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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 0T07

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00085

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245558**

2.STATE VENDOR OR MEDICAID NO.
(L2) **677840200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WINDOM**
(L4) **705 SIXTH STREET**
(L5) **WINDOM, MN** (L6) **56101**

4. TYPE OF ACTION: **7** (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 **03/07/2013** (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 **78** (L18)

13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Sandra Christle, HFE NE II — 03/12/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Program Specialist — 03/12/2013 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
05/01/1991
(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
Posted 03/29/2013 CO. 0T07

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/08/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5558

At the time of the standard survey completed January 22, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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 are required. The facility was given an opportunity to correct before remedies were imposed.

On March 7, 2013, the Minnesota Department of Health and, on February 22, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on January 22, 2013, effective February 26, 2013. Therefore, the remedies outlined in our letter dated January 31, 2013, will not be imposed.
See attached CMS-2567B forms for the results of the March 7, 2013 and February 22, 2013 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5558 March 12, 2013

Ms. Nancy Wepplo, Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, Minnesota 56101

Dear Ms. Wepplo:

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 February 26, 2013 the above facility is certified for:

78 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 12, 2013

Ms. Nancy Wepplo, Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, Minnesota 56101

RE: Project Number S5558021

Dear Ms. Wepplo:

On January 31, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 22, 2013. 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 March 7, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 22, 2013 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 January 22, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 26, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 22, 2013, effective February 26, 2013 and therefore remedies outlined in our letter to you dated January 31, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5558r113.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245558	A. Building B. Wing	3/7/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **02/22/2013**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **02/26/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **02/26/2013**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/31/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **02/19/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **02/26/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/sd	03/12/13	12841	03/07/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/17/2013			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245558	A. Building / B. Wing: 01 - MAIN BUILDING 01	2/22/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0048	Correction Completed 02/15/2013	ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 02/19/2013	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/sd	03/12/13	22373	02/22/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/22/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0T07

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00085

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245558**

2.STATE VENDOR OR MEDICAID NO.
(L2) **677840200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WINDOM**
(L4) **705 SIXTH STREET**
(L5) **WINDOM, MN** (L6) **56101**

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 **01/17/2013** (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 IMR	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 **78** (L18)

13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	78			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Angela Richey, HFE NE II 02/19/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/01/2013 (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
05/01/1991
(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
POSTED 3/8/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24-5558

At the time of the standard survey completed January 22, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 5488

January 31, 2013

Ms. Nancy Wepplo, Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, Minnesota 56101

RE: Project Number S5558021 and H5580010

Dear Ms. Wepplo:

On January 22, 2013, 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. In addition, at the time of the January 22, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5580010.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the January 22, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5580010 that was found to be unsubstantiated.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Gloria Derfus
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 26, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 26, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 April 17, 2013 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 17, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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:

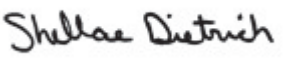
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5558s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	01/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(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 A standard recertification survey was conducted and a complaint investigation had also been completed at the time of the standard survey. An investigation of complaint #H5558010 was not substantiated during this survey. The facility's plan of correction (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 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.	F 000	RECEIVED FEB 14 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dignity for 1 of 8 residents (R12) who ate at table number eight in the main dining room. Findings include: During the evening meal on 1/14/13, at 5:30 p.m. a feeding assistant (FA)-A was observed to serve	F 241	Accepted 2-19-13 Jean Ouy	2/22/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy E. Weppler — TITLE: Administrator — (X6) DATE: 2-12-13

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 241	Continued From page 1 R12 at table number eight. FA-A came back to the hot server where two dietary aides, from the kitchen, dished up food for the residents. FA-A stated to dietary aide (DA)-A "the crabby lady [R12]at table eight wanted soup." FA-A shook her right index finger at DA-A and said to DA-A that the dietary aide was hard of hearing and could not see all that well either. FA-A continued to talk to staff members as they waited to pick up trays for the residents. FA-A commented, "I think they should have music, but they always pick the wrong songs." FA-A then served residents as their food was dished up. FA-A was observed to remark at table seven, "I'd be really sloppy if I tried to pick up the hamburger and cut it for you." There were two residents seated at table seven. On 1/14/13, at 6:20 p.m. DA-A confirmed she heard the remark about the "crabby resident" at table eight and the remark about "the hard of hearing." DA-A noted the finger pointing was directed at her and stated the comments were inappropriate. DA-A stated FA-A frequently made derogatory remarks about residents and staff. DA-A further stated she would brush off the remarks, even though she did not like the remarks. FA-A was interviewed on 1/14/13, at 6:30 p.m. and confirmed she had made the remarks about the "crabby resident." FA-A stated, "I didn't realize I could be heard. Oh, I'm sorry." On 1/17/13, at 1:30 p.m. the administrator confirmed the remarks made by FA-A were not appropriate and stated she would be talking to FA-A, to make sure FA-A understood that her comments were not acceptable.	F 241		

