CENTERS FOR MEDICARE & MEDICAID SERVICES

	MED	ICARE/MEDICA	AID CERTIFIC	ATION A	ND TRANSMITTAL	ID	: 2CLO	
	PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY AGENCY	Fa	acility ID: 00063	
MEDICARE/MEDICAID PROVIDER (L1) 245237 2.STATE VENDOR OR MEDICAID NO. (L2) 385318700	NO.	3. NAME AND ADI (L3) GOOD SAM. (L4) 200 SOUTH I (L5) REDWOOD	ARITAN SOCIET DEKALB STREE	ΓY - REDW	OOD FALLS (L6) 56283	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint	
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 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 43 (L37) (L38)	43 (L18) 43 (L17) N 19 SNF	B. Not in Comp Requirements a ICF (L42)	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP IS CERTIFIED AS: ace With quirements Based On: acceptable POC pliance with Program and/or Applied Waiv IID (L43)	09 ESRD 10 NF 11 ICF/IID 12 RHC	02	6. Scope of Service 7. Medical Director	DATE: (L35)	
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AF	PPROVAL	Date:	
Susanne Reuss,	Unit Supervis	sor (07/18/2016	(L19)	Kate JohnsTon, Program Specialist 08/15/2016 (L20)			
	PART II - TO	BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE OR SINGLE STAT	TE AGENCY		
DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to Pa 2. Facility is not Eligible			IPLIANCE WITH C ITS ACT:	IVIL	21. 1. Statement of Financ 2. Ownership/Control 3. Both of the Above :	rial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA	-1513)	
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	4. LTC AGREEME	NT	26. TERMINATION ACTION:	(L	30)	
OF PARTICIPATION 04/14/1981	BEGINNING I	DATE	ENDING DATE	3	VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Me	et Health/Safety	
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATIVI	ESANCTIONS	(L25)		03-Risk of Involuntary Termination	OTHER		
23. LIC EXTENSION DATE.	A. Suspension of				04-Other Reason for Withdrawal	07-Provider S	Status Change	
(L27)	B. Rescind Sus	pension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
	(L28)	00140		(L31)				

32. DETERMINATION OF APPROVAL DATE

07/06/2016

(L32)

Posted 08/11/2016 Co.

DETERMINATION APPROVAL

(L33)

31. RO RECEIPT OF CMS-1539



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245237 August 15, 2016

Mr. Marcus Parence, Administrator Good Samaritan Society - Redwood Falls 200 South Dekalb Street Redwood Falls, MN 56283

Dear Mr. Parence:

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 July 12, 2016 the above facility is certified for or recommended for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 15, 2016

Mr. Marcus Parence, Administrator Good Samaritan Society - Redwood Falls 200 South Dekalb Street Redwood Falls, MN 56283

RE: Project Number F5237024

Dear Mr. Parence:

On June 14, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 2, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 18, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 24, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 2, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 12, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 2, 2016, effective July 12, 2016 and therefore remedies outlined in our letter to you dated June 14, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245237 _{Y1}	B. Wing	Y2	7/18/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - REDWOOD FALLS		200 SOUTH DEKALB STREET		
		REDWOOD FALLS, MN 56283		
·	·			

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).

ITEN	М	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0226 483.13(c)	Correction	ID Prefix	F0280 	d)(3), 483.10(k)	Correction	ID Prefix	F0282 483.20(k)(3)(ii)		Correction
Reg. #		Completed	Reg. #	(2)	u)(0), 400.10(K)	Completed	Reg. #			Completed
LSC		07/12/2016	LSC			07/12/2016	LSC			07/12/2016
ID Prefix	F0309	Correction	ID Prefix	F0323		Correction	ID Prefix	F0334		Correction
Reg.#	483.25	Completed	Reg. #	483.25(h)	Completed	Reg. #	483.25(n)		Completed
LSC		07/12/2016	LSC			07/12/2016	LSC			07/12/2016
ID Prefix	F0441	Correction	ID Prefix	F0492		Correction	ID Prefix	F0502		Correction
Reg.#	483.65	Completed	Reg. #	483.75(b)	Completed	Reg. #	483.75(j)(1)		Completed
LSC		07/12/2016	LSC			07/12/2016	LSC			07/12/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix		_	Correction
Reg.#		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC			-	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC			-	LSC			
REVIEWEI STATE AG		REVIEWED BY (INITIALS) SR/KJ	DATE 08/15/2	2016	SIGNATURE OF SI		16022		DATE 07	/18/2016
REVIEWEI	D ВҮ	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 6/2/2016		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?				YES	в 🔲 но			

