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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DW8O

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00697

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245593**
2.STATE VENDOR OR MEDICAID NO.
(L2) **713343000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - ST JAMES**
(L4) **1000 SOUTH SECOND STREET**
(L5) **ST JAMES, MN** (L6) **56081**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/14/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **51** (L18)
13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
X Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Holly Kranz, Unit Supervisor 01/04/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 01/04/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245593

January 4, 2019

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

Dear Administrator:

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

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

Effective December 7, 2018 the above facility is certified for:

51 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
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
January 4, 2019

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

RE: Project Number S5593030

Dear Administrator:

On November 19, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on November 8, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 14, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 2, 2019 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 8, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 7, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 8, 2018, effective December 7, 2018 and therefore remedies outlined in our letter to you dated November 19, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DW8O

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00697

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2.STATE VENDOR OR MEDICAID NO.
(L2) **713343000**

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(L3) **GOOD SAMARITAN SOCIETY - ST JAMES**
(L4) **1000 SOUTH SECOND STREET**
(L5) **ST JAMES, MN** (L6) **56081**

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1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/08/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NE II 12/19/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 12/26/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
01/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 19, 2018

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

RE: Project Number S5593030

Dear Administrator:

On November 8, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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. In addition, at the time of the November 8, 2018 standard survey the Minnesota Department of Health, completed an investigation of complaint number H5593022 that was found to be unsubstantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is December 18, 2018.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (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 a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

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 February 8, 2019 (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 May 8, 2019 (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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
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
	245593	A. BUILDING _____ B. WING _____	11/08/2018

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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on November 5 through November 8, 2018 during a recertification survey. The facility was in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 11/5/18 through 11/8/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint #H5593022 was completed and was found to be unsubstantiated.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and	F 558		12/7/18

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

Electronically Signed | 11/28/2018

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.

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 _____	11/08/2018

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

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F 558	Continued From page 1 preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop interventions to accommodate needs and promote independence with eating for 1 of 1 resident (R21) who had difficulty reaching the table for meals in the dining room. Findings include: R21's quarterly Minimum Data Set (MDS) assessment dated 9/27/18, indicated R21's cognition was severely impaired, and that the resident required supervision with eating. R21's care plan printed 11/8/18, indicated the resident had an ADL (activities of daily living) self care performance deficit related to status post CVA (cerebrovascular accident/stroke) with right sided paralysis and weakness. The care plan further identified R21 was able to feed herself. On 11/6/18, at 12:08 p.m. R21 was observed seated in wheelchair (w/c) at the dining room table with 3 peers and one staff who was assisting another resident. The tabletop was at the level of R21's chest. R21 had to reach up with her left arm/hand in order to scoop the food off of her plate and to obtain her fluids; the resident was also leaning into the right armrest of her w/c. R21 consumed less than 25% of her meal. On 11/7/18, at 7:22 a.m. R21 was observed seated in w/c in the dining room with peer eating	F 558	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 insubstantial compliance with federal requirements of participation, this response and plan of correction constitutes the centers allegation of compliance in accordance with section 7305 of the State Operations Manual Resident #21 was referred to therapy on 11-7-18 for evaluation of table positioning. To identify other residents who potentially may be affected, therapy will screen residents who utilize wheelchairs during meal times. To ensure systematic changes are made, staff will be educated on observing residents for wheelchair positioning and table height while eating, and make referrals to therapy as needed. To monitor performance and solution effectiveness, random audits will be completed by the DNS or designee twice weekly for four weeks, then weekly for two months with results forwarded to the QAPI committee for review.	

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 _____	11/08/2018

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 558	Continued From page 2 her breakfast meal. R21 had a bowl of Rice Krispies with milk and 4 small glasses of thickened liquids. The tabletop remained at the level of R21's chest; the resident had to reach up with her left arm/hand in order to scoop the cereal out of the bowl and could not see into the bowl to see how much was left. At 7:51 a.m. surveyor asked the director of nursing (DON) to observe R21's positioning at the dining room table. The resident was observed picking up her bowl of cereal and tilting it towards her so she could see into it to see what was left. DON verified the table was too high for the resident and stated the table could be lowered. DON also noted R21 was leaning to the right side and that could contribute as well. DON further stated she would have occupational therapy look at R21's w/c cushion for better positioning.	F 558		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to accurately code the Minimum Data Set for 1 of 1 residents (R18) reviewed for medications. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Resident Facility Assessment Instrument (RAI) 3.0 User's Manual dated 10/2018, identified "Section N : Adverse consequences related to medications may result	F 641	Resident #18 MDS coding was corrected on the MDS and submitted to CMS on 11-19-18, and the care plan was updated to reflect the diuretic use. The Case Manager was reeducated by the facilities regional MDS consultant on Section N coding on 11-21-18. To identify other residents who may be affected, those who are receiving diuretics have been reviewed and updated as appropriate. To monitor performance and solution effectiveness, random audits of diuretic	11/21/18