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F 241	Continued From page 2 The undated Feeding Assistant Training Manual, Chapter 1 indicated, feeding assistants may: take the resident to the dining room; prepare food for eating; serve food; prepare the resident for the meal; provide encouragement and conversation during the meal; prepare food, by cutting the meat, so that the resident may self-feed; assist a resident as he or she drinks a beverage; in some cases, feed the resident; take the resident back to the room or to another area in the facility; and record food and fluid intake according to facility policy.	F 241		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to develop a care plan for 1 of 1 resident (R30) to meet the resident's needs as her condition declined. Findings include: R30's hospital Progress Note dated 12/13/12, noted R30 was admitted to the hospital on 12/12/12. The note indicated the physician had talked to R30's three daughters and one son-in-law as R30 had a "rough night." At one point R30 had become semi conscious. The physician indicated he had discussed comfort care, do not resuscitate (DNR) status, and "the patient certainly was in a state of overall decline."	F 281		2/26/13

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F 281	Continued From page 3 R30 was discharged to the facility on 12/14/12. R30 was admitted with diagnoses of congestive heart failure (CHF), severe renal dysfunction, coronary heart disease, hypothyroidism, and anxiety. The care plan dated 12/14/12, included the following problem areas: "1) alteration in self care related to CHF and inability to groom, dress, do oral cares and bath, 2) alteration in nutrition related to poor appetite, 3) potential for skin alteration related to impaired mobility, and 4) in mobility related to CHF and inability to transfer, move in bed, and ambulate." R30's care plan indicated the resident had fallen on 12/17/12, and a bed alarm was applied to track and identify needs. R30's care plan did not include hospice care/end of life care, R30's oxygen use, pain medications, psychosocial needs due to her decline in health. A Physician Order dated 12/21/12, ordered Hospice Care for end stage CHF and severe renal disease. On 1/16/13, at 9:45 a.m. the director of nursing (DON) stated R30 continued on skilled nursing care not Hospice as indicated in the physician's order. On 12/22/12, the DON stated she spoke with R30's two daughters and reviewed the Hospice and benefits. The family knew R30 had declined and faced dying. Hospice did not provide extra staff and was located in Worthington. The DON indicated she felt comfortable the charge nurse had assessed the R30's additional skilled care needs and agreed the resident would remain on skilled nursing care. The DON further indicated that R30's primary physician was "loose with hospice" and wanted to do whatever the	F 281		

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F 281	Continued From page 4 family wanted. R30 never had Hospice services but remained on palliative care. The DON stated she would have expected the staff to make changes on the R30's care plan as the resident condition declined.	F 281		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to adequately monitor the heat sanitation dishwashing temperatures (temp) and implement their policy, maintenance the ice machine, and ensure equipment, drawers and vent hoods were maintained in a sanitary manner to prevent food borne illness, and to store ice packs separately from foods. These practices had the potential to affect all 74 of 74 residents who eat in the facility. Findings include: During an initial tour of the kitchen, food was observed to be prepared and stored in an unsanitary manner.	F 371		2/26/13

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F 371	Continued From page 5 An initial tour of the kitchen was done on 1/13/13, at 2:10 p.m. with the dietary director (DD) and the registered dietician (RD). Both the DD and RD indicated they were new employees of the facility in the last two to three months. The DD stated they have been short on staff in the kitchen due to the flu. The DD stated the facility also made meals for the local prison and "today we made meals for 17 prisoners." The census on entrance for the facility was 74. Initial findings of the dietary kitchen on 1/13/12, were: - In the odds and ends baking bin there was powdered baking material of a white substance and a brown powder on the bottom of the bin. - The top of the plate and and soup bowl warmer had a white dried on substance mixed with food crumbs. The DD indicated the white substance might be from the cleaners they used. - The Hobart Mixer had cake dough on the housing for the mixer blade. The DD confirmed the mixer had been cleaned and put away. - The Kitchen Aide mixer had a white powdery substance on the arm of the mixer after the mixer had been washed and put away. - The hot plate warmer (oven) had food baked on blackened debris on the bottom. - There was two missing knobs on the bottom of the griddle (only used on Wednesdays). - Both sides of the overhead vent had a thick layer of dust (no cleaning schedule per the DD. - One of two drawers with ladles had shavings/food crumbs on the bottom of the drawer. - The Hobart oven had baked on blackened debris and food crumbs. The DD stated that they deep clean the ovens two to three times a week.	F 371		

