DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 2, 2021

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

RE: CCN: 245593
Cycle Start Date: August 31, 2021

Dear Administrator:

On September 23, 2021, we notified you a remedy was imposed. On October 12, 2021 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 4, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 8, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 23, 2021, 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 8, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 4, 2021, 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 Therefore, the NATCEP prohibition is rescinded.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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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Electronically delivered

November 2, 2021

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

Re: Reinspection Results
Event ID: DFL712

Dear Administrator:

On October 12, 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 August 31, 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 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
September 23, 2021

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

RE: CCN: 245593
Cycle Start Date: August 31, 2021

Dear Administrator:

On August 31, 2021, 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 8, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 8, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 8, 2021.

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.

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 $11,160; 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 8, 2021, 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 - St James will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 8, 2021. 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" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 February 28, 2022 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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
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
	245593	A. BUILDING _____ B. WING _____	C 08/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	**1000 SOUTH SECOND STREET ST JAMES, MN 56081**

(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 08/30/21 and 08/31/21, 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 complaint was found to be SUBSTANTIATED: H5593031C (MN75931), 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 §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 observation, interview and document review, the facility failed to comprehensively	F 689	F689 1. For resident #1 the Interdisciplinary	10/4/21

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

Electronically Signed | 10/01/2021

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F 689	Continued From page 1 assess and develop care planned interventions to prevent falls upon admission for 1 of 3 residents (R1) reviewed who were at risk of falling upon admission. R1 was actually harmed when the facility had not placed fall prevention interventions, R1 fell and fractured her ribs, leg, and wrist, was hospitalized, required surgery, and had declined in ability to perform activities of daily living (ADL's). Findings Include: R1's entry tracking Minimum Data Set (MDS) indicated R1 had been admitted on 8/10/21. R1 had a PPS (prospective payment system) MDS (for Medicare payment purposes) dated 8/16/21. The PPS assessment indicated R1 was cognitively intact with diagnoses including diabetes and right upper arm fracture. R1 required extensive assistance from one staff for bed mobility, transfers, dressing, toileting and hygiene. R1 could feed self with set up/supervision and ambulated in the corridor with one assist. The MDS indicated R1 had falls prior to admission, including a fall with a fracture. R1 had a discharge to hospital MDS completed on 8/17/21, which indicated she had a fall with a fracture since admission to the nursing facility. R1 had an entry (return from hospital) MDS on 8/27/21. R1's admission Minimum Data Set (MDS) dated 8/30/21, included, cognitively intact with diagnosis of right upper arm fracture. In addition, R1 now had a left femur (upper leg bone) fracture, a left wrist fracture and multiple rib fractures. R1 now required total staff assistance for all activities of daily living (ADL's), was not steady to stand up or transfer, had functional limitations of one lower	F 689	team met on 9/3/2021 and comprehensively assessed for falls and updated the care plan with interventions to prevent recurrence. 2. All Residents the interdisciplinary team will review their record for fall risk and then update their care plan with appropriate interventions. Completed by 10/4/2021. 3. Nursing staff were re-educated by the DNS on 9-7-21 regarding the policy and procedure for assessing falls risk on admission and with any significant change affecting falls risk, and care planning interventions for falls prevention. Those staff not in attendance will be provided the education and competency check prior to their next working shift. 4. The Director of Nursing and/or Designees will audit all new admissions and any current resident having a fall for 2 weeks, then weekly X 4. Assessments and Care planned interventions for falls is in place as appropriate. Results of these audits will be reviewed by the facility□s Quality committee for further recommendations.	

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F 689	Continued From page 2	F 689		

extremity and used a wheel chair for mobility.

R1's Diagnosis Report indicated the left femur fracture, left wrist fracture and rib fractures were all acquired during the nursing home stay with a date added to list of 8/27/21.

R1's Pre-Admission Data Collection Form dated 8/10/21, identified she was at risk for falls, and had previous falls with right arm fracture.

R1's Falls Tool dated 8/10/21, identified R1 was at, "medium" risk for falls. Risk factors included: falls within last 3 months, medications, psychological, cognitive status, impaired balance, pain, and poor memory. R1's, "Action Plan," included: refer to therapy and refer to provider. No other fall prevention interventions had been placed. The assessment was signed on 8/17/21, by a licensed practical nurse (LPN). R1's admitting medications included antihypertensive medications, an antipsychotic medication, a muscle relaxer, a sleep aide and an opioid pain reliever- all of which had the potential to cause falls. No referral to the facility's pharmacist had been made.

