Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 14, 2023

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

RE: CCN: 245593
Cycle Start Date: February 27, 2023

Dear Administrator:

On March 21, 2023, we notified you a remedy was imposed. On April 12, 2023 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 April 7, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 5, 2023 be discontinued as of April 7, 2023. (42 CFR 488.417 (b))

However, as we notified you in our letter of March 13, 2023, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 8, 2023. This does not apply to or affect any previously imposed NATCEP loss.

Your request for a continuing waiver involving the deficiency(ies) cited under F727 at the time of the February 27, 2023 abbreviated survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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April 14, 2023

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

Re: Reinspection Results
Event ID: Y3GT12 and O6EK12

Dear Administrator:

On April 12, 2023 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 surveys completed on February 27, 2023 and March 8, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
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
March 13, 2023

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

RE: CCN: 245593
Cycle Start Date: February 27, 2023

Dear Administrator:

On February 27, 2023, 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 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"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, 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 May 27, 2023 (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 August 27, 2023 (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, Compliance Analyst
Federal Enforcement | Health Regulation Division
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 02/27/2023

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 2/24/2023 and 2/27/2023, a standard abbreviated survey was conducted at your facility. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H55938758C (MN00091210) with deficiencies issued at F684 and F727. 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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 684	Plan of Correction Draft	4/7/23

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

Electronically Signed | 03/23/2023

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 684	Continued From page 1 review, the facility failed to comprehensively assess, develop appropriate interventions, and adequately monitor efficacy of interventions of bruises for 1 of 3 residents (R)1 reviewed for non-pressure related skin conditions. Findings include: R1's hospital admission summary dated 1/17/23, included diagnosis of rhabdomyolosis (damaged muscle cells that release harmful substances into the blood, causing kidney failure and other medical complications) R1 was admitted to the intensive care unit after sustaining a fall at home and lied on the floor for approximately 16-20 hours. R1's hospital discharge summary dated 1/25/23 included R1's diagnosis of rhabdomyolysis. R1's face sheet dated 1/25/23, indicated R1 was admitted to the facility on 1/25/23, however, the diagnosis of rhabdomyolysis was not included. R1's admitting Minimum Data Set (MDS) dated 1/28/23, identified R1 had moderate cognitive impairment. R1 required extensive assistance with dressing and toileting. R1's Nursing Admit Re-Admit Data Collection (NARA) skin assessment dated 1/25/23, at 3:58 p.m. did not identify the presence of bruising. R1's skin care plan dated 1/28/23, identified R1 had actual impairment to skin integrity related to left arm skin tear and an abrasion on his right foot. The care plan directed to monitor location, size and treatment of skin injury and report abnormalities or failure to heal. R1's care plan did not include or identify R1's diagnosis of	F 684	2567 Received Date: Center: Good Samaritan Society St. James Team Leaders: Administrator, DNS, Quality Nurse & IP Nurse 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. Deficiency tag F684 Quality of Care CFR (s): 483.25 1) What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident R1 comprehensive head to toe reassessments was completed and skin concerns documented, care planned, and provider notified. Also, corrective action was implemented on the nurse involved including performance improvement and education on new resident assessments per organization policy. 2) How you will identify other residents	

