### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH A	MED	ICARE/MEDICA			ND TRANSMITTAL E SURVEY AGENCY	R MEDICARE & ME	ID: 28OL Facility ID: 00956
<ol> <li>MEDICARE/MEDICAID PROVIDER NO (L1) 245488</li> <li>STATE VENDOR OR MEDICAID NO. (L2) 502043300</li> </ol>	Э.	<ol> <li>NAME AND ADI (L3) GOOD SAMA (L4) 100 BUFFAL (L5) BRAINERD,</li> </ol>	ARITAN SOCIE' O HILLS LANE		DLAND (L6) 56401	4. TYPE OF ACTIO 1. Initial 3. Termination 5. Validation	DN: <u>7 (</u> L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)		7. PROVIDER/SUP 01 Hospital	05 HHA	Y 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other r Complaint
6. DATE OF SURVEY 03/12/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDI	NG DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 41 (L37) (L38) 16. STATE SURVEY AGENCY REMARK	<ul> <li>41 (L18)</li> <li>41 (L17)</li> <li>19 SNF</li> <li>(L39)</li> </ul>	B. Not in Comp Requireme ICF (L42)	ce With quirements Based On: ccceptable POC pliance with Program nts and/or Applied V IID (L43)		And/Or Approved Waivers Of 7 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: <b>A</b> 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Se 7. Medical Di	ervices Limit rector m Size
On March 12, 2014 a Post Certificat corrected the deficiencies issued pur Effective February 17, 2014, the fact 17. SURVEYOR SIGNATURE Lyla Burkman, Unit	rsuant to the Janua	ry 30, 2014 standa r <u>41 skilled nursin</u> Date :	ard survey, effec		1	MS 2567b for the result	s of this visit.
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAI	OFFICE OR SINGLE STA	ATE AGENCY	
<ol> <li>DETERMINATION OF ELIGIBILITY</li> <li>X 1. Facility is Eligible to Part</li> <li>2. Facility is not Eligible</li> </ol>	icipate (L21)		IPLIANCE WITH C ITS ACT:	IVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (He e :	CFA-1513)
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	4. LTC AGREEME	ENT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION <b>07/01/1987</b>	BEGINNING	DATE	ENDING DATI	E	VOLUNTARY 01-Merger, Closure	00 <u>INVOLU</u> 05-Fail to	J <u>NTARY</u> 9 Meet Health/Safety
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATIVI A. Suspension of		(L25)		02-Dissatisfaction W/ Reimburser 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	n <u>OTHER</u>	) Meet Agreement der Status Change
(L27)	B. Rescind Sus		(L44) (L45)			00-Activ	e
28. TERMINATION DATE:	29	. INTERMEDIARY/C			30. REMARKS		
	2)	00140					
	(L28)	00140		(L31)			
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION C 03/24/2014	DF APPROVAL DAT	ГЕ (L33)	DETERMINATION APPR	OVAL	



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

General Information: (651) 201-5000 \* TDD/TTY: (651) 201-5797 \* Minnesota Relay Service: (800) 627-3529 \* www.health.state.mn.us For directions to any of the MDH locations, call (651) 201-5000 \* An Equal Opportunity Employer



### 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

Good Samaritan Society - Woodland March 28, 2014 Page 2

### Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245488	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 3/12/2014
Name of Facility			Street Address, City, State, Zip Code	
GOOD SAMARITAN SOCIETY - WOODLAND		ID	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	(Y4)	ltem		(Y5)	Date	(Y4)	ltem		(Y5)	Date
			Correction					Correction					Correction
ID Prefi	× F0282		Completed 02/17/2014		ID Prefix	F0311		Completed 02/17/2014		ID Prefix			Completed
	# 483.20(k)(3)(ii)		02/1//2014			483.25(a)(2)				Reg. #			
LS						405.25(d)(2)							
									+-				
			Correction					Correction					Correction
ID Prefi	x		Completed		ID Prefix			Completed		ID Prefix			Completed
Reg.	#				Reg. #					Reg. #			
LS					LSC								
			Correction					Correction					Correction
ID Prefi	x		Completed		ID Prefix			Completed		ID Prefix			Completed
Reg.					Reg. #			-		Reg. #			
LSC													
			O a mar a ti a m					O					O and the set
			Correction Completed					Correction Completed					Correction Completed
ID Prefi	x		Completed		ID Prefix			-		ID Prefix			
Reg.					Reg. #					Reg. #			
LSO	C				LSC					LSC			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefi	x				ID Prefix					ID Prefix			
Reg. : LSO					Reg. # LSC					Reg. #			
					130				+-	130			
Reviewed I	By Review	wed E	8y	Da	te:	Signature of	Surve	yor:				Date:	
State Agen	cy MN	1/LE	}	03	8/28/20	14	28	035				03/1	12/2014
Reviewed I	By Review	wed E	8y	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup 1	o Survey Completed on	n:					-				a Summary of		
	1/30/2014					Unco	recte	u Denciencies		-2007) Sent t	o the Facility?	YES	NO