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F 371	Continued From page 6 - Throughout the kitchen there was food debris on the floor and the DD stated maintenance cleaned the floor once a day after the evening meal. - The flour in bin was uncovered. The DD indicated staff had been baking earlier in the day. - The dish washer temp was 160 degrees Farenheidt (F), there was a temperature log for dish washing temp, no was temp taken that morning. The DD indicated they had been having maintenance and ECO lab, (a business that ensured complicance with manufacturer's recommendation) watched the temp due to lower temps. The DD and RD confirmed the above findings during an initial tour of the kitchen. During kitchen observation on 1/17/13, at 8:40 a.m. dietary aide (DA)-B was doing the morning dishes in the dish room. The facility was utilizing a Hobart heat sanitizing dishwasher. The instructions read that the dishwasher temperatures should reach 180 degrees F for the rinse, that was utilized as the method to sanitize the dishes. At that time, the dishwasher rinse temperature, which was read on a digital screen, was at 173 degrees F. The DA-B pushed the rack of dishes through the dishwasher and started another set of soiled dishes. DA-B stated the temperature before that run was 180 degrees F and thought the temperature gauge was broken, and not reading correctly so she would continue to run dishes. DA-B stated if she had problems with the dishwasher reaching the proper temperature she would report to the dietary manager (DM)-A and/or maintenance. The second dishwasher rinse temperature read 178	F 371		

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F 371	Continued From page 7 degrees F. DA-B pushed those dishes through to the clean side, the third temperature read 182 degrees F. DA-B pushed those dishes through to the clean side and started another load. The temperature read 176 degrees F, another load was pushed through and read 181 degrees F, another load was pushed through and read 176 degrees F. DA-B confirmed the temperatures have been below 180 degrees F today and in the past few weeks. At 8:45 a.m., DM-A confirmed the facility had issues with the dishwasher getting up to temperature. DM-A stated maintenance was monitoring the dishwasher "frequently," to ensure the temperatures were adequate to sanitize the dishes. DM-A verified not all the temperatures were reaching 180 degrees F. DM-A confirmed the Dish Machine Temperature Log Thermal Sanitizing sheet had incomplete data and illustrated for the month of 1/13 that 16 out 42 record temperatures were below 180 degrees F. The log identified the lowest recorded temperatures on 1/10/13, at 162 degrees F and on 1/12/13, at 154 degrees F. On 1/17/13, at 9:48 a.m. the Environmental Assistant (EA)-A verified any dishwashing temperatures under 180 degrees F should be reported to maintenance. EA-A reported the last time he worked on the dishwasher was about two months ago. After review of the Dish Machine Temperature Log Thermal Sanitizing sheet EA-A confirmed he was not notified of the low temperatures, which concerned him that temperatures were as low as 154 degrees F. EA-A was not sure if the dietary staff should stop doing dishes if the water was not getting up to temperature. EA-A stated there was not a	F 371		

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F 371	Continued From page 8	F 371		

maintenance person here during the evening shift, therefore there may be miscommunication with reporting these temperatures if low temperatures occured in the evening. EA-A stated the laundry room was next door to the dish room and there had been issues in the past with water not getting up to proper temperature during the day because so much water was being used.

On 1/17/13, at 10:16 a.m. DM-A confirmed the facility did not do rack and dish/utensil surface temperatures, and was not sure how to obtain this temperature. DM-A was instructed to obtain a calibrated thermometer, and place on a dish rack. The thermometer was ran through the dishwasher, the temperature read 160 degrees F. DM-A stated this was not part of their procedure for checking to ensure the temperature reaches acceptable levels to prevent food borne illness. DM-A reported her staff were trained upon hire on when and who to report out of range temperatures to. DM-A stated on the evening shift there were maintenance staff here for dietary staff to report these out of range temperatures to and that reeducation needs to be completed.