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F 684	Continued From page 2 rhabdomyolysis and/or presence of bruising. R1's Daily Skilled Note dated 1/26/23, indicated there was a skin tear [with bruising] to the left elbow. R1's Daily Skilled Notes dated 1/27/23 and 1/28/23 indicated R1 did not have skin issues or concerns. No Daily Skilled Note was found for 1/29/23. R1's Daily Skilled notes between 1/30/23 to 2/2/23, indicated R1 did not have skin issues or concerns. R1's progress note dated 2/3/23 at 7:31 a.m., included R1 had purple bruising to his whole chest area and his belly button. Progress note dated 1:11 p.m. indicated the physician was notified of the bruising who indicated the bruising was not from medication. R1's Daily Skilled Note dated 2/4/23, indicated R1 was being observed for skin issues or concerns and documentation indicated bruising to whole chest, abdomen, right elbow, and back of right arm. The facility, Change in Condition Evaluation, dated 2/5/23, at 2:11 p.m. indicated R1 was experiencing functional decline, shortness of breath, weakness/steadiness, increased confusion, and nurse practitioner (NP)-A was notified. NP-A ordered a portable x-ray (PPX) and laboratory test. However, NP-A was notified that a PPX was not available until 2/6/23. NP-A directed R1 to be transferred to the emergency department.	F 684	having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents in the facility have the potential to be affected by the same deficient practice. DNS reviewed all new admission/readmissions from the last 90-days to verify Nursing Admit Re-Admit Data Collection assessment, and skin observations are completed and accurate in identifying skin alterations. 3) What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. To ensure systemic changes are sustained, all nursing staff will be educated on the admission documentation policy and Nursing Admit Re-Admit assessment UDA in pointclickcare. 4) How will 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. Random audits for new admissions will be conducted by the DNS/designee two times per week for three months, then once weekly for two months to ensure complete head to toe assessments including skin observations are accurately documented. Audit results will be brought to the monthly QAPI meeting with appropriate follow up indicated to ensure solutions are sustained. 5) The date for correction and the title of the person responsible for correction of deficiency. Correction date will be March	

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F 684	Continued From page 3 Pictures provided to the state agency on 2/27/23. The pictures of R1's chest and abdomen identified extensive bruising in various stages of healing. The pictures showed healing bruises that was yellow/brown, greenish bruising indicative of lessor healing than yellow/brown, and dark blue/purple indicative of newly formed bruising. The bruising was observed at nipple line, across the entire chest, and extended up the chest towards the clavicle (collar bone), into the right axilla (arm pit), and midline to the navel. R1 had bruising to his left elbow area which extended towards the right axilla. During an interview on 2/27/23, at 7:22 a.m. family member (FM)-A indicated when R1 fell at home he landed face down on his chest and laid on the floor for approximately 16-20 hours. FM-A indicated upon admission to the facility R1 had areas of redness to his upper chest. She had not been notified of the bruising until 2/5/23. . During an interview on 2/24/23, at 12:45 p.m. LPN-A stated when she pulled up R1's shirt on 2/3/23, at 7:31 a.m. to administer insulin, she observed a bruise around R1's navel. Upon pulling up the shirt, LPN-A observed large, dark purple bruising on R1's upper chest. The bruising had not been identified before that time. During an interview on 2/27/23, at 12:42 p.m. NP-A stated since there was yellow bruising on R1's chest and abdomen, the bruises would have been present upon R1's admission. Further, NP-A was not informed R1 had chest/abdominal bruising on admission. NP-A stated if she would have known of bruising, she would have ordered	F 684	22,2023 and Director of Nursing Services or designee will be responsible.	

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F 684	Continued From page 4 the bruises be assessed everyday and to be notified of any changes. During an interview on 2/27/23, at 1:23 p.m. RN-A stated she was part of the team that performed R1's admission to the facility. RN-A stated she did not complete the physical exam, nor did she know R1 had chest bruising. During an interview on 2/27/23, at 2:10 p.m. director of nursing (DON) stated she was not informed of R1's chest bruising until the interdisciplinary team (IDT) met during the morning on 2/5/23. IDT discussed what/how it happened that R1's bruising was not identified on admission. A determination was not identified. The facility policy, Admission Documentation - Rehab/Skilled, dated 04/25/2022, directed staff to verify initial identifying data previously obtained which included physical examination and discharge summary from other institutions. R1's medical record indicated the hospital admission and discharge summary was not included in the facility's admission documentation. The facility policy, Skin Assessment Pressure Ulcer Prevention and Documentation Requirements - Rehab/Skilled, dated 04/26/2022, educated a bruise or contusion is an injury when the skin is not broken, and discoloration was characteristic of the injury. The bruise should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation, and R1's care plan. No documentation of R1's chest bruising was found in R1's admission assessment, Daily Skilled Note, or Care Plan until 2/4/23.	F 684		

