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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 28OL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00956

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245488**

2.STATE VENDOR OR MEDICAID NO.
(L2) **502043300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WOODLAND**
(L4) **100 BUFFALO HILLS LANE**
(L5) **BRAINERD, MN** (L6) **56401**

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 **03/12/2014** (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)
06/30

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

12.Total Facility Beds **41** (L18)

13.Total Certified Beds **41** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With
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
___ 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: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	41			
(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):
On March 12, 2014 a Post Certification Revisit was completed by review of the plan of correction. Based on the plan of correction, we have determined that the facility corrected the deficiencies issued pursuant to the January 30, 2014 standard survey, effective February 17, 2014. Refer to the CMS 2567b for the results of this visit.

Effective February 17, 2014, the facility is certified for 41 skilled nursing facility beds.

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor — 03/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 05/16/2014 (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
07/01/1987
(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
03/24/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5488

March 28, 2014

Ms. Jennifer Grams, Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, Minnesota 56401

Dear Ms. Grams:

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 17, 2014 the above facility is certified for::

41 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 41 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

March 28, 2014

Ms. Jennifer Grams, Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, Minnesota 56401

RE: Project Number S5488024

Dear Ms. Grams:

On February 5, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 30, 2014 This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On March 12, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 30, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 17, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 30, 2014, effective February 17, 2014 and therefore remedies outlined in our letter to you dated February 5, 2014, 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us
Enclosure

cc: Licensing and Certification File 5488r14.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245488	A. Building B. Wing	3/12/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	02/17/2014	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	02/17/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/LB	03/28/2014	28035	03/12/2014
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
1/30/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 28OL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00956

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(L1) **245488**

2.STATE VENDOR OR MEDICAID NO.
(L2) **502043300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WOODLAND**
(L4) **100 BUFFALO HILLS LANE**
(L5) **BRAINERD, MN** (L6) **56401**

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 **01/30/2014** (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)
06/30

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

12.Total Facility Beds **41** (L18)

13.Total Certified Beds **41** (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	IID
	41			
(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):

At the time of the January 30, 2014 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE — Date :
Yvonne Switajewski, HFE NEII — 02/26/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
MPM
Mark Meath, Program Specialist — 03/22/2014 (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
07/01/1987
(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 3/24/2014 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8422

February 5, 2014

Ms.. Jennifer Grams, Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, Minnesota 56401

RE: Project Number S5488024

Dear Ms. Grams:

On January 30, 2014, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601
Telephone: (218) 308-2104
Fax: (218) 308-2122

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 March 11, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 30, 2014 (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 30, 2014 (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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Disclaimer

Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING _____ B. WING _____	01/30/2014

RECEIVED FEB 2 2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

(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 THE FACILITY 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 ONSITE 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		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services as directed by the resident's written care plan for 2 of 2 residents (R29, R56) who required assistance with ambulation. Findings include: R29 did not receive ambulation services as directed by the individual care plan. R29's care plan dated 1/20/14, indicated R29 was	F 282	Please see attached pages for plan of correction. Approved 2/26/14 LB	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Grams — TITLE: Administrator — (X6) DATE: 2/14/14

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
	245488	A. BUILDING _____ B. WING _____	01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

(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 282	Continued From page 1	F 282		

receiving nursing rehabilitation services which included a functional maintenance program (FMP) for ambulation. The care plan indicated R29 was to be ambulated as weight bearing tolerated (WBAT) to right lower extremity with assist of one staff with a front wheeled walker (FWW) and assist of 1 staff 100 feet (ft.) twice daily.

The nursing assistant Rehabilitation Nursing documentation on the Kiosk from 1/21/14, to 1/29/14, indicated
R29 ambulated six out of 18 opportunities, refused three times, and documentation also indicated not applicable (N/A) one time.

R29's Kiosk daily documentation from 1/21/14-1/29/14, revealed the following:

-1/29/14, R29 ambulated one time.
-1/28/14, R29 ambulated one time.
-1/27/14, R29 ambulated one time.
-1/26/14, R29 ambulated one time and refused one time.
-1/25/24, R29 refused one time.
-1/24/14, blank- no documentation noted.
-1/23/14, R29 ambulated one time and refused one time.
-1/22/14, R29 ambulated one time and refused one time.
-1/21/14, R29 ambulated zero times and the form had N/A checked.