The facility's policy and procedure for Sanitation and Dishwashing revised 7/09, instructed staff to follow the manufactures instructions for operation, turn on the machine, fill with water, check temperatures for proper temperature for wash and rinse cycle. It identified the rinse cycle should reach 180 degrees Fahrenheit (F). In addition, it identified that 160 degrees F or greater at the rack and dish/utensil surfaces would also be acceptable. It indicated if temperatures were outside acceptable parameters, staff will notify the director of dietary

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F 371	Continued From page 9 services (DDS) or maintenance before proceeding with dishwashing. Ice Machine: On 1/17/13, at 9:04 a.m. the DM-A confirmed the Scotsman ice machine in the dining room had a black and white build up at the internal area of the mouth of the chute. There was also some slimy scale build up on the internal part of the chute that was forming a ring and water was continuously dripping out of the spout of the ice chute. DM-A reported the housekeeping department cleaned the ice chutes. At 9:05 a.m. the housekeeping director (HD)-A verified the housekeeping floater was responsible cleaning the ice machine chutes every Tuesday. HD-A confirmed that the last Tuesday there was not a float and the task did not get completed. On 1/17/13, at 9:06 a.m. housekeeper (H)-A stated the ice machine was cleaned every Tuesday by the assigned person. H-A confirmed she has been responsible in the past for cleaning the external part of the ice machine. H-A demonstrated she cleaned the outside of the chutes and the base of the ice machine but did not take off, soak or clean the inside of the chutes where the ice touches. The Scotsman Dispensing Ice Machine Manufactures Instructions (undated) instructed staff to sanitation the dispense area; spouts, sink, grill and splash panel periodically. The policy instructed to pull down the ice chute, remove, wash and sanitize. In addition, it directed the internal components needed to be cleaned and sanitized at least twice per year.	F 371		

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F 371	Continued From page 10 The Direct Supply Instructions for Ice Machine Maintenance log indicated the ice machine maintenance which included sanitize interior and de-lime was due on 12/31/12. On 1/17/13, at 9:41 a.m. EA-A confirmed the task was over due and was not completed. EA-A stated "they just hadn't gotten to it yet." Utensil Drawers: On 1/17/13, at 8:57 a.m. two of three utensil drawers by the food preperation area directly across the the grill top had debri in the drawers. DM-A confirmed the drawers were not on a cleaning schedule and the facility had not implemented any cleaning schedule/logs. DM-A confirmed the ventilation hoods above the grill were cleaned by cook-A, who has had medical problems and had been unable to work for the past several weeks. Three gel ice packs for multiple resident use were observed to be stored with foods. On 1/17/13, at 2:30 p.m. the center medication room freezer was observed to have three gel ice packs (two large blue, one smaller lighter blue) stored amongst ice cream and popsicles. The infection control nurse present during the observation, confirmed the ice packs were for resident use and should not be stored with foods. The infection control nurse explained she thought the packs were wrapped in towels when used, but was unclear if they were cleaned between resident uses. The infection control nurse confirmed the facility lacked a policy for the cleaning and storage of the ice packs.	F 371		

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F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. 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:	F 431		1/31/13

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F 431	Continued From page 12 Based on observation, interview, and document review, the facility failed to label medications when opened on 1 of 3 units and failed to remove expired medication on 1 of 3 units. Findings include: The South nursing unit had a multiple dose vial of Aplisol Injection 0.1 ml, used for tuberculosis testing, in the refrigerator that had been opened but not dated when opened. The vial had no label to indicate when the pharmacy dispensed the medication to the facility. The insert package information undated, vial should be discarded after 30 days. Licensed practical nurse (LPN)-A on 1/17/13, at 2:20 p.m. could not verify the date the vial had been opened, when the vial was sent to the facility or if the medication had recently administered. Hydrocortisone 1% solution, used for severe inflammation, for R75 expired on 9/12. The LPN-A verified these findings on the South unit on 1/17/13, at 2:25 p.m. LPN-A indicated she would call the pharmacy and have a new tube of Hydrocortisone sent out for R75. The facility had a Policy and Procedure for Bulk over-The-Counter Medications dated January 2007, which indicated staff should:date the bulk medication container when it is opened." The facility did not implement the policy on dating multi-dose/bulk vials.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		2/19/13