DEPARTMENT OF	HEALTH AND	HUMAN SEI	RVICES			<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>					
		MED	ICARE/MEDICA	ID CERTIFIC	CATION A	ND TRANSMITTAL	ID	: 280L			
		PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY AGENCY	Fa	cility ID: 00956			
1. MEDICARE/MEDICAI	D PROVIDER NO.		3. NAME AND ADI (L3) GOOL	DRESS OF FACILI D SAMARIT A	TY AN SOCI	ETY - WOODLAND	4. TYPE OF ACTION:	<u><b>2</b>(</u> L8)			
2.STATE VENDOR OR M (L2) <b>50204330</b>			(17)	JFFALO HII	LLS LAN	E (L6) <b>56401</b>	<ol> <li>Initial</li> <li>Termination</li> <li>Validation</li> </ol>	<ol> <li>Recertification</li> <li>CHOW</li> <li>Complaint</li> </ol>			
5. EFFECTIVE DATE CH	7. PROVIDER/SUF	<b>NERD, MN</b> PLIER CATEGOR	Y	<u>02</u> (L7)	7. On-Site Visit	9. Other					
(L9)			01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Con	nplaint			
<ol> <li>6. DATE OF SURVEY</li> <li>8. ACCREDITATION STATEMENT</li> </ol>	01/30/2014 ATUS:	4 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING I	DATE: (L35)			
0 Unaccredited 2 AOA	1 TJC 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	06/30				
11LTC PERIOD OF CER	FIFICATION		10.THE FACILITY	IS CERTIFIED AS:	:						
From (a):			A. In Complian	ce With		And/Or Approved Waivers Of	The Following Requirements:				
To (b) :			Program Re Compliance			2. Technical Personnel 3. 24 Hour RN	6. Scope of Servic 7. Medical Directo				
12.Total Facility Beds		<b>41</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	(F)8. Patient Room Si				
13.Total Certified Beds		<b>41</b> (L17)	X B. Not in Comp Requireme	bliance with Program nts and/or Applied		5. Life Safety Code * Code: <b>B</b> *	9. Beds/Room (L12)				
14. LTC CERTIFIED BED	BREAKDOWN					15. FACILITY MEETS					
18 SNF	18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)				
	41										
(L37)	(L38)	(L39)	(L42)	(L43)							

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 :	18. STATE SURVEY AGENCY APPROVAL	Date:		
<u>Yvonne Switajewski, H</u>	HFE NEII	02/26/2014 (L19)	<u>Mark Meath, Program S</u>	MPM pecialist03/22/2014		
	PART II - TO BE COM	IPLETED BY HCFA REGIONA	L OFFICE OR SINGLE STATE AGEN	СҮ		
19. DETERMINATION OF ELIGIBILITY		20. COMPLIANCE WITH CIVIL	<ol> <li>Statement of Financial Solvency (HCFA-2572)</li> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> </ol>			
1. Facility is Eligible to Participate		RIGHTS ACT:	3. Both of the Above :	osure Stmt (HCFA-1515)		
2. Facility is not Eligible	(L21)			_		
22. ORIGINAL DATE	23. LTC AGREEMENT	24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNING DATE	ENDING DATE	VOLUNTARY <b>00</b>	INVOLUNTARY		
07/01/1987			01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANCTION	DNS	03-Risk of Involuntary Termination	OTHER		
	A. Suspension of Admissio	ns:	04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)	B. Rescind Suspension Da	(L44) te:		00-Active		
		(L45)				
28. TERMINATION DATE:	29. INTERM	EDIARY/CARRIER NO.	30. REMARKS			
	001					
	(L28)	(L31)	Posted 3/24/2014 ML			
31. RO RECEIPT OF CMS-1539	32. DETERM	INATION OF APPROVAL DATE				
	(L32)	(L33)	DETERMINATION APPROVAL			



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;

Good Samaritan Society - Woodland February 5, 2014 Page 3

- 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

Good Samaritan Society - Woodland February 5, 2014 Page 4

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

Good Samaritan Society - Woodland February 5, 2014 Page 5

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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,

Kumalu 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 AND PLAN OF CO	DEFICIENCIES	& MEDICAID SERVICES	- yes	``.	ONB NO.	0938-0391
	ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	and the life of th		E SURVEY PLETED
		245488	B. WING	<b>FEB</b> 2 (2, 2,0)4	01/3	30/2014
NAME OF PROV	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
GOOD SAM/	ARITAN SOCIETY	- WOODLAND	nay nara ang ang ang ang ang ang ang ang ang ang	100 BUFFALO HILLS LANE BRAINERD, MN 56401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 000 IN	NITIAL COMMENT	S	F 00	0		
W CC AC BC CM VE UF OI CC SL RE AC F 282 48 SS=D PE Th m ac	VILL SERVE AS YO OMPLIANCE UPO CCEPTANCE. YC OTTOM OF THE MS-2567 FORM V ERIFICATION OF PON RECEIPT O NSITE REVISIT O ONDUCTED TO UBSTANTIAL CO EGULATIONS HA CCORDANCE W 83.20(k)(3)(ii) SEP ERSONS/PER CA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. RVICES BY QUALIFIED	F 28	<sup>92</sup> Please see attached pages correction.	for plan of	
by B re se pl	y: Based on observa eview, the facility f ervices as directe	NT is not met as evidenced tion, interview and document ailed to provide ambulation d by the resident's written care lents (R29, R56) who required bulation.			Approved 2/24/14 2B	
Fi	indings include:					
	R29 did not receive lirected by the indi	e ambulation services as vidual care plan.				
R	R29's care plan da	ted 1/20/14, indicated R29 was				
alm	Alr Gra	DER/SUPPLIER REPRESENTATIVE'S SIG		TITLE Administration	Hor d	(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.