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F 684	Continued From page 5 The facility policy, Pressure Ulcer/Wound Care Resource Packet - Rehab/Skilled, dated 05/26/2022, directed Section M of the Minimum Data Set (MDS) was to be used to document wounds related to skin injury. No initial assessment of R1's chest or abdominal bruising was found. The facility policy, Skin Tear Treatment And Prevention - Rehab/Skilled, dated 04/26/2022, directed staff to document size of skin tear and shape, and document treatment. Documentation to be captured in PCC, under Skin Observation. Documentation to include issues such as ecchymosis (bruised skin). No documentation of R1's chest or abdominal bruising was found until 2/4/23.	F 684		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure registered nurse (RN)	F 727	F727 RN 8 Hrs. /7days/Wk., Full Time DON	4/7/23

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F 727	Continued From page 6	F 727		

coverage for eight consecutive hours per day, seven days per week. This had the potential to affect all 35 residents in the facility.

Findings include:

During an interview on 2/27/23, at 10:35 a.m. interim director of nursing (IDON) registered nurse (RN) stated her working schedule was Monday through Friday from 8:00 a.m. to 4:00 p.m. and was not required to work on weekends. IDON explained RN-A was scheduled to work Monday through Friday from 8-4:30 p.m. but also worked some weekends. The facility was not currently utilizing a staffing agency for RN coverage. The only RN's currently working at the facility was herself and RN-A. IDON stated there was RN coverage eight hours per day on Monday through Friday but not on all weekends. Staffing schedules dated 1/1/23 through 2/26/23, were reviewed with the IDON, she reported the following weekends did not have RN coverage:

1/01/23	no RN scheduled
1/07/23 - 1/08/23	no RN scheduled
1/14/23 - 1/15/23	no RN scheduled
1/21/23 - 1/22/23	no RN scheduled
2/04/23 - 2/05/23	no RN scheduled
2/18/23 - 2/19/23	no RN scheduled

During an interview on 2/27/23, at 11:00 a.m. facility administrator (ADM) stated the facility was not in compliance with RN coverage on all weekends. ADM scheduled RN-A to work some weekends but some weekends there was no RN coverage. Licensed practical nurses were scheduled on the weekends when there was no RN scheduled. ADM explained the facility has been attempting to recruit RN's and was in

1. Daily and weekly recruitment efforts continue to attract and retain registered nurses. Facility Administrator has weekly calls with a human resources talent advisor to discuss new recruitment efforts, wage analysis, and advertisement.
2. Facility will continue to request registered nurses through staffing agencies.
3. The facility will utilize the DON and MDS Coordinator as backup RN coverage.
4. The facility will apply for the RN waiver through the appropriate agency.
5. DNS/ designee will continue to monitor RN coverage hours in the building.

RN Waiver

To: Elizabeth Silkey
From: Josh Domeier
Date: 3/14/2023

Re:Request for a RN Waiver in a Minnesota SNF CCN# 245593

Good Samaritan Society St. James, located at 1000 2nd Street South St. James, MN 56081, hereby requests a one-year waiver to ¿483.3S(b)-the SNF requirement to have a registered nurse for at least 8 consecutive hours a day, 7 days a week at the facility. The facility understands it will need to request a renewal of the waiver after one year if adequate RN coverages remains an issue. This waiver request is consistent with the waiver requirements detailed at

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F 727	Continued From page 7 constant contact with staffing agencies however all efforts have not been successful for RN coverage. The facility policy, Nursing Services Staff - Rehabilitation/Skilled Care & Long Term Care, dated 10/21/2022, directed RN services will be used for at least eight consecutive hours a day, seven days a week (except when waived by state regulations).	F 727	¿483.35(f)(l). To support the granting of a waiver, the facility provides the following information: 1. Good Samaritan Society St. James, it is located in a rural area in Southern Minnesota with a and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area 2. Good Samaritan Society St. James, has made, and will continue to make, the following diligent efforts to hire Registered Nurses: a. Offering wages at the community prevailing rate for nursing facilities (and above) b. Advertising open positions in the following manner to include posting on (ex: social media, local paper etc. MUST be from multiple resources). c. Synopsis of what you have posted on those sites 3. Good Samaritan Society St. James will continue to have one full-time registered nurse who is regularly on duty at the facility 35-40 hours a week (this nurse may or may not be the DON, and may perform some DON and some clinical duties if the facility so desires); and the facility either- a. Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hour period or;	