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(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 441	Continued From page 13 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	01/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(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 441	Continued From page 14 review, the facility failed to ensure a pulse oximeter (equipment used to check oxygen saturation) which was used for multiple resident use, was disinfected between each resident use to prevent the potential spread of infections for 4 of 4 residents (R82, R93, R16, R56) randomly observed to have their oxygen saturations checked. The facility lacked a policy and procedure directing the disinfecting of the pulse oximeter. In addition, the facility failed to ensure linens were handled in a manner which prevented the potential spread of infections. These practices had the potential to affect all 74 of 74 residents residing in the facility. Findings include: The pulse oximeter was not cleaned between resident use for R82, R93, R16 and R56; the facility lacked a policy and procedure directing how to disinfect and store the pulse oximeter. On 1/14/13, at 5:11 p.m. during observation of the medication pass in the facility dining room, the registered nurse (RN)-K was observed to check the oxygen saturation level for R82 with a pulse oximeter. RN-K was observed to place the pulse oximeter on R82's finger, obtain the reading and return to the medication cart. RN-K stated R82's oxygen saturations were "96%." RN-K placed the pulse oximeter on the top of the medication cart and continued with the medication pass. RN-K was then observed to subsequently check the oxygen saturation levels on R93 and R16 without cleaning the oximeter between applying it to each resident's finger. - At 6:21 p.m. RN-K confirmed they had checked the oxygen saturations on R93 and R16. RN-K	F 441		

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GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

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F 441	Continued From page 15	F 441		

stated R16 "had pneumonia" and the oxygen saturations would need to be "checked again."
- At 6:33 p.m. when asked if the pulse oximeter had been cleaned between resident use, RN-K stated "no" and confirmed the pulse oximeter was not cleaned between each resident use. When asked if the oximeter could be a potential means to spread infections, RN-K stated "yes," and added, "I suppose...they could sneeze into their hand." RN-K then made a gesture mimicking to cover a sneeze, placed their hand near their face, then made a touching gesture of the index finger in a pulse oximeter. RN-K stated the pulse oximeter was not stored in the top drawer of the medication cart and produced the oximeter from the front left pocket of their scrubs. When asked if there was a policy and procedure for cleaning the pulse oximeter, RN-K stated "no" and stated they were not aware of the procedure for cleaning the pulse oximeter.

On 1/15/13, at 9:44 a.m. R82 confirmed he wore oxygen continuously, stated he had recently had respiratory problems and was "back on his feet for a little over a week." R82 stated his oxygen saturation levels were "checked every shift." R82 stated he "thought" he had seen staff use the "Mediwipes" to wipe down the pulse oximeter.

On 1/16/13, at 1:38 p.m. RN-A was observed to remove the pulse oximeter from the top drawer of the medication cart, enter R56's room and check her oxygen saturation level. RN-A attempted to obtain a pulse oximeter reading from multiple fingers while R56 was wearing oxygen at 4 liters per minute (LPM).
- At 1:42 p.m. R56 was laid in the bed and the oxygen was removed. RN-A attempted to

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F 441	Continued From page 16 recheck the oxygen saturations, was unable to obtain a reading, instructed a nursing assistant to apply warm packs to R56's fingers and left the room. While carrying the oximeter in her hand, RN-A returned to the nursing desk, obtained supplies for a dressing change and entered R93's room at 1:45 p.m. RN-A sat on the bed and placed the pulse oximeter directly on R93's bed. The pulse oximeter remained on the bed until the completion of the dressing change. - At 1:50 p.m. RN-A returned to R56's room (directly across the hall from R93), placed the pulse oximeter on R56's finger and obtained a reading of 90% on room air. RN-A confirmed the pulse oximeter was not cleaned between resident use. When asked what the cleaning procedure was for the pulse oximeter, RN-A stated they did not know the procedure for cleaning the equipment and further stated they "usually" would use alcohol wipes to disinfectthe oximeter. RN-A further stated, "We clean it once in awhile." RN-A confirmed the pulse oximeter was a potential source for the spread of infection. On 1/17/13, at 9:29 a.m. the nurse manager (NM) -A stated she expected the staff to use wipes used for sanitizing the glucometer (Mediwipes). NM-A stated the wipes could be used on any surface and confirmed the pulse oximeter should have been cleaned between each resident use. NM-A confirmed the uncleaned pulse oximeter was a potential source for the spread of infection. A policy and procedure for the cleaning of the pulse oximeter was requested at the time. - At approximately 10:00 a.m. the Standard Precautions policy and procedure dated as revised on 7/2009, was provided. The policy directed:	F 441		