R1's initial care plan dated 8/10/21, addressed, "The resident has an ADL self care performance deficit R/T [related to] decline in functional mobility R/T fx [fracture of the upper end of right humerus [upper arm], diabetes, ckd [chronic kidney disease] stage 3, htn [hypertension] and frequent falls." However the care plan failed to address R1's risk of falling, previous falls or to direct staff on any fall prevention interventions.

R1's Physical Therapy (PT) Plan of Care dated 08/11/21, indicated R1 has generalized weakness

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F 689	Continued From page 3	F 689		

and difficulty in walking. The plan of care indicated therapy was necessary to improve strength and balance. The PT care plan did not direct staff on how to assist R1 in preventing falls.

R1's progress note dated 8/17/21, at 5:50 a.m. included, "Resident was found on the floor laying on her left side with head leaning towards the wall with blood spot on her head." The note indicated staff had helped R1 back to bed, had dressed a new skin tear on her left elbow, had been given cold compress for her head and pain medication. The responsible party, director of nursing (DON) and administrator had been notified and would give report to incoming nurse. R1's progress note dated 8/17/21, at 6:47 a.m. indicated R1 was being sent to the emergency room due to pain and swelling.

R1's Fall Scene Huddle Worksheet dated 08/17/21, identified R1 had an unwitnessed fall at 5:22 a.m. R1 was found on the floor, next to her bed. R1 indicated she was ambulating, lost strength and balance, slipped, and fell. R1 was complaining of right hip pain and was transported to the hospital. This fall report did not identify any fall prevention interventions that were in place at the time of the fall.

R1's facility submitted incident form dated 8/17/21, included, "CNA's [certified nursing assistant] at the nurses station and heard a loud noise. Went down the hall and observed lying on the floor in her room on her left side. Resident admitted to G.S.S St. James from one of the local hospitals on 08/10/2021 with diagnosis of History of Falling, Unspecified Fracture of the Upper end of the Right Humerus, Subsequent encounter for Fracture with routine healing, Primary Essential

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F 689	Continued From page 4	F 689		

Hypertension following hospital stay. Resident was sent to Mayo Clinic St. James hospital for further evaluation. Hospital was later called to follow up on resident's status and Director of Nursing was informed resident was diagnosed with fracture of the left wrist, femur fracture, and 3 right rib fracture. Per report obtained, left wrist and femur fracture appears to be new. Right rib fractures questionable as they could be due to previous fall on August 4th. Resident is alert and oriented to person, place and time. Call light audit report completed, and no indication of resident using her call light to request for assistance. Investigation underway."

R1's follow up report dated 8/20/21, indicated R1's care plan had been followed at the time of the fall and facility policy was followed. No actions had been taken to prevent reoccurrence other than, "frequent checks put into place."

A risk for falls care plan was added on 8/25/21, after R1 had fallen in the facility and fractured her ribs, wrist and femur.

During an observation on 8/30/21, at 12:25 p.m. R1 had a right shoulder immobilize in place and a plaster cast on left arm from elbow to palm.

When interviewed on 8/30/21, at 12:30 p.m. R1 stated she was in constant pain and did not want to move. She had fallen at home and fractured her right arm. R1 stated now she fell at the facility and fractured her left arm and cannot do, "anything for myself." R1 stated she needs help for everything including with eating, and cannot get out of bed to toilet and has to rely on a bedpan. Stating it was upsetting to be totally dependent upon the staff now.

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F 689	Continued From page 5	F 689		

When interviewed on 8/31/21, at 9:05 a.m. the director of nursing (DON) stated, the case manager was responsible for initiating care planned interventions upon admission. The case manager was no longer with the facility and the DON was now responsible. The DON stated he was not aware R1 had fallen prior to admission, but knew she was afraid of falling. The DON stated R1 did not have a care plan to address falls upon admission because R1 was alert, used the call light for assistance and had not been getting up by herself.

When interviewed on 8/31/21, at 9:31 a.m. nursing assistant (NA)-A and NA-B stated they learn of fall prevention interventions from the Section 2 Nurse's Station Communication Book. They were not aware of any fall interventions for R1 prior to her fall and hospitalization.

The Section 2 Nurse's Station Communication Book failed to identify any fall prevention interventions for R1 prior to hospitalization, and did not contain any as of 8/31/21.

When interviewed on 8/31/21, at 9:50 a.m. LPN-A stated he was unaware of any fall prevention interventions for R1 prior to hospitalization. LPN-A was unaware of any new fall prevention interventions in place since her return from the hospital either.

When interviewed on 8/31/21, at 9:59 a.m. the DON stated the NAs receive a report from the charge nurse on any changes to care plan and the NAs have access to a Kardex for tasks and interventions and use a Group sheet for communication. R1's Kardex dated 8/31/21, was

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F 689	Continued From page 6	F 689		

reviewed and did not have any fall interventions listed for R1. The Group sheet, undated, was reviewed and also did not contain any fall prevention interventions for R1.