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 _____	11/08/2018

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 641	Continued From page 3 in serious harm or death, emergency department visits, and rehospitalizations and affect the resident's health, safety, and quality of life. "Drug regimen review is intended to improve resident safety by identifying and addressing potential and actual clinically significant medication issues at the time of a resident's admission (start of SNF PPS stay) and throughout the resident's stay (through Part A PPS discharge)." Further, the manual provided several coding instructions directing staff to select any current diagnosis for each medication identified. R18's quarterly MDS dated 9/19/18, identified R18 had severe cognitive impairment. The admission MDS dated 6/29/18 revealed that the resident received a diuretic medication. The quarterly MDS dated 9/19/18 indicated R18 no longer received a diuretic medication. Document review of the medication administration record indicated R18 had received Lasix 40 milligrams one time a day for hypertensive chronic kidney disease since admission on 6/22/18. 11/07/18 09:38 AM during a interview with the registered nurse, (RN- A), she confirmed that the 9/19/18 MDS assessment failed to address daily diuretic use, and furthermore, revealed that the use of the diuretic was not addressed on the resident plan of care. During a interview on 11/07/18 at 9:42 a.m., with (RN-B) responsible for R18, she confirmed that she neglected to mark the diuretic use on the MDS, and that the resulting care plan did not address a plan for its use. RN-B confirmed that she would make the correction, and add it to the	F 641	coding of section N of the MDS and care planning of diuretics will be completed by the DNS or designee weekly for one month then monthly for two months with results forwarded to the QAPI committee for review.	

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 _____	11/08/2018

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

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F 641	Continued From page 4 care plan. A facility Assessment (MDS) policy was requested and the director of nursing DON indicated that the RAI manual was used.	F 641		
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 review, the facility failed to provide proper wheelchair positioning for 1 of 1 resident (R21) who was reviewed for positioning needs. Findings include: On 11/5/18, at 6:06 p.m. R21 was observed seated in wheelchair (w/c) in the dining room receiving assistance with the supper meal. Resident was leaning into the right side armrest of the w/c. At 6:39 p.m., a nursing assistant (NA) was observed propelling R21 to her room as the resident had finished eating. At 6:44 p.m., R21 was observed seated in w/c in her room; the resident continued to lean into the right side armrest of the w/c. A small pillow was observed on the right side of the w/c to aid with positioning though the pillow had slid forward and was not	F 684	Resident #21 was referred to therapy for a wheelchair positioning evaluation on 11-7-18. To identify other residents who potentially may be affected, all residents utilizing a wheelchair will be screened by therapy for proper positioning. To ensure systemic changes are made, staff will be educated on observation and communication when residents are in need of evaluation for wheelchair positioning. To monitor performance and solution effectiveness, random wheelchair position audits will be completed by the DNS or designee once weekly for one month, then monthly for two months with results forwarded to the QAPI committee for review.	12/7/18

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F 684	Continued From page 5	F 684		

keeping the resident from leaning to the right.

R21's quarterly Minimum Data Set (MDS) assessment dated 9/27/18, indicated R21's cognition was severely impaired, and that the resident required total dependence with transfers, and extensive assistance with bed mobility, locomotion on/off unit, personal hygiene, toileting, and dressing.

R21's care plan printed 11/8/18, indicated the resident had an ADL (activities of daily living) self care performance deficit related to status post CVA (cerebrovascular accident/stroke) with right sided paralysis and weakness evidenced by needing physical assist with ADL's and bathing.

On 11/6/18, at 10:00 a.m. R21 was observed seated in w/c in the dining room area by herself. The resident was leaning to the right with right shoulder leaning into the arm of the w/c. Surveyor asked the resident if the chair was comfortable for her and she stated, "No it's not". Resident then confirmed with leaning into the right side of the chair it wasn't very comfortable. Surveyor asked the resident if she would be interested in trying to find a chair that was more comfortable and she stated, "Oh, that would be nice". At 10:05 a.m. staff moved R21 into the TV room for an upcoming activity; staff did not reposition the resident who continued to lean into the right armrest of the w/c.