Correction

ID Prefix

ID Prefix

		POST	-CERT	IFICATIO	N REVISIT RI	EPORT	•		
	ER / SUPPLIER / CLIA / CATION NUMBER	MULTIPLE CONS	TRUCTION MAIN BUIL	_DING 01				DATE OF REVI	SIT
245237	Y1	B. Wing					Y2	7/24/2016	Y3
NAME O	F FACILITY				STREET ADDRESS, CIT	Y, STATE, ZI	P CODE		
GOOD SAMARITAN SOCIETY - REDWOOD FALLS			200 SOUTH DEKALB ST	TREET					
	REDWOOD FALLS, MN 56283								
provision the surve	d and the date such corrent number and the identificate report form).	ation prefix code p	oreviously s	hown on the CMS	2567 (prefix codes sho	wn to the lef	•	ent on	
ITE		DATE	ITEM		DATE	ITEM		DAT	
Y	4	Y5	Y4		Y5	Y4		Y5	i
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Corre	ection
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Com	pleted
LSC	K0025	07/12/2016	LSC	K0029	07/12/2016	LSC	K0038	07/12	/2016

Correction

ID Prefix

Correction

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2CLO Facility ID: 00063

	PART I - TO BE COMPLETED BY THE						STATE SURVEY AGENCY Facility ID: 00063			
MEDICARE/MEDICAID PROVIDER NO (L1) 245237 2.STATE VENDOR OR MEDICAID NO.		3. NAME AND ADD (L3) GOOD SAM . (L4) 200 SOUTH	ARITAN SOCIE	CCIETY - REDWOOD FALLS FREET			4. TYPE OF ACTION 1. Initial 3. Termination	2 (L8) 2. Recertification 4. CHOW		
(L2) 385318700		(L5) REDWOOD	FALLS, MN		(L6)	56283	5. Validation	6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWNI (L9)	ERSHIP	7. PROVIDER/SUF	PPLIER CATEGOR	Y 09 ESRD	<u>02</u> (L7	7) 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint			
6. DATE OF SURVEY 06/02/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(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 ENDING	G DATE: (L35)		
2 AOA 3 Other		10 7715 54 677 1777	IG GERTHEIER AG							
11LTC PERIOD OF CERTIFICATION From (a):		10.THE FACILITY		:	And/Or Approved Waivers Of The Following Requirements:					
From (a): To (b):		A. In Compliar Program Rec Compliance	quirements		2. Tec	hnical Personnel	6. Scope of Ser 7. Medical Dire 8. Patient Room	vices Limit		
12.Total Facility Beds	43 (L18)		ecceptable 1 GC			e Safety Code	9. Beds/Room	. GIZC		
13.Total Certified Beds	43 (L17)		pliance with Program and/or Applied Waiv		* Code:	B*	9. Beus/Room (L12)			
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY	MEETS				
18 SNF 18/19 SNF 43	19 SNF	ICF	IID		1861 (e) (1) or	r 1861 (j) (1):	(L15)			
(L37) (L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGENCY REMARKS	(IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):							
17. SURVEYOR SIGNATURE	17. SURVEYOR SIGNATURE Date :				18. STATE SUF	RVEY AGENCY API	PROVAL	Date:		
LoAnn DeGagne,	HFE NE I	[06/24/2016	(L19)	Kate JohnsTon, Program Specialist 07/01/2016 (L20)					
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAL	OFFICE OR	SINGLE STAT	E AGENCY			
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Partic	sinata		IPLIANCE WITH O	CIVIL	1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above :					
2. Facility is not Eligible	(L21)									
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEMI	ENT	26. TERMINA	TION ACTION:		(L30)		
OF PARTICIPATION 04/14/1981	BEGINNING	DATE	ENDING DAT	Е	VOLUNTARY 01-Merger, Clos			TARY Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction	on W/ Reimbursemer	nt 06-Fail to M	Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATIVE				03-Risk of Involu- 04-Other Reason	antary Termination for Withdrawal	<u>OTHER</u> 07-Provide	r Status Change		
(L27)	B. Rescind Sus	pension Date:	(L44) (L45)				00-Active			
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS					
		00140								
	(L28)	00140		(L31)						
31. RO RECEIPT OF CMS-1539	32	DETERMINATION (OF APPROVAL DA	TE	Posted 07/	06/2016 Co.				
	(L32)			(L33)	DETERMIN	ATION APPRO	VAL			



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 14, 2016

Mr.. Marcus Parence, Administrator Good Samaritan Society - Redwood Falls 200 South Dekalb Street Redwood Falls, Minnesota 56283

RE: Project Number S5237023

Dear Mr.. Parence:

On June 2, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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>Electronic 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:

Susanne Reuss, Unit Supervisor Metro A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: Susanne.reuss@state.mn.us

Phone: (651) 201-3793 Fax: (651) 215-9697

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 July 12, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 12, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- 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 ePoC 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 ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 September 2, 2016 (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 December 2, 2016 (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 Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

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

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

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

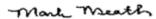
Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

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

Sincerely,



Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 06/24/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245237	B. WING _	·····	06/02/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION	
F 000	INITIAL COMMENT	-S	F 00	00		
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve from the otance. Because you are four signature is not required first page of the CMS-2567 to submission of the POC will ion of compliance.				
	on-site revisit of you validate that substa		F 22	26	7/12/16	
	policies and proced mistreatment, negle	velop and implement written ures that prohibit ect, and abuse of residents on of resident property.				
	by: Based on interview facility failed to conduct background study for (nursing assistant (included direct contuinings include: The facility Abuse a 9/13, included, "The employ individuals of the facility and the employ individuals of the facility and the employ individuals of the facility and	and document review the duct reference checks and or 1 of 5 newly hired employee NA)-C) whose position fact with multiple residents.		1.The background study was cor for NA-C on June 12th 2016 and reference checks were completed June 21, 2016. 2.All new hired employees will be reviewed for completion of backg study and reference checks 3.Re-training for all department hensuring that reference checks at background study are completed hire on June 22, 2016 4.Human Resource Director, or he	d on eround eads for end prior to	
ABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE	

Electronically Signed

06/23/2016

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.