On 1/27/14, at 7:30 p.m. R29 was observed in her room, seated in a wheelchair. At that time R56 stated she had been discontinued from physical therapy (PT) on 1/24/14. R29 also stated she should be walking two times a day but staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING _____ B. WING _____	01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

(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 282	Continued From page 2	F 282		

had not been walking her two times a day. R29 stated the evening staff were always so busy and did not have the time to ambulate her.

On 1/28/14, at 7:15 a.m. R29 stated staff had ambulated her one time on 1/27/14.

On 1/28/14, at 11:30 a.m. physical therapy assistant (PTA) verified R29 was discharged from physical therapy on 1/24/14, and was to be ambulated two times a day by the nursing staff.

On 1/29/14, at 8:30 a.m. R29 stated staff had ambulated her one time on 1/28/14.

On 1/30/14, at 8:45 a.m. R29 stated staff had ambulated her one time on 1/29/14. R29 also stated she would really like to walk two times a day so she could get stronger and go home.

On 1/29/14, at 3:00 p.m. nursing assistant (NA)-B stated she was an evening staff person and reviewed her NA care assignment sheet with the surveyor. NA-B stated the care assignment sheet identified which residents needed to be ambulated on her shift. NA-B confirmed R29 was not identified on the care sheet as needing to be ambulated.

On 1/30/14, at 9:55 a.m. NA-C, confirmed she worked evenings and stated R29 was included in her list of residents to care for.
However, NA-C stated there were only two residents identified in her group of residents to care for that required ambulation assistance and R29 was not one of them.

On 1/30/14, at 10:20 a.m. registered nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING _____ B. WING _____	01/30/2014

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GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

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F 282	Continued From page 3	F 282		

(RN)-A verified R29's care plan was correct and confirmed R29 was to be ambulated two times a day as directed by the FMP plan and on the Kiosk for the NA's to document ambulation.

R56 did not receive ambulation services as directed by the individual care plan.

R56's care plan dated 11/5/13, indicated R56 was on a nursing rehabilitation program and was to ambulate with assist of one staff with a FWW, distance as tolerated 5-30 ft. two times a day.

The nursing assistant rehabilitation documentation on the Kiosk from 1/1/14, through 1/29/14, indicated R56 ambulated ten out of 56 opportunities, refused 26 times, and 16 times N/A was documented.

On 1/27/14, at 7:00 p.m. R56 was observed in his room, seated in a wheelchair. At that time R56 stated staff did not take him for walks everyday like he was supposed to be. R56 also stated staff think I should ask them to take me for a walk but I think they should be asking me to go for a walk and they don't.

On 1/30/14, at 8:10 a.m. R56 was observed sitting by the dining table. R56 stated he went for a walk last night and it went pretty well.

On 1/29/14, at 3:05 p.m. NA-A who worked evenings stated she had seven residents on her list to walk and did not always have time to ambulate everyone as directed. NA-A stated when the facility worked short on the evening shift she just did not have the time to walk the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING _____ B. WING _____	01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

(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 282	Continued From page 4 residents. NA-A stated if she did not have time to walk a resident, she documented "N/A" on the Kiosk. On 1/30/14, at 10:05 RN-A verified R56's care plan was correct and was not followed.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services in order to improve and/or maintain the resident's ambulation ability for 2 of 2 residents (R29, R56) who required an ambulation services. Findings include: R29 was not provided ambulation services as directed by the care plan. R29's Medical Diagnosis List dated 7/19/13, indicated R29's diagnoses included congestive heart failure (CHF) and after care of a healing traumatic fractured upper leg/ankle. R29's quarterly Minimum Data Set (MDS) dated 10/21/13, indicated R29 had intact cognition and required extensive assist with bed mobility, transfers and was non-ambulatory. The 7/26/13, activity of daily living (ADL) Care Area Assessment (CAA) indicated R29 required extensive assist with bed mobility and was	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING _____ B. WING _____	01/30/2014

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GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