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	IPLE CONSTRUCTION		TE SURVEY MPLETED
		245488	B. WING		01	/30/2014
	PROVIDER OR SUPPLIER	240400	1	STREET ADDRESS, CITY, STATE, ZIP CODE		13012014
		- WOODLAND		100 BUFFALO HILLS LANE BRAINERD, MN 56401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETIO DATE
F 282	included a function (FMP) for ambulati R29 was to be ambulati R29 was to be ambulati R29 was to be ambulati R29 was to be ambulate assist of one staff v (FWW) and assist daily. The nursing assist documentation on 1/29/14, indicated R29 ambulated six refused three times indicated not applic R29's Kiosk daily of 1/21/14-1/29/14, R29 ambulated six refused three times indicated not applic R29's Kiosk daily of 1/21/14-1/29/14, R29 amb -1/26/14, R29 amb -1/26/14, R29 amb one time. -1/22/14, R29 amb one time. -1/22/14, R29 amb one time. -1/21/14, R29 amb	ehabilitation services which al maintenance program on. The care plan indicated pulated as weight bearing o right lower extremity with with a front wheeled walker of 1 staff 100 feet (ft.) twice ant Rehabilitation Nursing the Kiosk from 1/21/14, to out of 18 opportunities, s, and documentation also cable (N/A) one time. locumentation from evealed the following: pulated one time. pulated one time. pulated one time.	F 28	32		

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING B. WING 245488 01/30/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 100 BUFFALO HILLS LANE **GOOD SAMARITAN SOCIETY - WOODLAND** BRAINERD, MN 56401 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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

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		HAND HUMAN SERVICES				FORM	): 02/04/201 /I APPROVEI ). 0938-039
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245488	B. WING			01	/30/2014
	PROVIDER OR SUPPLIER			100	REET ADDRESS, CITY, STATE, ZIP CO DIENTIALO HILLS LANE CAINERD, MN 56401	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 282	confirmed R29 wa day as directed by for the NA's to doc	age 3 9's care plan was correct and s to be ambulated two times a the FMP plan and on the Kiosk cument ambulation. e ambulation services as		282			
	on a nursing rehat ambulate with ass distance as tolerat The nursing assist documentation on 1/1/14, through 1/2	ated 11/5/13, indicated R56 was bilitation program and was to ist of one staff with a FWW, ted 5-30 ft. two times a day. tant rehabilitation the Kiosk from 29/14, indicated R56 ambulated ortunities, refused 26 times, and					
	room, seated in a stated staff did no like he was suppo think I should ask	0 p.m. R56 was observed in his wheelchair. At that time R56 t take him for walks everyday sed to be. R56 also stated staff them to take me for a walk but be asking me to go for a walk					
	sitting by the dinin	0 a.m. R56 was observed g table. R56 stated he went for nd it went pretty well.		an ang ang ang ang ang ang ang ang ang a			
	evenings stated sl list to walk and did ambulate everyon when the facility w	5 p.m. NA-A who worked he had seven residents on her d not always have time to e as directed. NA-A stated vorked short on the evening shif ave the time to walk the	t	and a failed a second result of the failed by			

Facility ID: 00956

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PRINTED: 02/04/2014

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 245488 **B** WING 01/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **100 BUFFALO HILLS LANE** GOOD SAMARITAN SOCIETY - WOODLAND BRAINERD, MN 56401 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 4 F 282 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 311 483.25(a)(2) TREATMENT/SERVICES TO F 311 SS=D 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 guarterly 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