	(X3) DATE SURVEY COMPLETED	
245237 B. WING 06/0	2/2016	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALLS STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226 Continued From page 1 court of law or have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property." The facility Background Investigations policy and procedure, revised 4/16, included, "All offers of employment shall be conditioned on the successful completion of the federal exclusion and criminal background check, the results of personal and professional reference checks and any other pre-employment requirements such as physical assessments, state-specific criminal background check or screens for illegal drugs and alcohol." During an interview on 6/2/16, at 2:26 p.m., the office manager stated NA-C was hired on 1/19/16, after observing through a school program and then decided she wanted to work at the facility. On 12/1/15, NA-C signed the authorization for the background check, but the office manager was unable to locate the completed background check and lacked evidence of completing reference checks. During an interview on 6/2/16, at 3:15 p.m., the administrator verified NA-C's background check and reference checks could not be located. F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment.	7/12/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245237	B. WING		06/02/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
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F 280	within 7 days after comprehensive assinterdisciplinary teaphysician, a register for the resident, and disciplines as deterand, to the extent puther resident, the relegal representative and revised by a teeach assessment.	age 2 the completion of the sessment; prepared by an arm, that includes the attending ared nurse with responsibility dother appropriate staff in armined by the resident's needs, practicable, the participation of sident's family or the resident's e; and periodically reviewed arm of qualified persons after	F 280			
	review, the facility f 1 of 3 residents (R3 Findings include: R30's quarterly mir 5/20/16, indicated s impairment. R30's dated 11/13/15, ind based on impaired hearing, and the us R30 had the following On 2/7/16, R30 we to her wheelchair. I included placing a R30's toileting schell- On 5/19/16, R30 we next to her wheelch	as found lying on the floor next nterventions after this fall personal alarm and increasing		1.Care plan reviewed and fall interventions put into place for R30. 2.All other resident s care plans we reviewed for appropriate fall interver 3.All residents are assessed upon admission for fall risk using the Falls Assessment. Re-training of all lice staff will be completed on care plans fall interventions on June28, 29 and 2016. 4.Audits of residents at risk for falls plan to be audited weekly to ensure compliance. DNS, or designee, will responsible for compliance.QA&A Committee will provide direction or change, if necessary, and will dictate continuation or completion of audits on compliance.	ntions. s Risk ensed ning 30th care	

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F 280	- On 5/21/16, R30 v next to her bed. Intrincluded placing a fibed. On 6/1/16, at 6:49 ptransferred into bed assistant (NA)-D. A on the ground beside was aware that R30 had a bed alarm to out of bed. During an interview was unable to state further stated she ver for fall interventions. Later that day at 8: being transferred in During the observative reason for the fistated the fall mat was a "fall risk." NA had Dysem in her verslipping out; however the R30's wheelchat Dysem in R30's most current listed a personal beintervention, to "remore exit building unative control of the c	sem in her wheelchair. was found lying on the floor erventions after this fall fall mat on the floor next to her o.m., R30 was observed being and repositioned by nursing floor mat was observed lying de R30's bed. i.59 p.m., NA-D stated she o had a history of falling and notify staff if R30 was getting on 6/2/16, at 7:34 a.m., NA-E fall interventions for R30, but would check R30's care plan i. 15 a.m., R30 was observed to bed by NA-E and NA-F. tion, NA-E was not aware of loor mat; however, NA-F was on the floor because R30 a-F went on to state R30 also wheelchair to prevent her from er, when she went to check on air, she stated there wasn't any	F 28				

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F 282 SS=D	stated the facility had thought R30 no long interview, RN-C cor a bed alarm and RN should be taken off unable to find any of fall prevention on R 483.20(k)(3)(ii) SER PERSONS/PER CATThe services provided by the statement of the services provided by the services provided	a.m., register nurse (RN)-B ad gone alarm free and ger had a bed alarm. During offirmed that R30 did not have N-B stated the intervention the care plan. RN-B was ther interventions related for 30's care plan. RVICES BY QUALIFIED	F 2			7/12/16
	by: Based on observat review the facility fa interventions to pre residents (R54) rev Findings include: R54's admission Mi 2/18/16, indicated F impairment and nee transfer. The MDS diagnoses cancer, I mellitus, osteoporos cataracts. The MDS history of falls prior related to a fall prio	vent further falls for 1 of 3 iewed for accidents. nimum Data Set (MDS) dated R54 had severe memory eded extensive assistance to identified the following hypertension, diabetes sis, fracture, dementia and 6 further indicated R54 had a to admission with a fracture		1.Fall interventions reviewed and pplace for R54. Night light is in room and is in working order. 2.All other resident's care plans we reviewed for fall interventions to enthey are in place. 3.All residents are assessed upon admission for fall risk using the Fall Assessment. Appropriate intervent are care planned to meet each resi individual needs. 4.Re-training of all Nursing Staff will completed on fall interventions and planning June 28, 29,30th 2016 Didesignee, will be responsible for compliance. Audits for placement interventions will be conducted rand at least 3 x weeks x 1 month. QA& Committee will provide direction or	re sure Is Risk tions dent's Il be care NS or t of domly	

