to-stand mechanical lift with one staff assist that was updated on 7/20/22, Sit-Stand-Walk Data Collection Tool. R1's nursing progress note dated, 9/19/20, identified the nurse was called to the room by NA-A. R1 was noted to be sitting on the floor leaning against the toilet with legs curled up. NA-A reported the resident became weak and was not able to complete the transfer properly resulting in resident to lose balance and fell to the ground. R1 complained of pain in her buttocks and top of left knee. The nurse's assessment identified R1 had swelling and bruising above left knee and R1 was complaining of severe pain. R1 was transferred to the emergency room by ambulance. A follow up progress note dated 9/20/22, indicated R1 was admitted to the hospital for a diagnosis of severe distal femur fracture. A progress note dated 9/23/22, included R1 was not a candidate for surgery and was readmitted to the facility on hospice/palliative cares. Progress dated 9/24/22, indicated R1	2 830		

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2 830	Continued From page 5 died. During an interview on 9/30/22, at 12:25 p.m. NA-B indicated she provided cares for R1 and always used the sit-to-stand mechanical lift for transfers. During an interview on 9/30/22, at 1:50 p.m. NA-C stated she always used a sit-to-stand lift to transfer R1. She further stated although the care plan said you can pivot transfer or use the lift; it had been a long time since she had seen R1 transferred by pivot transfer. During an interview on 9/30/22, at 2:15p.m. licensed practical nurse (LPN)-A indicated she was working the night of R1's fall and responded to NA-A's request for help. She indicated the sit-to-stand lift was in R1's room with the sling attached to it and R1 was on the bathroom floor. R1's left knee began to swell quickly and sent her to the emergency room. LPN-A stated NA-A had pivot transferred from her wheelchair to the toilet in the bathroom. Stated there were a lot of new NAs. NA's were supposed to follow the resident's Kardex (abbreviated care plan used by direct care staff) or the flow sheet with resident's transfer status on it for quick reference. LPN-A reviewed and verified R1's transfer status on the flow sheet was pivot transfer or sit-to-stand mechanical lift. LPN-A indicated the transfer flow sheet and Kardex did not reflect the most recent transfer assessment on 7/20/22. During an interview on 10/3/22, at 10:35 a.m. NA-D indicated the resident transfer ability was communicated on the computer Kardex; NA's had a printed sheet for quick reference. NA-D indicated R1 always transferred to the toilet with the sit-to-stand lift. R1 could not pivot transfer	2 830		

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2 830	Continued From page 6 because even with the use of the sit-to-stand, R1's knees would "creak and crack". During an interview on 10/3/22, at 10:40 a.m. NA-E stated staff followed the resident's Kardex. The Kardex told them how residents were supposed to be transferred according to the care plan. NA-E explained R1 always used the sit-to-stand lift and did not know if R1 would have been able to pivot transfer. During an interview on 10/3/22, at 10:45 a.m. LPN-B indicated R1 was a sit-to-stand transfer and the NAs were to refer to the resident Kardex for the care planned transfer method. During an interview on 10/4/22, at 7:15 a.m. NA-A stated she assisted R1 at the time of the incident. NA-A indicated she was employed by a staffing agency but had worked at the facility for a couple months. NA-A explained she had pivot transferred R1 to the toilet and did not use a mechanical lift. However, when it was time to stand up R1 could not stand because her knees hurt. The attempted to stand R1 using the sit-to-stand lift. When she was lifting R1 up, R1's knee gave out so she lowered R1 to the floor. NA-A then took the sit-to-stand sling off, removed the lift from the bathroom, and called the nurse. NA-A indicated she had been trained to transfer R1. NA-A stated she was following the Kardex and R1 could pivot transfer or use the sit-to-stand lift in the bathroom. During an interview on 9/30/22, at 12:50 p.m. the director of nursing (DON) indicated she did not complete the resident assessments and did not know if the sit/stand/walk assessment determined if a resident could pivot transfer. DON reviewed R1's functional ability assessment and verified the	2 830		

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2 830	Continued From page 7 assessment did not identify R1's ability to pivot transfer. Further verified the Kardex was what the NAs would reference to determine how to transfer a resident as the Kardex reflects what the care planned interventions were. DON indicated the facility's incident investigation identified R1 was care planned for either a pivot transfer or a sit-to-stand "depending on how she was doing" and did not identify the lack of revision to R1's care plan with results from the 7/20/22 assessment. DON indicated R1's care plan should have been revised after the assessment was completed. The facility did not provide a policy for updating the care plan or mechanical lift transfers. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		