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	245593	A. BUILDING _____ B. WING _____	C 02/27/2023

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F 727	Continued From page 8	F 727	b. Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty; 4. Good Samaritan Society St. James believes a waiver of the requirement will not endanger the health or safety of individuals staying in the facility (a reference to the Medical Director agreeing to this statement and waiver request or an attached supporting letter from the Medical Director is also suggested); 5. Good Samaritan Society St. James agrees to having a registered nurse or a physician respond immediately to telephone calls from the facility. 6. If a waiver is granted the facility agrees to provide a notice of the waiver to the Office of Ombudsman for Long-Term Care, MOH Office of Health Facility Complaints, and the Office of Ombudsman for Mental Health and Developmental Disabilities 7. If a waiver is granted the facility agrees to provide a notice of the waiver to residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and resident representatives. The facility to date has utilized multiple platforms to recruit registered nurses	

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F 727	Continued From page 9	F 727	including newspapers in St. James, Sleepy Eye, and Madelia Minnesota. Attached is a spreadsheet showing how long the active requisitions have been posted across various online job boards and proof of advertisements showing duration of posts has been sent to the MDH supervisor.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 13, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: Y3GT11

Dear Administrator:

The above facility was surveyed on February 24, 2023 through February 27, 2023 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
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 _____	02/27/2023

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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, develop appropriate interventions, and adequately monitor efficacy of interventions of bruises for 1 of 3 residents (R)1 reviewed for non-pressure related skin conditions. Findings include: R1's hospital admission summary dated 1/17/23, included diagnosis of rhabdomyolosis (damaged muscle cells that release harmful substances into the blood, causing kidney failure and other medical complications) R1 was admitted to the intensive care unit after sustaining a fall at home and lied on the floor for approximately 16-20 hours. R1's hospital discharge summary dated 1/25/23 included R1's diagnosis of rhabdomyolysis. R1's face sheet dated 1/25/23, indicated R1 was	2 830	Corrected	4/7/23

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

Electronically Signed | 03/23/23

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2 830	Continued From page 1 admitted to the facility on 1/25/23, however, the diagnosis of rhabdomyolysis was not included. R1's admitting Minimum Data Set (MDS) dated 1/28/23, identified R1 had moderate cognitive impairment. R1 required extensive assistance with dressing and toileting. R1's Nursing Admit Re-Admit Data Collection (NARA) skin assessment dated 1/25/23, at 3:58 p.m. did not identify the presence of bruising. R1's skin care plan dated 1/28/23, identified R1 had actual impairment to skin integrity related to left arm skin tear and an abrasion on his right foot. The care plan directed to monitor location, size and treatment of skin injury and report abnormalities or failure to heal. R1's care plan did not include or identify R1's diagnosis of rhabdomyolysis and/or presence of bruising. R1's Daily Skilled Note dated 1/26/23, indicated there was a skin tear [with bruising] to the left elbow. R1's Daily Skilled Notes dated 1/27/23 and 1/28/23 indicated R1 did not have skin issues or concerns. No Daily Skilled Note was found for 1/29/23. R1's Daily Skilled notes between 1/30/23 to 2/2/23, indicated R1 did not have skin issues or concerns. R1's progress note dated 2/3/23 at 7:31 a.m., included R1 had purple bruising to his whole chest area and his belly button. Progress note dated 1:11 p.m. indicated the physician was notified of the bruising who indicated the bruising	2 830		