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F 282	was at risk for falls impulsive behavior transfers. Intervention resident to not benditems, encourage the for assistance, encouncities that prome activities that prome activity, ensure approom, monitor resident and mobility, in blood pressures (lyphasures to check by a change in posidays and then updated and the starting 5/11/16 on the p.m. the a.m. shift. -5/11/16 p.m. shift loothostatic BP's -5/12/16 a.m. and pressure recorded but loothostatic BP's. The documentation of other commentation of other	related to confusion and and would attempt unsafe self ons included remind the dover and pick up dropped he use of the grabber or call burage to participate in ote exercise and physical ropriate footwear, night light in lent for significant changes in ursing to check orthostaticing, sitting, standing blood for low blood pressure caused tion) twice a day for three ate the physician. dministration record and blood re reviewed for twice daily essure (BP) documentation shift and ending 5/14/16 on acked any documentation of a.m. shift lacked any nostatic BP's. a.m. a sitting BP of 126/16 acked a record of lying and p.m. shift lacked any rthostatic BP's standing BP of 126/74, lying	F 2		nd will dictate		
	recorded.	itting BP of 94/53 were					

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F 282		a.m. R54's room was observed s not observed to be in the	F 28	2		
	registered nurse (R BP's were not docu	on 6/2/16, at 11:49 a.m. N)-C verified the orthostatic mented as completed.				
	director of nursing s	on 6/2/16, at 12:22 p.m. the services (DNS) stated she ned interventions to be				
	R54 did not have a	p.m. the DNS verified that night light in his bedroom or ould have been placed in ce.				
F 309 SS=D	received.	ns was requested and not CARE/SERVICES FOR EING	F 30	9		7/12/16
	provide the necessor maintain the high mental, and psychological provides the provides and provides the provi	receive and the facility must ary care and services to attain nest practicable physical, osocial well-being, in e comprehensive assessment				
	by: Based on observat review, the facility fa	NT is not met as evidenced tion, interview, and document ailed monitor bruises for 1 of 3 to were reviewed for non		1.Resident R11 had skin assessm completed June 2, 2016. 2.Daily skin assessment audits will		

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F 309	rehab after being heminimum data set (BIMS of 14 and wa admission care are listed her as needin bed mobility causin related skin condition. R11's current physical listed coumadin (a.d. 1.25 mg (milligram and Thursday and cevery Monday and unspecified atrial filt. During observation three quarter size bright forearm and onoted on the top of one had hurt her buappear." On 6/1/16, at 6:38 proted on R11 and, have a new bruise approximately the sample and the staff bruises. R11 was on sleeve night gown in the staff bruises. R11 was on sleeve night gown in the staff bruises. R11 was on sleeve night gown in the staff bruises. R11 was on sleeve night gown in the staff bruises.	o the facility on 4/13/16 for ospitalized. Her admission MDS), dated 4/20/16, had a s cognitively intact. R11's a assessment, dated 4/26/16, ag extensive assistance with g her to be at risk for pressure	F 30	completed on designated bath residents 3.All nursing staff will be retra 28,29,30th 2016 on skin asse 4.Weekly skin assessments vaudited by DNS or designee treoccurrence of deficiency for QA&A Committee will provide change, if necessary, and will continuation or completion of on compliance.	ined on June issments will be o prevent one month direction or dictate	

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F 309	observations were baths. The nurses observation sheet is and scan it into the She also stated nere charge nurse, case resident's family. The Furthermore, TMAR11 having any bruits (RN)-A state the progress notes by verbally telling so She further stated a progress note if a known if the bruises or documentation. During an interview stated the nurses or documentation. During an interview stated the nurses or documentation. During an interview stated the nurses or documentation regalso stated the ward, if she had been the clinic nurse for R11's progress not admission. The progress or skin R11's "daily skilled"	ration aide (TMA)-A stated skin made with the residents' would fill out the skin of there were any skin concerns electronic medical record. We bruises were reported to the manager, administrator, and hen were investigated. A stated she was not aware of sises recently. The stated she was not aware of sises recently. The stated she was not aware of sises recently. The stated she was not aware of sises recently. The stated she was not aware of staff member to staff member. The staff could document a staff could report in staff could not mention on 6/2/16, at 2:05 p.m., RN-B were expected to monitor for additions on bath days, but had been a "breakdown" in arding the monitoring. She is unaware of R11's bruises on aware, would have notified further instruction.	F 309			