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F 311	Continued From page 5 non-ambulatory. R29's physical therapy (PT) plan of care dated 12/2/13, indicated R29 was treated for a leg fracture in which PT was discontinued on 1/24/14, with recommendations to continue the same functional maintenance program (FMP) for ambulation with nursing staff. R29's Notice of Resident Change form dated 1/16/14, and completed by PT/OT indicated R29 was to ambulate with a FWW with stand by assist (SBA), goal: 100 feet (ft.) two times a day. R29's care plan dated 1/20/14, indicated R29 was receiving nursing rehabilitation services which included a functional maintenance program (FMP) for ambulation. The care plan indicated R29 was to be ambulated as weight bearing tolerated (WBAT) to right lower extremity with assist of one staff with a front wheeled walker (FWW) and assist of 1 staff 100 ft. twice daily. R29's significant change MDS review note dated 1/22/14, indicated R29's cognition had improved and had intact cognition, was alert and oriented, verbalized needs and ambulated with assist from one staff. The nursing assistant registered (NAR) Rehabilitation Nursing documentation on the Kiosk from 1/21/14, to 1/29/14, indicated R29 ambulated six out of 18 opportunities, refused three times, and documentation also indicated not applicable (N/A) one time. R29's Kiosk daily documentation from 1/21/14-1/29/14, revealed the following:	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING _____ B. WING _____	01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

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F 311	Continued From page 6 -1/29/14, R29 ambulated one time. -1/28/14, R29 ambulated one time. -1/27/14, R29 ambulated one time. -1/26/14, R29 ambulated one time and refused one time. -1/25/24, R29 refused one time. -1/24/14, blank- no documentation noted. -1/23/14, R29 ambulated one time and refused one time. -1/22/14, R29 ambulated one time and refused one time. -1/21/14, R29 ambulated zero times and the form had N/A checked. On 1/27/14, at 7:30 p.m. R29 was observed in her room, seated in a wheelchair. At that time R56 stated she had been discontinued from physical therapy (PT) on 1/24/14. R29 also stated she should be walking two times a day but staff had not been walking her two times a day. R29 stated the evening staff were always so busy and did not have the time to ambulate her. On 1/28/14, at 7:15 a.m. R29 stated staff had ambulated her one time on 1/27/14. On 1/28/14, at 11:30 a.m. physical therapy assistant (PTA) verified R29 was discharged from physical therapy on 1/24/14, and was to be ambulated two times a day by the nursing staff. On 1/29/14, at 8:30 a.m. R29 stated staff had ambulated her one time on 1/28/14. On 1/29/14, at 3:00 p.m. nursing assistant (NA)-B stated she was an evening staff person and reviewed her NA care assignment sheet with the surveyor. NA-B stated the care assignment sheet	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

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F 311	Continued From page 7 identified which residents needed to be ambulated on her shift. NA-B confirmed R29 was not identified on the care sheet as needing to be ambulated on the evening shift. On 1/30/14, at 8:45 a.m. R29 stated staff had ambulated her one time on 1/29/14. R29 also stated she would really like to walk two times a day so she could get stronger and go home. On 1/30/14, at 9:55 a.m. NA-C, verified she worked evenings and R29 was included in her list of residents to care for. NA-C stated there were two residents identified on her resident list who required ambulation services on the evening shift and confirmed R29 was not one of them. On 1/30/14, at 10:20 a.m. registered nurse (RN)-A verified R29's care plan was correct and confirmed R29 was to be ambulated two times a day as directed by the FMP plan and on the Kiosk for the NA's to document ambulation. On 1/30/14, at 10:35 a.m. NA-D, verified she had cared for R29 on 1/29/14, and stated she had not walked R29 on the evening shift. NA-D stated she had documented in the medical record "N/A" because she had never ambulated R29 and R29 never asked to be ambulated. NA-D also stated R29 was identified on her resident care sheet as not needing to be ambulated. R56 was not provided with ambulation services as directed by the care plan. R56's Medical Diagnoses List, undated, indicated	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

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F 311	Continued From page 8	F 311		

R56's diagnoses included acute respiratory failure, chronic airway obstruction, pneumonia, malignant neoplasm bronchus and lung and peripheral vascular disease. R56's admission MDS dated 11/12/13, indicated R56 had intact cognition and required extensive staff assistance with bed mobility and walking. R56's ADL CAA dated 11/14/13, indicated R56 required extensive staff assistance with walking.

R56's care plan dated 11/5/13, indicated R56 was on a nursing rehabilitation program and was to ambulate with assist of one staff with a FWW, distance as tolerated 5-30 ft. two times a day.