The facility Care Plan Policy last revised 10/16/20, directs the Baseline Care Plan provide effective person-centered care instructions that meet professional standards of care. The policy directs the Comprehensive Care Plan contain measurable objectives and time frames to meet the resident's medical needs.

The facility Falls Prevention & Management Policy last revised 04/06/21, directed staff to identify fall risk factors and implement interventions before a fall occurs. The policy further directs to take a proactive approach before a fall occurs, that on admission to review the discharge summary from the transferring agency; care plan appropriate fall prevention interventions; and communicate fall risks and interventions to prevent a fall per the 24-Hour Report, care plan and Kardex.

Electronically delivered
September 23, 2021

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

Re: State Nursing Home Licensing Orders
Event ID: DFL711

Dear Administrator:

The above facility was surveyed on August 30, 2021 through August 31, 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 64900
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
	00697	A. BUILDING: _____ B. WING _____	C 08/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

(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
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 08/30/20 and 08/31/21, 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: H5593031C (MN75931) with a licensing order issued at 0830. 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 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.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	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 observation, interview and document review, the facility failed to comprehensively assess and develop care planned interventions to prevent falls upon admission for 1 of 3 residents (R1) reviewed who were at risk of falling upon admission. R1 was actually harmed when the facility had not placed fall prevention interventions, R1 fell and fractured her ribs, leg, and wrist, was hospitalized, required surgery, and had declined in ability to perform activities of daily living (ADL's).	2 830	Corrected	10/4/21

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2 830	Continued From page 3 Findings Include: R1's entry tracking Minimum Data Set (MDS) indicated R1 had been admitted on 8/10/21. R1 had a PPS (prospective payment system) MDS (for Medicare payment purposes) dated 8/16/21. The PPS assessment indicated R1 was cognitively intact with diagnoses including diabetes and right upper arm fracture. R1 required extensive assistance from one staff for bed mobility, transfers, dressing, toileting and hygiene. R1 could feed self with set up/supervision and ambulated in the corridor with one assist. The MDS indicated R1 had falls prior to admission, including a fall with a fracture. R1 had a discharge to hospital MDS completed on 8/17/21, which indicated she had a fall with a fracture since admission to the nursing facility. R1 had an entry (return from hospital) MDS on 8/27/21. R1's admission Minimum Data Set (MDS) dated 8/30/21, included, cognitively intact with diagnosis of right upper arm fracture. In addition, R1 now had a left femur (upper leg bone) fracture, a left wrist fracture and multiple rib fractures. R1 now required total staff assistance for all activities of daily living (ADL's), was not steady to stand up or transfer, had functional limitations of one lower extremity and used a wheel chair for mobility. R1's Diagnosis Report indicated the left femur fracture, left wrist fracture and rib fractures were all acquired during the nursing home stay with a date added to list of 8/27/21. R1's Pre-Admission Data Collection Form dated 8/10/21, identified she was at risk for falls, and had previous falls with right arm fracture.	2 830		

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2 830	Continued From page 4 R1's Falls Tool dated 8/10/21, identified R1 was at, "medium" risk for falls. Risk factors included: falls within last 3 months, medications, psychological, cognitive status, impaired balance, pain, and poor memory. R1's, "Action Plan," included: refer to therapy and refer to provider. No other fall prevention interventions had been placed. The assessment was signed on 8/17/21, by a licensed practical nurse (LPN). R1's admitting medications included antihypertensive medications, an antipsychotic medication, a muscle relaxer, a sleep aide and an opioid pain reliever- all of which had the potential to cause falls. No referral to the facility's pharmacist had been made. R1's initial care plan dated 8/10/21, addressed, "The resident has an ADL self care performance deficit R/T [related to] decline in functional mobility R/T fx [fracture of the upper end of right humerus [upper arm], diabetes, ckd [chronic kidney disease] stage 3, htn [hypertension] and frequent falls." However the care plan failed to address R1's risk of falling, previous falls or to direct staff on any fall prevention interventions. R1's Physical Therapy (PT) Plan of Care dated 08/11/21, indicated R1 has generalized weakness and difficulty in walking. The plan of care indicated therapy was necessary to improve strength and balance. The PT care plan did not direct staff on how to assist R1 in preventing falls. R1's progress note dated 8/17/21, at 5:50 a.m. included, "Resident was found on the floor laying on her left side with head leaning towards the wall with blood spot on her head." The note indicated staff had helped R1 back to bed, had dressed a new skin tear on her left elbow, had been given cold compress for her head and pain medication.	2 830		