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245488	B. WING			01/30/2014	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 100 BUFFALO HILLS LANE		
GOOD S	AMARITAN SOCIETY	- WOODLAND			BRAINERD, MN 56401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 311	non-ambulatory.	ge 5 apy (PT) plan of care dated	F3	311			
	fracture in which P <sup>-</sup> with recommendati	R29 was treated for a leg F was discontinued on 1/24/14, ons to continue the same ance program (FMP) for rsing staff.					
	1/16/14, and compl was to ambulate wi	sident Change form dated eted by PT/OT indicated R29 th a FWW with stand by assist et (ft.) two times a day.					
	receiving nursing re included a function (FMP) for ambulation R29 was to be ambulation tolerated (WBAT) to assist of one staff w	ted 1/20/14, indicated R29 was ehabilitation services which al maintenance program on. The care plan indicated pulated as weight bearing o right lower extremity with with a front wheeled walker of 1 staff 100 ft. twice daily.					
	1/22/14, indicated I and had intact cogi	nange MDS review note dated R29's cognition had improved nition, was alert and oriented, nd ambulated with assist from					
	Rehabilitation Nurs Kiosk from 1/21/14 R29 ambulated six refused three times	ant registered (NAR) sing documentation on the , to 1/29/14, indicated out of 18 opportunities, s, and documentation also cable (N/A) one time.					
		locumentation from evealed the following:					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		245488	B. WING			01/	30/2014	
NAME OF I	PROVIDER OR SUPPLIER	L			TREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WOODLAND		-	00 BUFFALO HILLS LANE BRAINERD, MN 56401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 311	<ul> <li>-1/29/14, R29 amb</li> <li>-1/28/14, R29 amb</li> <li>-1/27/14, R29 amb</li> <li>-1/26/14, R29 amb</li> <li>one time.</li> <li>-1/25/24, R29 refus</li> <li>-1/24/14, blank- no</li> <li>-1/23/14, R29 amb</li> <li>one time.</li> <li>-1/22/14, R29 amb</li> <li>one time.</li> <li>-1/21/14, R29 amb</li> <li>had N/A checked.</li> </ul> On 1/27/14, at 7:30 <ul> <li>her room, seated in</li> <li>R56 stated she had</li> <li>physical therapy (P</li> <li>she should be walk</li> <li>had not been walki</li> <li>stated the evening</li> <li>did not have the tim</li> <li>On 1/28/14, at 7:15</li> <li>ambulated her one</li> <li>On 1/28/14, at 11:3</li> <li>assistant (PTA) ver</li> <li>physical therapy or</li> <li>ambulated her one</li> <li>On 1/29/14, at 8:30</li> <li>ambulated her one</li> <li>On 1/29/14, at 3:00</li> <li>stated she was an</li> <li>reviewed her NA c</li> </ul>	<ul> <li>bulated one time.</li> <li>bulated one time.</li> <li>bulated one time.</li> <li>bulated one time and refused</li> <li>bed one time.</li> <li>bound one time and refused</li> <li>commentation noted.</li> <li>bulated one time and refused</li> <li>bulated zero times and the form</li> <li>c) p.m. R29 was observed in</li> <li>bulated zero times and the form</li> <li>c) p.m. R29 was observed in</li> <li>bulated zero times and the form</li> <li>c) p.m. R29 was observed in</li> <li>bulated zero times and the form</li> <li>c) p.m. R29 was observed in</li> <li>c) a.m. R29 was observed in</li> <li>c) a.m. R29 stated staff had</li> <li>c) a.m. R29 stated staff had</li> <li>c) a.m. R29 was discharged from</li> <li>c) a.m. R29 stated staff had</li> </ul>		311				

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		AND HUMAN SERVICES			FORM	02/04/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		245488	B. WING	 	01/3	30/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WOODLAND		100 BUFFALO HILLS LANE BRAINERD, MN 56401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 311	ambulated on her s not identified on the ambulated on the e On 1/30/14, at 8:45 ambulated her one stated she would re day so she could ge On 1/30/14, at 9:55 worked evenings a of residents to care two residents to care two residents ident required ambulatio and confirmed R29 On 1/30/14, at 10:2 (RN)-A verified R29 confirmed R29 was day as directed by for the NA's to doct On 1/30/14, at 10:3 cared for R29 on 1 walked R29 on the had documented in because she had r never asked to be R29 was identified not needing to be a R56 was not provid as directed by the formation of the	idents needed to be shift. NA-B confirmed R29 was a care sheet as needing to be evening shift. a.m. R29 stated staff had time on 1/29/14. R29 also eally like to walk two times a et stronger and go home. a.m. NA-C, verified she nd R29 was included in her list e for. NA-C stated there were ified on her resident list who n services on the evening shift was not one of them. 20 a.m. registered nurse D's care plan was correct and the FMP plan and on the Kiosk ument ambulation. 35 a.m. NA-D, verified she had /29/14, and stated she had not evening shift. NA-D stated she n the medical record "N/A" hever ambulated R29 and R29 ambulated. NA-D also stated on her resident care sheet as ambulated.				
	R56's Medical Diag	gnoses List, undated, indicated				<u> </u>

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 245488 01/30/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **100 BUFFALO HILLS LANE** GOOD SAMARITAN SOCIETY - WOODLAND BRAINERD, MN 56401 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 311 F 311 Continued From page 8 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

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		AND HUMAN SERVICES				FORM	02/04/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		E SURVEY PLETED
		245488	B. WING	;		01/3	30/2014
NAME OF	PROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WOODLAND		1	100 BUFFALO HILLS LANE BRAINERD, MN 56401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	walk the residents. have time to walk a "N/A" on the Kiosk. On 1/30/14, at 10:0 started on a nursin 12/16/13, and verif correct. RN-A state followed as directe On 1/30/14, at 11:1 (DON) confirmed F ambulation service confirmed the NA o identification of wh ambulation assista The facility policy t dated 9/12, indica resident in maintai to encourage exer- well-being. The po	NA-A stated if she did not a resident, she documented 05 RN-A confirmed R56 was g ambulation program on ied R56's care plan was ed R56's care plan was not d. 10 a.m. the director of nursing R29 and R56 had not received as as directed. The DON also		311			

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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.