The NAR Rehabilitation documentation on the Kiosk from
1/1/14, through 1/29/14, indicated R56 ambulated ten out of 56 opportunities, refused 26 times, and 16 times N/A was documented.

On 1/27/14, at 7:00 p.m. R56 was observed in his room, seated in a wheelchair. At this time R56 stated staff did not take him for walks everyday like he was supposed to be. R56 also stated staff think I should ask them to take me for a walk but I think they should be asking me to go for a walk and they don't.

On 1/30/14, at 8:10 a.m. R56 was observed seated by the dining table. R56 stated he went for a walk last night and it went pretty well.

On 1/29/14, at 3:05 p.m. NA-A verified she had worked evenings and stated she had seven residents on her list to walk and did not always have time to ambulate everyone as directed. NA-A stated when the facility worked short on the evening shift she just did not have the time to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING _____ B. WING _____	01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

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F 311	Continued From page 9 walk the residents. NA-A stated if she did not have time to walk a resident, she documented "N/A" on the Kiosk. On 1/30/14, at 10:05 RN-A confirmed R56 was started on a nursing ambulation program on 12/16/13, and verified R56's care plan was correct. RN-A stated R56's care plan was not followed as directed. On 1/30/14, at 11:10 a.m. the director of nursing (DON) confirmed R29 and R56 had not received ambulation services as directed. The DON also confirmed the NA care sheets lacked identification of which residents required ambulation assistance and they should have. The facility policy titled Ambulation of Resident" dated 9/12, indicated the purpose was to assist resident in maintaining the ability to ambulate and to encourage exercise and promote physical well-being. The policy indicated staff were to review resident information on the Kiosk prior to ambulation.	F 311		

F 282 Services by qualified persons/per care plan
MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use

1. Residents #29 and 56 are now ambulating to and from meals as directed by the plan of care. Immediate education occurred with the staff involved that was not implementing the plan of care.

2. All residents care planned for assistance with ambulation are at risk of being affected by this deficient practice. The care plans of all residents who receive assistance with ambulation were reviewed to ensure they are receiving the needed assistance and their care plans updated as needed. All residents currently requiring assistance with ambulation are receiving it according to their care plan.

3. Mandatory nursing staff education took place on 1/30/2014, and 2/5/2014 and included education on the care plan implementation including ambulation assistance. All nursing assistants were re-educated on the importance of providing care according to the resident's individual plan of care and as defined on the kiosks and proper documentation of the care provided. Nursing staff were also educated on the care assignment sheets, following care plan versus assignment sheets, and the appropriate use of "N/A" and "no" in documentation.

4. Observation, resident interview and documentation audits will be done on ambulation by DON/designee to ensure that plans of care are being implemented as indicated. These audits will be completed 3x/wk for 4 weeks for residents #29 and 56 and randomly for all other residents receiving ambulation services. Results will be forwarded to the Quality Assurance committee for further recommendations.

5. Date of Completion 2/17/2014.

F 311 Treatment/Services to improve/maintain ADL's
MN Rule 4658.0525 Subp. 6 A Rehab-ADLs

1. Residents # 29 and 56 are now ambulating twice daily as directed by the plan of care. Immediate education occurred with the staff involved that was not implementing the plan of care.

2. All residents care planned for assistance with ambulation are at risk of being affected by this deficient practice. The care plans of all residents who receive assistance with ambulation were reviewed to ensure they are receiving the needed assistance and their care plans updated as needed. All residents currently requiring assistance with ambulation are receiving it according to their care plan.

3. Mandatory nursing staff education took place on 1/30/2014, and 2/5/2014 and included education on the care plan implementation including ambulation assistance. All nursing assistants were re-educated on the importance of providing care according to the resident's individual plan of care and as defined on the kiosks and proper documentation of the care provided. Nursing staff were also educated on the care assignment sheets, following care plan versus assignment sheets, and the appropriate use of "N/A" and "no" in documentation.

4. Observation, resident interview and documentation audits will be done on ambulation by DON/designee to ensure that plans of care are being implemented as indicated. These audits will be completed 3x/wk for 4 weeks for residents #29 and 56 and randomly for all other residents receiving ambulation services. Results will be forwarded to the Quality Assurance committee for further recommendations.

5. Date of Completion 2/17/2014.

Good Samaritan Society Woodland

Exit 1/30/2014

F282 D
Based on interview and document review the facility failed to provide services in accordance with resident's written care plan for 2 or 2 residents (R29, R56) that required assistance with ambulation.