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F 323 SS=D	R11's "skin observareviewed from admindicated "no skin control and address any skilist any current skin 483.25(h) FREE OF HAZARDS/SUPER The facility must enenvironment remainas is possible; and	I R11's skin was normal. Ition" assessments were ission. The assessments onditions observed." Ition assessments were ission. The assessments onditions observed." It is a seen as a seen a seen as a seen a	F 3:			7/12/16
	by: Based on observat review the facility fa and/or implement ir falls for 2 of 3 resid accidents. Findings include: R54's admission Mi 2/18/16, indicated F impairment and nee transfer. The MDS diagnoses: cancer, mellitus, osteoporos	ion, interview and document iled to fully investigate a fall atterventions to prevent further ents (R54, R30) reviewed for mimum Data Set (MDS) dated R54 had severe memory eded extensive assistance to identified the following hypertension, diabetes sis, fracture, dementia and a further indicated R54 had a		1.Fall interventions reviewed and place for R54 and R30. 2.All other resident scare plans we reviewed for fall interventions to enthey are in place. 3.All residents are assessed upon admission for fall risk using the Fat Assessment. Appropriate interventionare care planned to meet each resindividual needs. 4.Re-training of all Nursing Staff we completed on fall interventions and planning on June 28,29 30th,2016 or designee, will be responsible for compliance. Audits for placements	vere isure Ils Risk tions ident s Il be I care . DNS,	

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F 323	history of falls prior related to a fall prior R54's fall Care Area 2/24/16, indicated F during transitions a and diuretics. The Crisk factors: osteop depression, loss of and visual impairme was at high risk for developed to decre improvement of strewith physical and or impaired balance. R54's care plan data trisk for falls relation behavior and would Interventions included behavior and pick the use of the grable encourage to partice exercise and physical footwear, night light significant changes to check orthostatics sitting, standing blo blood pressure cautwice a day for three physician. R54's Fall Tools we dates: - 2/11/16 on admissifall risk	to admission with a fracture	F3	23	interventions will be conducted ran at least 3x week x 1 month. QA&A Committee will provide direction or change, if necessary, and will dicta continuation or completion of audits on compliance.	te	

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F 323	Continued From pa fall risk - 3/14/16 following fall risk	ge 11 a fall and indicated a medium	F3	323			
		a fall and indicated a medium					
	- 3/29/16 following fall risk	a fall and indicated a medium					
	- 4/6/16 following a fall risk	fall and indicated a medium					
	- 4/20/16 following fall risk	a fall and indicated a medium					
	- 5/6/16 following a fall risk	fall and indicated a medium					
	- 5/11/16 following risk	a fall and indicated a low fall					
	R54's fall investigat the following falls:	ion forms indicated R54 had					
	bathroom sitting on next to the toilet and stated that the floor out from under him bathroom. Vital sign documented. Bathrough R54 did not receive have a walking boof fibula fracture. Inte	m. R54 was found in the the wheelchair foot pedals d the call light was on. R54 was slippery and his foot slid as he was trying to get to the is and blood sugars were not doom floor noted to not be wet. an injury. R54 was noted to to on his right foot due to a rvention added was to wait for help due to weakness.					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		E SURVEY MPLETED
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F 323	- 2/19/16, at 8:00 p sitting in the doorw he slipped out of th trying to get up. Vit not documented. R Intervention added after meals and du bedtime, care plan - 3/6/16, at 3:50 a.r in his room. Vital s not documented. R Interventions includight, not to self trai walker to remind hi was on an antibiotic - 3/14/16, at 8:45 p next to his recliner, Resident stated he from his chair to go sugars were not do an injury. Interventi resident shirt 3/27/16, at 2:30 p floor next to his rectiving to get to his blood sugars were receive an injury. Ir remained in physic and had memory is - 3/29/16, 2:20 p.m floor of the TV roor him tipped over. Reneeded to sit down were not document	a.m. R54 was found on the floor ay of the bathroom. R54 stated be wheelchair when he was al signs and blood sugars were t54 did not receive an injury. Was to encourage R54 to toilet ring the morning and at was updated. The matter of the morning and at was updated. The matter of the morning and at was updated. The matter of the morning and at was updated. The matter of the morning and at was updated. The matter of the morning and at was updated. The matter of the morning and at was updated. The matter of the morning and at was updated. The matter of the morning and at was updated. The matter of the morning and at was updated. The matter of the morning and at was a sign to his important of the morning and and blood of the morning and the morning an	F3	23		

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F 323	discontinued on 4/work with therapy ambulation. - 4/6/16, at 9:00 a. in the middle of his trying to get to his sugars were not do an injury. Intervent receiving therapy aboot. R54 has a hidue to cognitive im - 4/20/16, at 10:25 floor beside his be stated he didn't kn signs and blood sure R54 did not receiving were resident educand resident will be four hours promptly hydrochlorothiazid blood pressure) du - 5/6/16, at 3:15 a. the floor with his can he was coming ba Sugar 125, BP 115 temperature 97.7 and 96%. No injury was an anight light plus of the state of the state of the was a documented. R54 Intervention added.	and his walking boot was to be 12/16. R54 will continue to for strengthening and and and R54 was found on the floor aroom. R54 stated he was recliner. Vital signs and blood ocumented. R54 did not receive ions's included R54 was still and continues to wear a cam story of unsafe self transfers apairments. p.m. R54 was found on the d, call light was sounding. R54 ow what he was doing. Vital agars were not documented. In an injury. Interventions added a total total and every y. MD discontinued are (medication for controlling are to low blood pressures. m. R54 was found sitting on all light sounding. R54 stated as from the bathroom. Blood and oxygen saturation levels and oxygen saturation levels noted. Intervention added acced in his bedroom. m. R54 found sitting on the not blood sugars were not did not receive an injury. I was for nursing to obtain ressures twice daily for three	F3	23		