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2 830	Continued From page 5 The responsible party, director of nursing (DON) and administrator had been notified and would give report to incoming nurse. R1's progress note dated 8/17/21, at 6:47 a.m. indicated R1 was being sent to the emergency room due to pain and swelling. R1's Fall Scene Huddle Worksheet dated 08/17/21, identified R1 had an unwitnessed fall at 5:22 a.m. R1 was found on the floor, next to her bed. R1 indicated she was ambulating, lost strength and balance, slipped, and fell. R1 was complaining of right hip pain and was transported to the hospital. This fall report did not identify any fall prevention interventions that were in place at the time of the fall. R1's facility submitted incident form dated 8/17/21, included, "CNA's [certified nursing assistant] at the nurses station and heard a loud noise. Went down the hall and observed lying on the floor in her room on her left side. Resident admitted to G.S.S St. James from one of the local hospitals on 08/10/2021 with diagnosis of History of Falling, Unspecified Fracture of the Upper end of the Right Humerus, Subsequent encounter for Fracture with routine healing, Primary Essential Hypertension following hospital stay. Resident was sent to Mayo Clinic St. James hospital for further evaluation. Hospital was later called to follow up on resident's status and Director of Nursing was informed resident was diagnosed with fracture of the left wrist, femur fracture, and 3 right rib fracture. Per report obtained, left wrist and femur fracture appears to be new. Right rib fractures questionable as they could be due to previous fall on August 4th. Resident is alert and oriented to person, place and time. Call light audit report completed, and no indication of resident using her call light to request for assistance.	2 830		

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2 830	Continued From page 6 Investigation underway." R1's follow up report dated 8/20/21, indicated R1's care plan had been followed at the time of the fall and facility policy was followed. No actions had been taken to prevent reoccurrence other than, "frequent checks put into place." A risk for falls care plan was added on 8/25/21, after R1 had fallen in the facility and fractured her ribs, wrist and femur. During an observation on 8/30/21, at 12:25 p.m. R1 had a right shoulder immobilize in place and a plaster cast on left arm from elbow to palm. When interviewed on 8/30/21, at 12:30 p.m. R1 stated she was in constant pain and did not want to move. She had fallen at home and fractured her right arm. R1 stated now she fell at the facility and fractured her left arm and cannot do, "anything for myself." R1 stated she needs help for everything including with eating, and cannot get out of bed to toilet and has to rely on a bedpan. Stating it was upsetting to be totally dependent upon the staff now. When interviewed on 8/31/21, at 9:05 a.m. the director of nursing (DON) stated, the case manager was responsible for initiating care planned interventions upon admission. The case manager was no longer with the facility and the DON was now responsible. The DON stated he was not aware R1 had fallen prior to admission, but knew she was afraid of falling. The DON stated R1 did not have a care plan to address falls upon admission because R1 was alert, used the call light for assistance and had not been getting up by herself.	2 830		

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2 830	Continued From page 7	2 830		

When interviewed on 8/31/21, at 9:31 a.m. nursing assistant (NA)-A and NA-B stated they learn of fall prevention interventions from the Section 2 Nurse's Station Communication Book. They were not aware of any fall interventions for R1 prior to her fall and hospitalization.

The Section 2 Nurse's Station Communication Book failed to identify any fall prevention interventions for R1 prior to hospitalization, and did not contain any as of 8/31/21.

When interviewed on 8/31/21, at 9:50 a.m. LPN-A stated he was unaware of any fall prevention interventions for R1 prior to hospitalization. LPN-A was unaware of any new fall prevention interventions in place since her return from the hospital either.

When interviewed on 8/31/21, at 9:59 a.m. the DON stated the NAs receive a report from the charge nurse on any changes to care plan and the NAs have access to a Kardex for tasks and interventions and use a Group sheet for communication. R1's Kardex dated 8/31/21, was reviewed and did not have any fall interventions listed for R1. The Group sheet, undated, was reviewed and also did not contain any fall prevention interventions for R1.

The facility Care Plan Policy last revised 10/16/20, directs the Baseline Care Plan provide effective person-centered care instructions that meet professional standards of care. The policy directs the Comprehensive Care Plan contain measurable objectives and time frames to meet the resident's medical needs.

The facility Falls Prevention & Management Policy last revised 04/06/21, directed staff to

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2 830	Continued From page 8 identify fall risk factors and implement interventions before a fall occurs. The policy further directs to take a proactive approach before a fall occurs, that on admission to review the discharge summary from the transferring agency; care plan appropriate fall prevention interventions; and communicate fall risks and interventions to prevent a fall per the 24-Hour Report, care plan and Kardex. SUGGESTED METHOD OF CORRECTION: The director of nursing 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		