F311 D
Based on observation, interview and document review the facility failed to provide ambulation services in order to improve and/or maintain the resident's ambulation ability for 2 of 2 residents (R29, R56) who required an ambulation program.

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	245488	A. BUILDING **01 - 100 MAIN BUILDING** B. WING _____	**01/28/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	**100 BUFFALO HILLS LANE BRAINERD, MN 56401**

(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	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society, Woodland was found 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. Good Samaritan Society, Woodland is a 1-story building without a basement. The building was constructed in 1982 and was determined to be of Type V(111) construction. The building is separated from the apartment building with a 2-hour fire barrier and is divided into 3 smoke zones with 1-hour fire barriers. The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 42 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING **01 - 100 MAIN BUILDING** B. WING _____	**01/28/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	**100 BUFFALO HILLS LANE BRAINERD, MN 56401**

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MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8422

February 5, 2014

Ms.. Jennifer Grams, Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, Minnesota 56401

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5488024

Dear Ms. Grams:

The above facility was surveyed on January 27, 2014 through January 30, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules.

At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF

MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health,

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601
Telephone: (218) 308-2104
Fax: (218) 308-2122

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00956	A. BUILDING: _____ B. WING _____	01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 27th, 28th, 29th and 30th, 2014 surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Monitoring, Licensing and Certification Program; 705 5th street Suite A, Bemidji, MN 56601.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced	2 565		

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2 565	Continued From page 2 by: Based on observation, interview and document review, the facility failed to provide ambulation services as directed by the resident's written care plan for 2 of 2 residents (R29, R56) who required assistance with ambulation. Findings include: R29 did not receive ambulation services as directed by the individual care plan. R29's care plan dated 1/20/14, indicated R29 was receiving nursing rehabilitation services which included a functional maintenance program (FMP) for ambulation. The care plan indicated R29 was to be ambulated as weight bearing tolerated (WBAT) to right lower extremity with assist of one staff with a front wheeled walker (FWW) and assist of 1 staff 100 feet (ft.) twice daily. The nursing assistant Rehabilitation Nursing documentation on the Kiosk from 1/21/14, to 1/29/14, indicated R29 ambulated six out of 18 opportunities, refused three times, and documentation also indicated not applicable (N/A) one time. R29's Kiosk daily documentation from 1/21/14-1/29/14, revealed the following: -1/29/14, R29 ambulated one time. -1/28/14, R29 ambulated one time. -1/27/14, R29 ambulated one time. -1/26/14, R29 ambulated one time and refused one time. -1/25/24, R29 refused one time. -1/24/14, blank- no documentation noted. -1/23/14, R29 ambulated one time and refused	2 565		

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2 565	Continued From page 3 one time. -1/22/14, R29 ambulated one time and refused one time. -1/21/14, R29 ambulated zero times and the form had N/A checked. On 1/27/14, at 7:30 p.m. R29 was observed in her room, seated in a wheelchair. At that time R56 stated she had been discontinued from physical therapy (PT) on 1/24/14. R29 also stated she should be walking two times a day but staff had not been walking her two times a day. R29 stated the evening staff were always so busy and did not have the time to ambulate her. On 1/28/14, at 7:15 a.m. R29 stated staff had ambulated her one time on 1/27/14. On 1/28/14, at 11:30 a.m. physical therapy assistant (PTA) verified R29 was discharged from physical therapy on 1/24/14, and was to be ambulated two times a day by the nursing staff. On 1/29/14, at 8:30 a.m. R29 stated staff had ambulated her one time on 1/28/14. On 1/30/14, at 8:45 a.m. R29 stated staff had ambulated her one time on 1/29/14. R29 also stated she would really like to walk two times a day so she could get stronger and go home. On 1/29/14, at 3:00 p.m. nursing assistant (NA)-B stated she was an evening staff person and reviewed her NA care assignment sheet with the surveyor. NA-B stated the care assignment sheet identified which residents needed to be ambulated on her shift. NA-B confirmed R29 was not identified on the care sheet as needing to be	2 565		