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2 830	Continued From page 2 was not from medication. R1's Daily Skilled Note dated 2/4/23, indicated R1 was being observed for skin issues or concerns and documentation indicated bruising to whole chest, abdomen, right elbow, and back of right arm. The facility, Change in Condition Evaluation, dated 2/5/23, at 2:11 p.m. indicated R1 was experiencing functional decline, shortness of breath, weakness/steadiness, increased confusion, and nurse practitioner (NP)-A was notified. NP-A ordered a portable x-ray (PPX) and laboratory test. However, NP-A was notified that a PPX was not available until 2/6/23. NP-A directed R1 to be transferred to the emergency department. Pictures provided to the state agency on 2/27/23. The pictures of R1's chest and abdomen identified extensive bruising in various stages of healing. The pictures showed healing bruises that was yellow/brown, greenish bruising indicative of lessor healing than yellow/brown, and dark blue/purple indicative of newly formed bruising. The bruising was observed at nipple line, across the entire chest, and extended up the chest towards the clavicle (collar bone), into the right axilla (arm pit), and midline to the navel. R1 had bruising to his left elbow area which extended towards the right axilla. During an interview on 2/27/23, at 7:22 a.m. family member (FM)-A indicated when R1 fell at home he landed face down on his chest and laid on the floor for approximately 16-20 hours. FM-A indicated upon admission to the facility R1 had areas of redness to his upper chest. She had not been notified of the bruising until 2/5/23.	2 830		

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2 830	Continued From page 3 . During an interview on 2/24/23, at 12:45 p.m. LPN-A stated when she pulled up R1's shirt on 2/3/23, at 7:31 a.m. to administer insulin, she observed a bruise around R1's navel. Upon pulling up the shirt, LPN-A observed large, dark purple bruising on R1's upper chest. The bruising had not been identified before that time. During an interview on 2/27/23, at 12:42 p.m. NP-A stated since there was yellow bruising on R1's chest and abdomen, the bruises would have been present upon R1's admission. Further, NP-A was not informed R1 had chest/abdominal bruising on admission. NP-A stated if she would have known of bruising, she would have ordered the bruises be assessed everyday and to be notified of any changes. During an interview on 2/27/23, at 1:23 p.m. RN-A stated she was part of the team that performed R1's admission to the facility. RN-A stated she did not complete the physical exam, nor did she know R1 had chest bruising. During an interview on 2/27/23, at 2:10 p.m. director of nursing (DON) stated she was not informed of R1's chest bruising until the interdisciplinary team (IDT) met during the morning on 2/5/23. IDT discussed what/how it happened that R1's bruising was not identified on admission. A determination was not identified. The facility policy, Admission Documentation - Rehab/Skilled, dated 04/25/2022, directed staff to verify initial identifying data previously obtained which included physical examination and discharge summary from other institutions. R1's medical record indicated the hospital admission	2 830		

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2 830	Continued From page 4 and discharge summary was not included in the facility's admission documentation. The facility policy, Skin Assessment Pressure Ulcer Prevention and Documentation Requirements - Rehab/Skilled, dated 04/26/2022, educated a bruise or contusion is an injury when the skin is not broken, and discoloration was characteristic of the injury. The bruise should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation, and R1's care plan. No documentation of R1's chest bruising was found in R1's admission assessment, Daily Skilled Note, or Care Plan until 2/4/23. The facility policy, Pressure Ulcer/Wound Care Resource Packet - Rehab/Skilled, dated 05/26/2022, directed Section M of the Minimum Data Set (MDS) was to be used to document wounds related to skin injury. No initial assessment of R1's chest or abdominal bruising was found. The facility policy, Skin Tear Treatment And Prevention - Rehab/Skilled, dated 04/26/2022, directed staff to document size of skin tear and shape, and document treatment. Documentation to be captured in PCC, under Skin Observation. Documentation to include issues such as ecchymosis (bruised skin). No documentation of R1's chest or abdominal bruising was found until 2/4/23. Suggested Method of Correction: The Directior of Nursing or designee could review policies and procedures, train staff, and implement measures to assure admission skin assessments, ongoing skin monitoring, and care plans are comprehensive based on the comprehensive	2 830		

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2 830	Continued From page 5 assessment. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		