INTERMETOR OF DEFICIENCIES       (X1) PROVIDER/SUPPLER/CLA       (X2) MULTIPLE CONSTRUCTION       (X2) DATE SUMM         AND FLAN OF CORRECTION       (X1) PROVIDER/SUPPLER/CLATION NUMBER       (X2) MULTIPLE CONSTRUCTION       (X2) DATE SUMM         GOOD SAMARITAN SOCIETY - WOODLAND       INTERCT ADDRESS, CITY STATE, ZIP CODE       (01/28/20)         MALE OF PROVIDER OR SUPPLER       SUMMARY STATEMENT OF DEFICIENCIES       STREET ADDRESS, CITY STATE, ZIP CODE       (01/28/20)         GOOD SAMARITAN SOCIETY - WOODLAND       INTERCE ADDRESS, CITY STATE, ZIP CODE       (01/28/20)         PREFIX       EACH DEFICIENCY MUST BE FRECEDED BY FULL REGULATORY       IN       FREVIX         YA       EACH DEFICIENCY MUST BE FRECEDED BY FULL REGULATORY       IN       FREVIX       CROSS-REFERENCED TO THE APPROPRIATE       CROSS-REFERENCED TO THE APPROPRIATE </th <th></th> <th>MENT OF HEALTH</th> <th>AND HUMAN SERV</th> <th>ICES</th> <th></th> <th>F5488003</th> <th>FORM</th> <th>: 01/30/2014 APPROVED ), 0938-0391</th>		MENT OF HEALTH	AND HUMAN SERV	ICES		F5488003	FORM	: 01/30/2014 APPROVED ), 0938-0391
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         100 BUFFAL O HILLS LANE       BRAINERD, MN 56401         (X) ID       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LOCIDENT/FWIGN INFORMATION)       PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH OEDICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LOCIDENT/FWIGN INFORMATION)       PREFIX       0         K 000       INITIAL COMMENTS       K 000       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, Woodiand was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483,70(a). 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 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 3 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 Arm 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.	STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE	R/CLIA	1° '		(X3) DATE S	URVEY
100 BUFFALO HILLS LANE BRAINERD, MN 56401         COOD SAMARYITAN SOCIETY - WOODLAND INTIAL COMMENTS TATEMENT OF DEFICIENCIES BRAINERD, MN 56401         SUMMARY STATEMENT OF DEFICIENCIES OR LSC IDENTIFYING INFORMATION)         PROVIDER'S PLAN OF CORRECTION (REACH OBRICENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)         K 000         INITIAL COMMENTS         K 000         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 wits 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 as a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitoref for automatic fire department notification installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The facility has a capacity of 42 beds and had a			245488		B. WING		01/2	8/2014
Image: Construct of the second state state of the second state state state of the second state of the second state state of the second								
(M) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES OR IS CDENTFING INFORMATION)         ID PREFIX TAG         PROVIDERS PLAN OF CORRECTION CALL CORRECTION CALL CORRECTION DEFICIENCY         CC           K 000         INITIAL COMMENTS         K 000         CK 000         CG         CGOS-REFERENCES TO THE SPROPRIATE DEFICIENCY         CC           K 000         INITIAL COMMENTS         K 000         K 000         CG         CG           FIRE SAFETY         A Life Safety Code Survey was conducted by the Minnescia 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 Food (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 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 is 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.         The facility has a capacity of 42 beds and had a	GOOD S	AMARITAN SOCIET	Y - WOODLAND					
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census of 40 at the time of the survey.         The requirement at 42 CFR, Subpart 483.70(a) is         MET.         LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE         TITLE		Type V(111) constru- separated from the 2-hour fire barrier a zones with 1-hour fi The building is fully accordance with NF Installation of Sprin The building has a to detection in the corri- corridors that is mo department notifica with NFPA 72 "The 1999 edition. Hazar fire detection that a accordance with the 2007 edition. The facility has a ca- census of 40 at the The requirement at MET.	action. The building i apartment building v nd is divided into 3 s ire barriers. sprinkler protected i FPA 13 Standard for kler Systems 1999 e fire alarm system wit ridors and spaces op nitored for automatic tion installed in acco National Fire Alarm roous areas have au re on the fire alarm s e Minnesota State Fi apacity of 42 beds ar time of the survey. 42 CFR, Subpart 48	s with a moke n the dition. h smoke ben to the c fire rdance Code" tomatic system in re Code nd had a 33.70(a) is			2	(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.

DEPART	MENT OF HEALTH	AND HUMAN SERV & MEDICAID SERV	ICES ICES				APPROVED
STATEMEN		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA		PLE CONSTRUCTION G 01 - 100 MAIN BUILDING	(X3) DATE S COMPL	URVEY ETED
		245488		B. WING		01/2	8/2014
	PROVIDER OR SUPPLIER				STATE, ZIP CODE		21
GOODS	AMARITAN SOCIE	ry - woodland		FFALO HI	LLS LANE 56401		
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							sheet Page 2 of 2

If continuation sheet Page 2 of 2

Printed: 01/30/2014



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 <u>only a suggestion</u> 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

Good Samaritan Society - Woodland February 5, 2014 Page 2 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,