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2 565	Continued From page 4 ambulated. On 1/30/14, at 9:55 a.m. NA-C, confirmed she worked evenings and stated R29 was included in her list of residents to care for. However, NA-C stated there were only two residents identified in her group of residents to care for that required ambulation assistance and R29 was not one of them. On 1/30/14, at 10:20 a.m. registered nurse (RN)-A verified R29's care plan was correct and confirmed R29 was to be ambulated two times a day as directed by the FMP plan and on the Kiosk for the NA's to document ambulation. R56 did not receive ambulation services as directed by the individual care plan. R56's care plan dated 11/5/13, indicated R56 was on a nursing rehabilitation program and was to ambulate with assist of one staff with a FWW, distance as tolerated 5-30 ft. two times a day. The nursing assistant rehabilitation documentation on the Kiosk from 1/1/14, through 1/29/14, indicated R56 ambulated ten out of 56 opportunities, refused 26 times, and 16 times N/A was documented. On 1/27/14, at 7:00 p.m. R56 was observed in his room, seated in a wheelchair. At that time R56 stated staff did not take him for walks everyday like he was supposed to be. R56 also stated staff think I should ask them to take me for a walk but I think they should be asking me to go for a walk and they don't.	2 565		

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2 565	Continued From page 5 On 1/30/14, at 8:10 a.m. R56 was observed sitting by the dining table. R56 stated he went for a walk last night and it went pretty well. On 1/29/14, at 3:05 p.m. NA-A who worked evenings stated she had seven residents on her list to walk and did not always have time to ambulate everyone as directed. NA-A stated when the facility worked short on the evening shift she just did not have the time to walk the residents. NA-A stated if she did not have time to walk a resident, she documented "N/A" on the Kiosk. On 1/30/14, at 10:05 RN-A verified R56's care plan was correct and was not followed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of	2 915		

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2 915	Continued From page 6 the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services in order to improve and/or maintain the resident's ambulation ability for 2 of 2 residents (R29, R56) who required an ambulation services. Findings include: R29 was not provided ambulation services as directed by the care plan. R29's Medical Diagnosis List dated 7/19/13, indicated R29's diagnoses included congestive heart failure (CHF) and after care of a healing traumatic fractured upper leg/ankle. R29's quarterly Minimum Data Set (MDS) dated 10/21/13, indicated R29 had intact cognition and required extensive assist with bed mobility, transfers and was non-ambulatory. The 7/26/13, activity of daily living (ADL) Care Area Assessment (CAA) indicated R29 required extensive assist with bed mobility and was non-ambulatory.	2 915		

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2 915	Continued From page 7 R29's physical therapy (PT) plan of care dated 12/2/13, indicated R29 was treated for a leg fracture in which PT was discontinued on 1/24/14, with recommendations to continue the same functional maintenance program (FMP) for ambulation with nursing staff. R29's Notice of Resident Change form dated 1/16/14, and completed by PT/OT indicated R29 was to ambulate with a FWW with stand by assist (SBA), goal: 100 feet (ft.) two times a day. R29's care plan dated 1/20/14, indicated R29 was receiving nursing rehabilitation services which included a functional maintenance program (FMP) for ambulation. The care plan indicated R29 was to be ambulated as weight bearing tolerated (WBAT) to right lower extremity with assist of one staff with a front wheeled walker (FWW) and assist of 1 staff 100 ft. twice daily. R29's significant change MDS review note dated 1/22/14, indicated R29's cognition had improved and had intact cognition, was alert and oriented, verbalized needs and ambulated with assist from one staff. The nursing assistant registered (NAR) Rehabilitation Nursing documentation on the Kiosk from 1/21/14, to 1/29/14, indicated R29 ambulated six out of 18 opportunities, refused three times, and documentation also indicated not applicable (N/A) one time. R29's Kiosk daily documentation from 1/21/14-1/29/14, revealed the following: -1/29/14, R29 ambulated one time. -1/28/14, R29 ambulated one time. -1/27/14, R29 ambulated one time.	2 915		