On 11/6/18, at 10:12 a.m. surveyor requested occupational therapy assistant (OTA)-A observe R21's positioning. OTA-A confirmed the resident's positioning was poor and that staff usually had a cushion on the right side to help prop the resident when leaning to the right.

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GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

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F 684	Continued From page 6	F 684		

OTA-A adjusted R21's positioning so that she was seated upright; once the resident was repositioned OTA-A noted that the resident's right knee was pushing into her left knee. OTA-A voiced concern with this also and stated a little higher cushion with an abductor could help with that though it would be up to the occupational therapist to evaluate. OTA-A stated it was her understanding that when the NA's see R21's positioning is off they are to reposition her as needed.

On 11/6/18, at 12:08 p.m. R21 was observed seated in wheelchair (w/c) at the dining room table with 3 peers and one staff who was assisting another resident. The tabletop was at the level of R21's chest. R21 had to reach up with her left arm/hand in order to scoop the food off of her plate and to obtain her fluids; the resident was also leaning into the right armrest of her w/c. R21 consumed less than 25% of her meal.

On 11/7/18, at 7:22 a.m. R21 was observed seated in w/c in the dining room with peer eating her breakfast meal. The resident was leaning into the right side of her w/c with no cushion supporting her right side and knees are pushed together. R21 had a bowl of Rice Krispies with milk and 4 small glasses of thickened liquids. The tabletop was at the level of R21's chest; the resident had to reach up with her left arm/hand in order to scoop the cereal out of the bowl and could not see into the bowl to see how much was left. At 7:51 a.m. surveyor asked the director of nursing (DON) to observe R21's positioning at the dining room table. The resident was observed picking up her bowl of cereal and tilting it towards her so she could see into it to see what was left.

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F 684	Continued From page 7 DON verified the table was too high for the resident and stated the table could be lowered. DON also noted R21 was leaning to the right side and confirmed that could also contribute to difficulty reaching up to the table.. DON stated she would have occupational therapy look at R21's w/c cushion for better positioning. When interviewed on 11/8/18, at 10:55 a.m. occupational therapist registered (OTR)-A confirmed R21 had not been assessed recently related to w/c positioning. OTR-A stated the resident liked to pull herself along the railing in the hallways with her left hand and that could shift her to the right side. OTR-A stated they could try a lateral support on the right side of the w/c to help support the resident although she might not keep it in. OTA-A approached R21 who was in the hallway and advised the resident that they were going to look at altering her w/c to make it more safe and comfortable for her; R21 indicated that would be nice.	F 684		
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		12/7/18

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F 761	Continued From page 8 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement a system to manage potential diversion of controlled medication with regard to a narcotic emergency kit (ekit), and failed to ensure narcotic medications were secured with a double lock system. This deficient practice had the potential to affect all 22 residents in the facility. During a observation of the storage area in the medication room on 11/5/18 at 5:23 p.m., the narcotic ekit (a small plastic box approximately 5 x 7 inches) was found sitting on a table in the medication room. The narcotic ekit was not secured in a secure locked unit and could be removed from the top of the table. During the observation registered nurse RN-C was present. RN-C indicated this was the normal practice for storage of the narcotic emergency kit. Furthermore RN-C revealed "they tell us we do not have to account for this anymore, it doesn't seem right to me". RN-C opened a notebook revealing a sheet of paper for the narcotic kit, with a post it note attached that stated, "do not need to count every day." This document indicated that	F 761	On 11-6-18 locks were installed on the med room cabinet door as well as the refrigerator, providing a double lock. To prevent further deficient practice and to ensure systemic changes are made, on 11-15-18 staff were educated on the need to double lock controlled narcotic medications, and were also educated on the facility policy and procedure for controlled substances that includes storage, reconciliation and destruction of the medications. Follow up education will be completed by 12-7-18. To monitor performance, the DNS or designee will perform random audits of the narcotic e-kit storage and documentation for compliance two times a week for one month then monthly for two months with results forwarded to the QAPI committee for review.	