Kumalu 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

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00956	B. WING		01/3	0/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		FALO HILLS RD, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all rule provided at the tag ile number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	surveyors of this De above provider and were issued. Wher please sign and dat orders and return th	rS: 8th, 29th and 30th, 2014 epartment's staff, visited the the following licensing orders n corrections are completed, te, make a copy of these ne original to the Minnesota lth, Division of Compliance		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURV COMPLETED	
		00956	B. WING		01/3	0/2014
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GOOD SA	AMARITAN SOCIETY		FALO HILLS RD, MN 5640			
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2 000	Continued From pa	ige 1	2 000			
		ng and Certification Program;		The assigned tag number a far left column entitled "ID The state statute/rule numl corresponding text of the s out of compliance is listed "Summary Statement of De column and replaces the " portion of the correction or column also includes the are in violation of the state statement, "This Rule is no evidenced by." Following findings are the Suggested Correction and the Time Pe Correction. PLEASE DISREGARD TH THE FOURTH COLUMN V STATES, "PROVIDER'S P CORRECTION." THIS APP FEDERAL DEFICIENCIES WILL APPEAR ON EACH THERE IS NO REQUIREN SUBMIT A PLAN OF COR VIOLATIONS OF MINNES STATUTES/RULES.	Prefix Tag." ber and the tate statute/rule in the eficiencies" To Comply" der. This findings which statute after the of met as the surveyors I Method of eriod For E HEADING OF VHICH LAN OF PLIES TO ONLY. THIS PAGE. MENT TO RECTION FOR	
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
		omprehensive plan of care I personnel involved in the t.				
	This MN Requirem	ent is not met as evidenced				

	ta Department of He	ealth				APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		00956	B. WING		01/	30/2014
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
GOOD S	AMARITAN SOCIETY		FALO HILLS L RD, MN 56401	ANE		
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TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
2 565	Continued From pa	age 2	2 565			
	by:					
	Based on observat	ion, interview and document				
		ailed to provide ambulation				
		d by the resident's written care dents (R29, R56) who required				
	assistance with am					
	Findings include:					
	R29 did not receive	e ambulation services as				
	directed by the indi					
	R29's care plan da	ted 1/20/14, indicated R29 wa	s			
		ehabilitation services which				
		al maintenance program				
		on. The care plan indicated pulated as weight bearing				
		o right lower extremity with				
		with a front wheeled walker				
	(FWW) and assist daily.	of 1 staff 100 feet (ft.) twice				
	The nursing assista	ant Rehabilitation Nursing				
	documentation on t	the Kiosk from 1/21/14, to				
	1/29/14, indicated	aut of 10 annorth mition				
		out of 18 opportunities, s, and documentation also				
		cable (N/A) one time.				
	R29's Kiosk daily d	ocumentation from				
		evealed the following:				
	-1/29/14, R29 amb					
	-1/28/14, R29 amb					
	-1/27/14, R29 amb	ulated one time. ulated one time and refused				
	one time.	טומנכט טווכ נווווכ מווט ופוטטפט				
	-1/25/24, R29 refus	sed one time.				
	-1/24/14, blank- no	documentation noted.				
	-1/23/14, R29 amb	ulated one time and refused				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00956	B. WING		01/30/2014	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE	• • • •	
OOD S	AMARITAN SOCIET		FALO HILLS L RD, MN 56401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE DATE
2 565	Continued From pa	age 3	2 565			
	one time.	pulated one time and refused pulated zero times and the form	1			
	her room, seated i R56 stated she ha physical therapy (F she should be walk had not been walk stated the evening	D p.m. R29 was observed in n a wheelchair. At that time d been discontinued from PT) on 1/24/14. R29 also stated king two times a day but staff ing her two times a day. R29 staff were always so busy and ne to ambulate her.				
	On 1/28/14, at 7:15 ambulated her one	5 a.m. R29 stated staff had time on 1/27/14.				
	assistant (PTA) ve physical therapy of	80 a.m. physical therapy rified R29 was discharged from n 1/24/14, and was to be es a day by the nursing staff.	n			
	On 1/29/14, at 8:30 ambulated her one	0 a.m. R29 stated staff had time on 1/28/14.				
	ambulated her one stated she would r	5 a.m. R29 stated staff had e time on 1/29/14. R29 also eally like to walk two times a jet stronger and go home.				
	stated she was an reviewed her NA c surveyor. NA-B sta identified which res ambulated on her	D p.m. nursing assistant (NA)-E evening staff person and are assignment sheet with the ated the care assignment shee sidents needed to be shift. NA-B confirmed R29 was e care sheet as needing to be	t			