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2 915	Continued From page 8 -1/26/14, R29 ambulated one time and refused one time. -1/25/24, R29 refused one time. -1/24/14, blank- no documentation noted. -1/23/14, R29 ambulated one time and refused one time. -1/22/14, R29 ambulated one time and refused one time. -1/21/14, R29 ambulated zero times and the form had N/A checked. On 1/27/14, at 7:30 p.m. R29 was observed in her room, seated in a wheelchair. At that time R56 stated she had been discontinued from physical therapy (PT) on 1/24/14. R29 also stated she should be walking two times a day but staff had not been walking her two times a day. R29 stated the evening staff were always so busy and did not have the time to ambulate her. On 1/28/14, at 7:15 a.m. R29 stated staff had ambulated her one time on 1/27/14. On 1/28/14, at 11:30 a.m. physical therapy assistant (PTA) verified R29 was discharged from physical therapy on 1/24/14, and was to be ambulated two times a day by the nursing staff. On 1/29/14, at 8:30 a.m. R29 stated staff had ambulated her one time on 1/28/14. On 1/29/14, at 3:00 p.m. nursing assistant (NA)-B stated she was an evening staff person and reviewed her NA care assignment sheet with the surveyor. NA-B stated the care assignment sheet identified which residents needed to be ambulated on her shift. NA-B confirmed R29 was not identified on the care sheet as needing to be ambulated on the evening shift.	2 915		

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2 915	Continued From page 9 On 1/30/14, at 8:45 a.m. R29 stated staff had ambulated her one time on 1/29/14. R29 also stated she would really like to walk two times a day so she could get stronger and go home. On 1/30/14, at 9:55 a.m. NA-C, verified she worked evenings and R29 was included in her list of residents to care for. NA-C stated there were two residents identified on her resident list who required ambulation services on the evening shift and confirmed R29 was not one of them. On 1/30/14, at 10:20 a.m. registered nurse (RN)-A verified R29's care plan was correct and confirmed R29 was to be ambulated two times a day as directed by the FMP plan and on the Kiosk for the NA's to document ambulation. On 1/30/14, at 10:35 a.m. NA-D, verified she had cared for R29 on 1/29/14, and stated she had not walked R29 on the evening shift. NA-D stated she had documented in the medical record "N/A" because she had never ambulated R29 and R29 never asked to be ambulated. NA-D also stated R29 was identified on her resident care sheet as not needing to be ambulated. R56 was not provided with ambulation services as directed by the care plan. R56's Medical Diagnoses List, undated, indicated R56's diagnoses included acute respiratory failure, chronic airway obstruction, pneumonia, malignant neoplasm bronchus and lung and peripheral vascular disease. R56's admission MDS dated 11/12/13, indicated R56 had intact	2 915		

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2 915	Continued From page 10	2 915		

cognition and required extensive staff assistance with bed mobility and walking. R56's ADL CAA dated 11/14/13, indicated R56 required extensive staff assistance with walking.

R56's care plan dated 11/5/13, indicated R56 was on a nursing rehabilitation program and was to ambulate with assist of one staff with a FWW, distance as tolerated 5-30 ft. two times a day.

The NAR Rehabilitation documentation on the Kiosk from
1/1/14, through 1/29/14, indicated R56 ambulated ten out of 56 opportunities, refused 26 times, and 16 times N/A was documented.

On 1/27/14, at 7:00 p.m. R56 was observed in his room, seated in a wheelchair. At this time R56 stated staff did not take him for walks everyday like he was supposed to be. R56 also stated staff think I should ask them to take me for a walk but I think they should be asking me to go for a walk and they don't.

On 1/30/14, at 8:10 a.m. R56 was observed seated by the dining table. R56 stated he went for a walk last night and it went pretty well.

On 1/29/14, at 3:05 p.m. NA-A verified she had worked evenings and stated she had seven residents on her list to walk and did not always have time to ambulate everyone as directed. NA-A stated when the facility worked short on the evening shift she just did not have the time to walk the residents. NA-A stated if she did not have time to walk a resident, she documented "N/A" on the Kiosk.

On 1/30/14, at 10:05 RN-A confirmed R56 was started on a nursing ambulation program on

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2 915	Continued From page 11 12/16/13, and verified R56's care plan was correct. RN-A stated R56's care plan was not followed as directed. On 1/30/14, at 11:10 a.m. the director of nursing (DON) confirmed R29 and R56 had not received ambulation services as directed. The DON also confirmed the NA care sheets lacked identification of which residents required ambulation assistance and they should have. The facility policy titled Ambulation of Resident" dated 9/12, indicated the purpose was to assist resident in maintaining the ability to ambulate and to encourage exercise and promote physical well-being. The policy indicated staff were to review resident information on the Kiosk prior to ambulation. SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with ambulation. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	2 915		