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F 441	Continued From page 17 "Resident-Care Equipment...2. Reusable equipment will not be used for the care of another resident until it has been appropriately cleaned and disinfected." Although the policy directed to clean reusable equipment between resident uses, the policy lacked direction for the procedure to clean the pulse oximeter, such as to use alcohol wipes versus Mediwipes. The policy lacked direction for the storage of the pulse oximeter. - At 12:14 p.m. the infection control nurse stated the Standard Precautions policy and procedure was not in effect as a "policy" in the facility, but as a "standard" for cleaning the equipment. The infection control nurse stated she had called the pulse oximeter company to find out how to disinfectthe oximeters according to manufacturer's recommendations. The infection control nurse confirmed the facility lacked a policy and procedure which directed how to disinfect and store the pulse oximeter. On 1/17/13, at 1:41 p.m. the infection control nurse confirmed not cleaning the pulse oximeter between resident use and storing the equipment in a nurse's pocket could potentially contribute to the spread infections. The infection control nurse provided a copy of an email from a supply company. The email indicated, "Use a soft cloth dampened with 70% isopropyl alcohol to clean the rubber that comes into contact with a finger during testing. Also clean the test finger using alcohol before and after each test. Caution - Do not pour or spray and [sic] liquids onto the device, and do not allow any liquid to enter any openings in the device. Allow the device to dry thoroughly before reusing."	F 441		

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F 441	Continued From page 18 Linens were not handled in a manner to minimize the risk for transmission of infections. On 1/16/13, at 7:24 a.m. nursing assistant (NA)-B donned gloves, picked up soiled slacks from R32's bathroom, carried the slacks down the hall to the other side of a split wing into the dirty utility room area. NA-B did not bag the soiled clothing for transport. On 1/16/13, at 7:39 a.m. NA-B stated she took R32's soiled slacks out of his room that morning down to the dirty utility room to wash out a bowel movement. NA-B confirmed she should have used a bag to transport soiled laundry down the hall. The certified nursing assistant training book (undated), provided to nursing assistants at orientation, directed staff to, "Always bring the soiled laundry cart with you to the rooms that way you are not carrying soiled linens through the hall."	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a sanitary environment for 10 of the 40 sampled residents	F 465		2/26/13

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F 465	Continued From page 19 (R26, R37, R57, R19, R52, R60, R58, R8, R38, and R49). Findings include: The environmental tour was conducted on 1/17/13, from 1:30 p.m. to 2:00 p.m. with the Director of Maintenance (DM) and Assistant Director of Maintenance (ADM) present during throughout the tour. The following concerns were noted: R26's room had a fan mounted on the wall, to the left of the door. The fan blades were covered with buildup of a dark colored dust like substance. R37's room had chipped paint approximately 10 centimeters (cm) in length on the wall above the head board of the bed. R57 and R19 residents' closet had an area of approximately 60 cm in length by 15 cm in depth of chipped paint on the wall. R52's room had chipped paint which measured 15 cm in length and approximately 8 cm of black markings above the head board of the bed. The ceiling in R60's bathroom had a large exposed hole where a vent would be placed. R58's room had chipped paint approximately 8 cm on the wall by the bed. R38's room had chipped paint 8 cm in length above the heat register. R8's room had chipped paint 40 cm in length above the bathroom sink. R49's room had a crack 244 cm in length across ceiling. The DM and ADM verified the above findings during the environmental tour. On 1/17/13, at 2:45 p.m. the DM revealed environmental audits were done weekly. The DM stated when environmental audits were done, the environmental staff did not "go into the residents' room." In addition, he stated the environmental	F 465		

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F 465	Continued From page 20 staff relied on the nursing staff to notify them of concerns related to residents' rooms. The DM verified nursing had not indicated any concerns on the maintenance request sheet for those identified resident rooms. On 1/17/13, at 4:30 p.m. the DM provided a blank Maintenance Request Sheet. The DM stated the Maintenance Request Sheet was the form used to perform weekly rounds in the facility. Review of the Maintenance Request Sheet dated 4/99, directed staff members to initiate and document maintenance requests. The sheet indicated maintenance staff were to check the forms placed in a three-ring binder twice daily, in the mornings and afternoons.	F 465		

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 facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.

F-241
Corrected Date: Feb 22, 2013

It is the current policy and procedure of GSS-Windom to treat residents with dignity and respect at all times.

FA-A had a coaching and counseling disciplinary session on Jan 24 (before she worked again) regarding her inappropriate actions in the dining room. She has since resigned and did not work any further shifts.

All residents are at risk for this deficient practice.

Re-education of all feeding assistants will occur by Feb 22 regarding resident dignity and respect and appropriate dining room conversation.

An audit of the feeding assistants during meal time will be conducted 1x per week x4 weeks by the CQI Coordinator or designee and then 1x per month x3 months. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

F-281
Corrected Date: Feb 26, 2013

It is the current policy and procedure of GSS-Windom to assess and care plan condition changes for every resident.

As this was a closed record, R30 had passed away on Dec 30, 2012.