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00956	B. WING		01/	30/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		FALO HILLS L RD, MN 56401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	ambulated. On 1/30/14, at 9:55 worked evenings at her list of residents However, NA-C sta residents identified care for that require R29 was not one of On 1/30/14, at 10:2 (RN)-A verified R29 confirmed R29 was	5 a.m. NA-C, confirmed she nd stated R29 was included in to care for. Ited there were only two in her group of residents to ed ambulation assistance and f them. 20 a.m. registered nurse B's care plan was correct and to be ambulated two times a the FMP plan and on the Kiosł				
	directed by the indir R56's care plan dat on a nursing rehabi ambulate with assis distance as tolerate The nursing assista documentation on t 1/1/14, through 1/2 ten out of 56 opport 16 times N/A was d On 1/27/14, at 7:00 room, seated in a w stated staff did not like he was suppos think I should ask th	ted 11/5/13, indicated R56 was ilitation program and was to st of one staff with a FWW, ed 5-30 ft. two times a day. ant rehabilitation the Kiosk from 9/14, indicated R56 ambulated tunities, refused 26 times, and	1			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00956	B. WING		01/	30/2014
AME OF F	PROVIDER OR SUPPLIEF		DDRESS, CITY, ST	ATE, ZIP CODE		
OOD S	AMARITAN SOCIET	Y - WOODLAND	FALO HILLS L RD, MN 56401	ANE		
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2 565	Continued From p	age 5	2 565			
	sitting by the dinin	0 a.m. R56 was observed g table. R56 stated he went for nd it went pretty well.				
	evenings stated sh list to walk and dic ambulate everyon when the facility w she just did not ha residents. NA-A st	5 p.m. NA-A who worked he had seven residents on her a not always have time to e as directed. NA-A stated vorked short on the evening shift we the time to walk the ated if she did not have time to he documented "N/A" on the				
		05 RN-A verified R56's care and was not followed.				
	The administrator system to educate	THOD OF CORRECTION: or designee could develop a staff and develop a monitoring staff are providing care as itten plan of care.	)			
	TIME PERIOD FC (21) days.	R CORRECTION: Twenty-one	e			
2 915	MN Rule 4658.052	25 Subp. 6 A Rehab - ADLs	2 915			
	comprehensive re home must ensure A. a resident i treatments and se abilities in activitie	s of daily living. Based on the sident assessment, a nursing e that: s given the appropriate rvices to maintain or improve s of daily living unless normal or characteristic part of				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED	
		00956	B. WING		01/	30/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		FALO HILLS L RD, MN 56401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From pa	ige 6	2 915			
	part, activities of da resident's ability to: (1) bathe, dres (2) transfer an (3) use the toil (4) eat; and (5) use speech	ss, and groom; d ambulate;				
	by: Based on observati review, the facility f services in order to resident's ambulation	ent is not met as evidenced ion, interview and document ailed to provide ambulation improve and/or maintain the on ability for 2 of 2 residents quired an ambulation services.				
	C C	led ambulation services as e plan.				
	indicated R29's dia heart failure (CHF) traumatic fractured quarterly Minimum 10/21/13, indicated required extensive transfers and was r activity of daily living Assessment (CAA)	nosis List dated 7/19/13, gnoses included congestive and after care of a healing upper leg/ankle. R29's Data Set (MDS) dated R29 had intact cognition and assist with bed mobility, non-ambulatory. The 7/26/13, g (ADL) Care Area indicated R29 required th bed mobility and was				

Minneso	ta Department of H	ealth			T ORM	APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00956	B. WING		01/3	30/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		FALO HILLS L			
		BRAINE	RD, MN 56401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 915	Continued From pa	age 7	2 915			
	12/2/13, indicated fracture in which P with recommendat functional mainten ambulation with nu R29's Notice of Re 1/16/14, and comp was to ambulate w (SBA), goal: 100 fe R29's care plan da	esident Change form dated leted by PT/OT indicated R29 ith a FWW with stand by assist set (ft.) two times a day. ited 1/20/14, indicated R29 was	t			
	included a function (FMP) for ambulati R29 was to be aml tolerated (WBAT) t assist of one staff	ehabilitation services which al maintenance program ion. The care plan indicated bulated as weight bearing to right lower extremity with with a front wheeled walker of 1 staff 100 ft. twice daily.				
	1/22/14, indicated and had intact cog	hange MDS review note dated R29's cognition had improved nition, was alert and oriented, and ambulated with assist from				
	Rehabilitation Nurs Kiosk from 1/21/14 R29 ambulated six refused three times	ant registered (NAR) sing documentation on the l, to 1/29/14, indicated c out of 18 opportunities, s, and documentation also cable (N/A) one time.				
		locumentation from evealed the following:				
pagete D	-1/29/14, R29 amb -1/28/14, R29 amb -1/27/14, R29 amb	ulated one time.				
nnesota D ATE FORI	epartment of Health M		<sup>6899</sup> 2	80L11	If continua	tion sheet 8 o