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	pressure record we orthostatic blood prestarting 5/11/16 on 5/14/16 on the a.m. 5/11/16 p.m. shift loothostatic BP's -5/12/16 a.m. and pressure recorded at bustanding BP's. The documentation of completed or of the completed or of the completed or of the completed on 5/14/16, at 5:49 pwas observed transhis room. NA-A ask the bathroom and Fasked R54 if he was R54 stated yes. NA-wheelchair to the sthe wheelchair foot around R54's waist in front of him. NA-R54 used the walkers.	administration record and blood bre reviewed for twice daily ressure (BP) documentation the p.m. shift and ending shift. acked any documentation of the p.m. shift lacked any hostatic BP's. a.m. a sitting BP of 126/16 at lacked a record of lying and p.m. shift lacked any orthostatic BP's standing BP of 126/74, lying sitting BP of 94/53 were d lacked any notification to the postatic BP's were not e orthostatic BP's that were	F3	23			

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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	, 3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	if he needed assists on 6/1/16, at 5:55 phad a lot of falls and him back from meand then transfer himsel his call light and coon. NA-A further stanything after each after meals. On 6/2/16, at 7:48 a informed of fall intervential after meals and to on 6/2/16, at 8:02 a stated that after a fathe staff that are we from where they fel pain and injury. RN resident has care phot make changes for a fall. RN-D stated that R due R54 being able own. On 6/2/16, at 8:51 and a night light war room or the bathroom when interviewed occupational therapy	ght and instructed him to use it ance. D.m. NA-A stated that R54 has d that staff needed to bring als right way, offer to toilet him im to the recliner or he would f. NA-A stated R54 rarely used uld not remember it ever being ated that they didn't change fall other than toileting him a.m. NA-B stated the aids are rventions in report and that ons were to toilet before and check on him every hour. a.m. registered nurse (RN)-D all they do a fall huddle with orking, assess the resident I, check for range of motion, -D further stated that if a lanned interventions they do unless there is a new reason ed that the fall paperwork is nagers box and they review the late the care plan if needed. 54 is difficult to prevent falls to walk but shouldn't on his	F3	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING		E SURVEY MPLETED
		245237	B. WING		06	/02/2016
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP CO 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	communicate if sor fall or if they have a seen due to falls. The many interventions many were not such and vision. The OT approached her react the fall and possible during stand up more minders to use hinterventions were removed from his wand that the facility interventions and the have another fall. It is should be done followed by the station but his powroom change record orthostatic BP's we completed.	e OT stated that the facility will meone is in therapy and has a a referral for someone to be the OT further stated they tried with R54 while in therapy and cessful due to his cognition stated that the facility had not garding fall interventions for harge from therapy. on 6/2/16, at 11:49 a.m. RN-C to business day following a fall, e interventions are reviewed beting. RN-C stated that R54's is call light and therapy effective initially, the sign was walker as it was not effective had tried numerous hey didn't work and he would RN-C stated that vital signs lowing each fall and that R54 bod sugar checked following a state of attorney declined the mmendation. RN-C verified the ere not documented as	F3	23		
	director of nursing expectations follow to notify herself and assessment, transithere is significant incident report and stated that followin intervention into plant.	on 6/2/16, at 12:22 p.m. the services (DNS) stated her ring a fall were for the nurses of the administrator, do a full fer to the emergency room if possible injury, complete an fall investigation. The DNS g a fall nursing is to put a new ace and then management is ts and interventions and make				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245237	B. WING _		06	/02/2016
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	-	702/2010
(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 CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	DNS stated that will were accurate to the care planned interved. DNS further stated should be assessed sugar level if some. On 6/2/16, at 12:51 R54 did not have a bathroom, and it should the plant of the property of the	es to the interventions. The th each fall the interventions he scenario, however expected rentions to be followed. The that absolutely vital signs d with every fall and a blood one is diabetic. p.m. the DNS verified that night light in his bedroom or hould have been placed in fine. Is requested and was not simum data set (MDS), dated she had severe cognitive care area assessment (CAA), licated she was at risk for falls balance, impaired vision and se of antipsychotics. In falls: In fall falls: In fall falls: In fall falls: In fall fall fall fall fall fall fall fal	F 32	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY MPLETED
		245237	B. WING		06	/02/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIF 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 323	assistant (NA)-D. A on the ground beside Later that night at 6 was aware that R30 had a bed alarm to out of bed. During an interview was unable to state further stated she was unable to state further stated she was a light for fall interventions. Later that day at 8: being transferred in During the observathe reason for the final mat was a "fall risk." NA had Dysem in her was lipping out; however the R30's wheelchat Dysem in R30's wheelchat alarm as a current alarm as a current.	d and repositioned by nursing a floor mat was observed lying de R30's bed. 6:59 p.m., NA-D stated she of had a history of falling and notify staff if R30 was getting for on 6/2/16, at 7:34 a.m., NA-E fall interventions for R30, but would check R30's care plan states. 15 a.m., R30 was observed and bed by NA-E and NA-F. Ition, NA-E was not aware of loor mat; however, NA-F was on the floor because R30 also wheelchair to prevent her from er, when she went to check on air, she stated their wasn't any eelchair. careplan listed a personal bed intervention, last revised on	F3	23		
	exit building unatter for R30 to have a lot toileting. R30's care Dysem in her whee On 6/2/16, at 8:20 a stated the facility has thought R30 no lon interview, RN-C cora bed alarm and RI	d resident not to stand up or nded." The care plan did direct ow bed, floor mat, and to offer e plan did not address putting elchair to prevent falls. a.m., register nurse (RN)-B ad gone alarm free and ger had a bed alarm. During nfirmed that R30 did not have N-B stated the intervention the care plan. RN-B was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245237	B. WING		06/	02/2016	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALLS				STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE	
F 323 F 334 SS=D	fall prevention on R	other interventions related for	F 3			7/12/16	
	that ensure that (i) Before offering the each resident, or the representative receiveness and potentimmunization; (ii) Each resident is immunization October annually, unless the contraindicated or timmunized during the representative has immunization; and (iv) The resident's representative was the benefits and poimmunization; and (B) That the resident influenza immunization influenza immunization of the facility must detail the tensure that (i) Before offering the immunization, each legal representative	ives education regarding the ial side effects of the offered an influenza oer 1 through March 31 erimmunization is medically he resident has already been his time period; the resident's legal the opportunity to refuse medical record includes indicates, at a minimum, the ent or resident's legal provided education regarding tential side effects of influenza ent either received the tion or did not receive the tion due to medical refusal.					