All residents who have a condition decline will be reviewed for appropriate care plan updates by Feb 26.

All nurses were re-educated on Jan 22 on the importance of residents having a current care plan.

An audit of residents with condition declines will be conducted 1x per week x3 months by the CQI Coordinator or designee. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

F-371
Corrected Date: Feb 26, 2013

All kitchen equipment noted in the survey was cleaned on Jan 13, by or under the direction of the Dietary Director. It is the policy and procedure that all of the equipment will be cleaned upon completion of using them. The floor is to be swept each shift or more often if necessary. The knobs for the griddle are stored underneath the griddle to prevent bumping them. There are cleaning lists for all of these items.

During the survey inspection of Jan 17, the worksheet used to monitor and record dishwasher temps was found to not be in accordance with the dishwasher manufacturer's guidelines. The worksheet called for the dishwasher temperatures to be 180 degrees when the manufacturer required 160 degrees. Our procedure and documentation worksheet were amended to reflect the manufacturer's guidelines. Additionally, new thermometers were obtained for the dishwasher and employees were educated to use them with each load as required, per policy. Additionally, employees were re-educated to inform the dietary director, per policy, if a dishwasher temp falls below 160 degrees.

The ice machine was cleaned, both inside and out on Jan 17 and 18, per manufacturer's instructions. A new tray, grill, and spout were ordered and subsequently installed on Jan 25. The cleaning schedules were updated to include cleaning the entire spout and all outer components once per week. The internal components are scheduled to be cleaned 4 times per year, quarterly.

The ice packs are now stored in the medication refrigerator (where no food is stored) inside a plastic bag. Additionally, the ice packs are sanitized between uses.

All residents in the facility have the potential to be affected by the deficient practices.

It is the current policy and procedure to maintain our kitchen equipment and ice machine in a clean and sanitary manner and to follow the dishwasher policies and procedures. The kitchen staff will be re-educated Feb 20 on these policies and procedures and the related survey issues. The maintenance and environmental services department will be educated Feb 19 on the new procedures.

The nurses were educated Jan 22 on the new ice pack procedures.

An audit of kitchen equipment cleanliness will be conducted 1x per shift x 12weeks and 1x per week x6 months (or until the CQI committee is satisfied with compliance results, whichever is greater) by the CQI Coordinator or designee, with appropriate follow up initiated by the Director of Dietary Services. Additionally, cleaning and dishwasher temperature logs will be reviewed monthly by the infection control committee for continued compliance.
An ice machine audit will occur 1x per week for 3 months and 1x per month for 3 months.
An ice pack audit of storage and use will occur 1x per week for 12 weeks.
All audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

2-19-13 @ 12:25 p.m.
Nancy Weppler
campus administrator

F-431
Corrected Date: Jan 31, 2013

It is the current policy and procedure of GSS-Windom to label all bulk over-the-counter medications and to dispose of medications by their expiration dates.

Both of the medications in question were disposed of on Jan 17.

On Jan 17, each nurse station was inspected for expired and unlabeled medications, which if found, were disposed of. On the Jan 31 medication exchange, a new label was applied to all stock medications which indicates date opened, per our current policy.

All residents in the facility have the potential to be affected by the deficient practices.

All nurses were re-educated on Jan 22 regarding proper medication labeling and storage.

An audit of medications for labeling and expiration dates will be conducted 1x per week x13 weeks by the CQI Coordinator or designee and then 1x per month x3 months and then on-going, based on the results, as needed. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

F-441
Corrected Date: Feb 19, 2013

Based on Manufacturer's recommendations, a procedure for cleaning the pulse oximeter was developed and a storage plan was implemented on Feb 11.

It is the current policy and procedure of GSS-Windom that any soiled linen, transported in the hallway, be contained inside a plastic bag or be put directly into the moveable hamper located outside of the resident's room. This procedure was confirmed by NA-B at the time of the incident.

All residents are at risk for the deficient practices.

The nurses were educated on Jan 22 on a preliminary procedure regarding cleaning the resident's finger. By Feb 15, each nurse will be educated on the complete new procedure for cleaning and storing the oximeter.

By Feb 19, all nursing assistants will be re-educated to the linen handling policy and procedure.

An audit of oximeter cleaning and storage will be conducted daily for 1 week and then weekly for 12 weeks by the CQI coordinator or designee.
An audit of certified nursing assistant linen handling will be conducted 3x per week on various shifts for 3 month and then 1x per week on various shifts for 3 months.
Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

F-465
Corrected Date: Feb 26, 2013

It is the current policy and procedure of GSS-Windom to maintain the resident rooms and spaces in a clean, functional, sanitary, and comfortable environment.