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00956	B. WING		01/	30/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		FALO HILLS L RD, MN 56401			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 915	Continued From pa	ige 8	2 915			
	<ul> <li>-1/26/14, R29 ambo one time.</li> <li>-1/25/24, R29 refus</li> <li>-1/24/14, blank- no</li> <li>-1/23/14, R29 ambo one time.</li> <li>-1/22/14, R29 ambo one time.</li> <li>-1/21/14, R29 ambo had N/A checked.</li> </ul> On 1/27/14, at 7:30 her room, seated in R56 stated she had physical therapy (P she should be walk had not been walkin stated the evening did not have the tim On 1/28/14, at 7:15 ambulated her one On 1/28/14, at 11:3 assistant (PTA) ver physical therapy on ambulated her one On 1/29/14, at 8:30 ambulated her one On 1/29/14, at 3:00 stated she was an or reviewed her NA car	ulated one time and refused sed one time. documentation noted. ulated one time and refused ulated one time and refused ulated one time and refused ulated zero times and the form p.m. R29 was observed in a wheelchair. At that time d been discontinued from T) on 1/24/14. R29 also stated ing two times a day but staff ng her two times a day. R29 staff were always so busy and the to ambulate her. 6 a.m. R29 stated staff had time on 1/27/14. 0 a.m. physical therapy ified R29 was discharged from a 1/24/14, and was to be es a day by the nursing staff. a.m. R29 stated staff had time on 1/28/14. p.m. nursing assistant (NA)-B evening staff person and are assignment sheet with the				
	identified which res ambulated on her s	ted the care assignment sheet idents needed to be shift. NA-B confirmed R29 was a care sheet as needing to be evening shift.				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00956	B. WING		01/	01/30/2014	
IAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST	TATE, ZIP CODE		30/2014	
-	AMARITAN SOCIETY		FALO HILLS L	ANE			
00000	1	BRAINE	RD, MN 56401				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 915	Continued From pa	age 9	2 915				
	ambulated her one stated she would re day so she could g On 1/30/14, at 9:55 worked evenings a of residents to care two residents ident required ambulatio and confirmed R29 On 1/30/14, at 10:2 (RN)-A verified R29 confirmed R29 was	5 a.m. R29 stated staff had time on 1/29/14. R29 also eally like to walk two times a et stronger and go home. 5 a.m. NA-C, verified she nd R29 was included in her lise of or. NA-C stated there were ified on her resident list who n services on the evening shif 9 was not one of them. 20 a.m. registered nurse 9's care plan was correct and s to be ambulated two times a the FMP plan and on the Kios ument ambulation.	t				
	cared for R29 on 1. walked R29 on the had documented in because she had n never asked to be	85 a.m. NA-D, verified she had /29/14, and stated she had no evening shift. NA-D stated sh in the medical record "N/A" never ambulated R29 and R29 ambulated. NA-D also stated on her resident care sheet as ambulated.	t e				
	R56 was not provic as directed by the c	led with ambulation services care plan.					
	R56's diagnoses in failure, chronic airw malignant neoplasr peripheral vascular	gnoses List, undated, indicated icluded acute respiratory vay obstruction, pneumonia, m bronchus and lung and r disease. R56's admission (3, indicated R56 had intact	E				

If continuation sheet 10 of 12

Minnesc	ta Department of He	ealth			TORM	APPROVEL
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00956	B. WING		01/30/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S			
GOOD S	AMARITAN SOCIETY		FALO HILLS L RD, 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
2 915	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.					
	on a nursing rehab ambulate with assi	ted 11/5/13, indicated R56 was ilitation program and was to st of one staff with a FWW, ed 5-30 ft. two times a day.				
	Kiosk from 1/1/14, through 1/2 ten out of 56 oppor	ation documentation on the 29/14, indicated R56 ambulated tunities, refused 26 times, and				
	room, seated in a v stated staff did not like he was suppos think I should ask t	D p.m. R56 was observed in his wheelchair. At this time R56 take him for walks everyday sed to be. R56 also stated staff hem to take me for a walk but we asking me to go for a walk				
	seated by the dinin	0 a.m. R56 was observed Ig table. R56 stated he went for Ind it went pretty well.				
	worked evenings a residents on her lis have time to ambu NA-A stated when evening shift she ju walk the residents.	5 p.m. NA-A verified she had and stated she had seven at to walk and did not always late everyone as directed. the facility worked short on the ust did not have the time to NA-A stated if she did not a resident, she documented				
	started on a nursin	05 RN-A confirmed R56 was g ambulation program on				
ATE FOR	epartment of Health M		<sup>6899</sup> 2	80L11	lf continuati	on sheet 11 of

Minnesota Department of He STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED 01/30/2014	
		00956			01/		
ME OF F	PROVIDER OR SUPPLIER	STREET A	DRESS, CITY, STATE, ZIP CODE				
OOD S	AMARITAN SOCIETY		FALO HILLS LA RD, MN 56401	ANE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
2 915	Continued From page 11		2 915				
	12/16/13, and verified R56's care plan was correct. RN-A stated R56's care plan was not followed as directed.						
	(DON) confirmed F ambulation service confirmed the NA c identification of whi	0 a.m. the director of nursing R29 and R56 had not received is as directed. The DON also care sheets lacked ich residents required nce and they should have.					
	dated 9/12, indicat resident in maintain to encourage exercise well-being. The pol	tled Ambulation of Resident" ted the purpose was to assist ning the ability to ambulate and cise and promote physical licy indicated staff were to prmation on the Kiosk prior to	I				
	The DON or design as necessary the p regarding the need ambulation. The D provide training for policies and proceed documentation. Th	THOD FOR CORRECTION: nee(s) could review and revise policies and procedures I for assistance with DON or designee (s) could all appropriate staff on these dures and importance of e DON or designee (s) could all residents are receiving ropriate care.					
	TIME PERIOD FO Twenty-One (21) D						