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F 761	Continued From page 9 the nursing staff had stopped signing for the narcotic ekit on 10/31/18. On 11/05/18 5:33 p.m., the director of nursing (DON) was interviewed, in the medication room, and agreed the narcotic ekit was not stored in a permanently affixed double lock storage area. The DON indicated when the emergency narcotic kit did not fit into the locked narcotic box in the locked new medication cart she was told by the pharmacy the small plastic strap on the emergency narcotic kit would serve as the second lock. The DON indicated she understood that the narcotics are to be double locked in a permanently affixed storage area, and agreed the current storage of the emergency narcotic kit was an opportunity for diversion. During observation and interview on 11/5/18, at 6:40 p.m. the DON presented the list of items in the narcotic ekit. The DON stated when it could not fit in the medication cart double locked unit, the pharmacy told her that the plastic lock served as a double lock. The DON confirmed, she was able to fit the narcotic ekit into the double locked narcotic storage compartment in the medication cart. The emergency narcotic kit contained the following medications: 2 syringes of morphine 10 milligrams (mg)/ 1 milliliter(ml) 6 tablets of morphine sulfate immediate release (IR) 15 mg 6 suppositories of morphine sulfate 5 mg 6 tablets of oxycodone 5 mg 6 tablets of oxycodone/APAP (Percocet) 5/325 mg 6 tablets of APAP/Codeine (Tylenol #3) 300/30	F 761		

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F 761	Continued From page 10 mg 6 tablets of hydrocodone/APAP (Vicodin) 5/325 mg 2 - 5 mg doses of Morphine concentrate solution (Roxanol) 20 mg/ml 4 tablets of Tramadol 50 mg 2 Ketoriac solution injections of Toradol 30 mg/ml 6 tablets of diphenoxylate/atropine (Lomotil) 2.5 mg 2 vials of lorazepam (Ativan) injectable 2mg/ml 2 vials of diazepam 10 mg/2 ml The facility policy entitled Controlled Substances, revised 5/26 revealed: Purpose: To provide verification and correct count of all controlled substances on hand. To provide safe storage for all controlled substances.	F 761		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society St. James was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/18/2018

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This one-story with partial basement facility was determined to be of Type V(000) construction. The original building was constructed in 1963, with additions in 1965, 1993, 1996 and 2002. The facility was fully sprinklered, and had a complete corridor smoke detection system with monitoring for automatic fire department notification. The facility has a capacity of 51 beds and had a census of 44 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance	K 353		11/12/18

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K 353	Continued From page 2 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain the automatic sprinkler system in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could affect 44 out of 44 residents. Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test	K 353	Olympic Fire was here on November 12th, 2018 and replaced all gauges on the fire sprinkler system. A tag was placed on the gauges with the replacement date and it was added to the facilities fire marshal inspection binder for the maintenance director or designee to monitor replacement date. This will be reviewed and monitored by the QAPI committee for continued compliance. This corrective action was fully completed on November 12th, 2018.	

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K 353	Continued From page 3 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 11/08/2018, it was observed that the gauges on the fire sprinkler system have not been replaced within the required time frame of 5 years. Gauges were installed in October, 2013. This deficient practice was verified by the Facility Maintenence Director.	K 353		

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society St. James was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145, or

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/18/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/08/2018**

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
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This one-story with partial basement facility was determined to be of Type V(000) construction. The original building was constructed in 1963, with additions in 1965, 1993, 1996 and 2002. The facility was fully sprinklered, and had a complete corridor smoke detection system with monitoring for automatic fire department notification. The facility has a capacity of 51 beds and had a census of 44 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection,	K 353		11/12/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/08/2018**

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GOOD SAMARITAN SOCIETY - ST JAMES	**1000 SOUTH SECOND STREET** **ST JAMES, MN 56081**

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K 353	Continued From page 2 Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain the automatic sprinkler system in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could affect 44 out of 44 residents. Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353	Olympic Fire was here on November 12th, 2018 and replaced all gauges on the fire sprinkler system. A tag was placed on the gauges with the replacement date and it was added to the facilities fire marshal inspection binder for the maintenance director or designee to monitor replacement date. This will be reviewed and monitored by the QAPI committee for continued compliance. This corrective action was fully completed on November 12th, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/08/2018**

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

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K 353	Continued From page 3 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 11/08/2018, it was observed that the gauges on the fire sprinkler system have not been replaced within the required time frame of 5 years. Gauges were installed in October, 2013. This deficient practice was verified by the Facility Maintenence Director.	K 353		