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALLS				STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTION		
F 334	immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization or the resident or the resident's legal representative refuses the second immunization.		F 334				
	by: Based on interview facility failed to ma vaccination status who refused the Pr failed to offer the in	NT is not met as evidenced w and document review, the intain documentation of for 2 of 5 residents (R23, R45) neumococcal vaccination and influenza vaccination to 1 of 5 to admitted to the facility during on.		1.Resident R23 is no longer in the R45, or their representative, received ducation regarding pneumococcavaccine. 2.All residents will be reviewed for pneumococcal and influenza vaccif none exists. education will be given.	current ination.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245237	B. WING		 	06/0	02/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALLS				STREET ADDRESS, 200 SOUTH DEKA REDWOOD FALI	_		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD FERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 334	Review of R23's refused the pneum there was no date into his medical record R45 was admitted Review of R45's refused the pneum there was no date into his medical record the pneumotocome of the pneumococcinterview, RN-C condocumentation registered nurse (F) documentation registered nurse (F) documentation state consents were kep longer had. A facility policy enting Residents, dated 2 "refused" in the residents, dated 2 "refused" in the resident or name of attorney)." It did obtain consent for R23 was admitted Review of R23's refreceived an influence and offered the influence of	to the facility on 3/18/16. cord indicated that he had ococcal vaccination; however, of refusal or consent scanned cord. to the facility on 2/11/16. cord indicated that he had ococcal vaccination; however of refusal or consent scanned	F3	regarding risi pneumococci resident cons administered medically consequenced refusal/medical maintained in 3.All new resultants admission for vaccination. The given regard pneumococci consents, medical frefuses or contradicted, refusal/medical maintained in licensed nursultants and procedur vaccines on 4.Audits of necompleted to deficiency medical medical medical formula compliance. The provide direct and will dictal medical medical provide direct and will dictal medical me	ks and benefits of cal and influenza vacci sents, medication will be a cal contradiction will be not the medical record. Sidents will be reviewed a current pneumococo. If none exists, educat arding risks and benefical vaccine. If resident edication will be admin vaccination is medical, documentation of cal contradiction will be not the medical record. Sees will be trained on pres related to pneumo June 28, 29, 30 2016. The ew residents will be not prevent reoccurrence onthly x 3. DNS, or all be responsible for QA&A Committee will be the continuation or complete continuation or complete continuation or complete continuation or complete continuation.	be ation is ation of e d on cal ion will its of t histered. lly e All policy coccal e of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		245237	B. WING			06/0	02/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		200	REET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH DEKALB STREET EDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	3/25/16, indicated hinfluenza vaccination the facility during the season. According to the Ce (CDC), the 2015-20 late, peaked in Mar 2016. During interview on		F3	334			
F 441 SS=F	influenza vaccination on the had been off had refused it. RN-I there wasn't any do A facility policy titled dated 2/15, directed consent upon admisinfluenza vaccination directed that "annuabe given for all residented through Mat the time of admisvaccinated for the cash. SPREAD, LINENS The facility must es Infection Control Pr	on status, including whether or fered the vaccination and if he B was unaware as to why	F 4	141			7/12/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	- REDWOOD FALLS		20	REET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH DEKALB STREET EDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	of disease and infer (a) Infection Contro The facility must es Program under wh (1) Investigates, coin the facility; (2) Decides what p should be applied t (3) Maintains a rec actions related to in (b) Preventing Spre (1) When the Infect determines that a r prevent the spread isolate the resident (2) The facility must communicable dise from direct contact direct contact will t (3) The facility must hands after each d hand washing is in professional practic (c) Linens Personnel must ha	development and transmission ection. of Program stablish an Infection Control ich it - ontrols, and prevents infections rocedures, such as isolation, to an individual resident; and ord of incidents and corrective infections. ead of Infection tion Control Program resident needs isolation to infection, the facility must it. est prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. et require staff to wash their irect resident contact for which dicated by accepted	F 4	41			