By Feb 25, the walls or ceilings in rooms for R37, R57/R19, R52, R60, R58, R38, R8, and R49, will be repaired. On Feb. 12, R26 had his/her room fan cleaned.

All resident rooms will be inspected and corrected, if necessary, by Feb. 26, for similar issues.

There is already a fan cleaning schedule in place and the maintenance staff is responsible for completing this work timely.
By Feb 26, the maintenance dept. will develop and implement a room inspection checklist to be completed quarterly on each room. This checklist will be completed by the maintenance staff.

On Feb. 19, the maintenance staff will be re-educated on these policies and procedures regarding room inspections and fan cleaning.

Monthly, the maintenance dept will submit, to the Safety Committee, the room inspection checklists and the fan cleaning schedule, to audit and assure completion of these duties in a timely manner. This will be done for 6 months. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

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Sogge Memorial
Remick Ridge Estates
Mikkelsen Manor
Home Care

Feb. 12, 2013

Gloria Derfus
MN Dept. of Health
PO Box 64900
St. Paul, MN 55164-0900

Dear Ms. Derfus:

Please find enclosed our plan of correction for our survey. If you should have any questions or concerns, please contact me. Thank you.

Sincerely,

Nancy E. Wepplo

Nancy Wepplo
Campus Administrator

Enclosure: Plan of Correction

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

F 5558022

PRINTED: 01/31/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/22/2013

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GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

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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, on January 22, 2013. At the time of this survey, Good Samaritan Society Windom was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 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	RECEIVED FEB 14 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok PB 2-19-13	

DC: 02.26.2013

EXIT: 01.17.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nancy E. Nagel	Administrator	2-12-13

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.

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 facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.

K-48
Corrected Date: Feb 15, 2013

On Feb 15, 2013, the Emergency Fire Plan was updated to include a written provision for the preparation of the floors and building for evacuation.

The Safety Coordinator will monitor the facility for future issues through the Safety Meeting audits and the CQI committee.

K-52
Corrected Date: Feb 19, 2013

It has always been the policy and procedure of the Good Samaritan Society-Windom to test the auto-dialer monthly. To assure compliance, the Safety Committee will be responsible to double check and document in their monthly meeting minutes the testing of the auto-dialer.

The Safety Coordinator will monitor the facility for future issues through the Safety Meeting audits and the CQI committee.

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GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(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: Barbara.Lundberg@state.mn.us, and 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. Good Samaritan Society Windom is a one-story building with partial basement, and was constructed at five different times. The original building was constructed in 1959, with building additions in 1962, 1972, 1994 and 2000. All buildings were determined to be of Type II(111) construction. The facility is fully sprinklered. The building has a fire alarm system with smoke detection in the corridors, including all spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a capacity of 78 beds and had a census of 73 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of	K 048		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 048	Continued From page 2 an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7 This STANDARD is not met as evidenced by: Based upon a review of available documentation, the facility's fire safety plan did not provide for all nine (9) of the required elements at NFPA 101 (00) Chapter 19, Section 19.7.2.2. This deficient practice could adversely affect 78 of 78 residents, staff and visitors. FINDINGS INCLUDE: On 01/22/2013 at 11:40 AM, during a review of the facility's emergency plan, it was confirmed that no written provision existed for the preparation of floors and building for evacuation, in accordance with NFPA 101 (00) Chapter 19, Section 19.7.2.2 (7). This finding was confirmed with the chief building engineer.	K 048		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 052	Continued From page 3 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with NFPA 70 National Electrical Code (1999 edition) and NFPA 72 National Fire Alarm Code (1999 edition). The system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70 (99) and NFPA 72 (99) and NFPA 101 Life Safety Code (2000 edition), Chapter 9, Section 9.6.1.4. This STANDARD is not met as evidenced by: Based upon a staff interview and review of available records, testing of the digital alarm communicator transmitter (DACT) had not been conducted in each month during the previous year. This deficient practice could adversely affect 78 of 78 residents, staff and visitors. FINDINGS INCLUDE: On 01/22/2013 at 11:25 AM, during a review of available records provided by the facility's chief building engineer, no documentation could be provided verifying the digital alarm communicator transmitter (DACT) was tested during the month of July, 2012. This deficient practice was not in conformance with CMS policy, as permitted by	K 052		

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K 052	Continued From page 4 NFPA 72 (99) Chapter 7, Section 7-3.2.	K 052		