	by: Based on observa review the facility fa	NT is not met as evidenced tion, interview and document ailed to ensure proper hand onal cares were performed for			1.All nursing staff will be retrained proper hand hygiene. Facility has implemented an infection control properties of the		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245237	B. WING			06/0	02/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		2	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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 441	of daily living. The from the bed and p pants, adjusted R47 or the way using the form the bed and p pants, adjusted R47 or the way using the form the bed and p pants, adjusted R47 or the from the way using the form the form the way using the form the form the way using the form the form the form the way using the form the form the form the form the form the way using the form	17) observed during activities acility also failed to develop a action control program that aurveilance and tracking of the potential to affect all 34	F 4	141	to monitor and track infections through the facility. 2. All nursing staff will be retrained proper hand hygiene June 28, 29, 2016. 3. Weekly audits will be completed prevent reoccurrence of deficiency DNS, or designee, will be response compliance. QA&A Committee will provide direction or change, if necessand will dictate continuation or composed of audits based on compliance.	on 30 to x 4. sible for essary,	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	into the wheelchair again to raise R47 into the wheelchair soiled gloves, NA-E sit-to-stand lift, put and moved the lift, platform of the whe pants, closed the lidisposable wipes a adjusted R47's clot took the bag out of bathroom door by t grabbed a new bag into the can, and the and washed her has it-to-stand lift out on the handles into hall, where two oth the sling that she he handles. NA-E prodict the utility room cleaned the common cares, NA-E was in should have remove washed her hands before touching equiting it into the stand butting it into the stand considered ready for the staff to follow the procedure for hands stated, "They should have should have should have staff to follow the staff t	and then used the remote up to readjust her placement. Still without removing the unhooked the sling from the both hands on the handles placed R47's feet onto the elchair, pulled up her own don the package that held the and moved the package, thing, latched R47's seat belt, the garbage can, opened the ouching the door handle, for the garbage and placed it then took off the soiled gloves ands. NA-E then pushed the off R47's room with both hands of the storage area across the er lifts were stored, and placed ad used for R47 across the cededed to move the commode off, donned clean gloves, and off the soiled gloves and after cleaning R47's peri area, uipment and other items, and ed the sit-to-stand lift before orage area where it was	F	141			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245237	B. WING		06	/02/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, 2 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 562	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 441	Handwashing proce	nge 26 lity's Hand Hygiene and edure, revised 3/16, did not or hand hygiene with glove	F 4	41		
	Control Reports fro infections were ided in facility) urinary tra acquired urinary tra upper/lower respiral community acquire infections, 35 noso types, and 9 community acquire infections in Center infection, site of infection, site of infection, a cathe antibiotic treatments of the infection o	e facility's Monthly Infection m 5/15 to 4/16, the following ntified: 25 nosocomial (aquired act infections, 2 community act infections, 15 nosocomial story tract infections, 2 d upper/lower respiratory tract comial infections of varying unity acquired infections of Monthly Report of Resident r listed the residents, date of ection, whether or not a culture usative agent if known, and nent used. It did not list any ting to the infection. In ns listed on the monthly report ntibiotics.				
	registered nurse (Recomputer of all inferies of the month to that report, RN-B fill Control Reports with type of infections, whose commander communification control rates stated the names of were taken off that Report of Resident	on 6/2/16, at 2:31 p.m., and the ctions in the facility from the other end of the month. With alled out the Monthly Infection the number of infections, whether the infections were munity aquired, and the efforthat month. She also of the residents with infections report to fill out the Monthly Infections in Center.				

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED
	245237	B. WING		06/02/2016
PROVIDER OR SUPPLIER	- REDWOOD FALLS	:	200 SOUTH DEKALB STREET	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLÉTION
timing of the report, with infections were the month and ongo completed. RN-B a infection control promechansim for trace their spread and completed and completed and comfortable enthat the plan "will at state regulations for applicable," but did tracking infections a plan. 483.75(b) COMPLY FEDERAL/STATE/L The facility must op compliance with all local laws, regulation accepted profession that apply to profess such a facility. This REQUIREMENT by: Based on interview facility failed to give non-coverage for 1	the names of the residents e not known until the end of bing surveillance could not be so acknowledged the current or		1.Resident R57 is no longer in the 2.No other residents are coming of traditional Medicare (Medicare A ar stay to issue an non-coverage deni 3.Case managers and business off manager will be re-trained on wher	f a old B) al cice
R57 was discharge	d from the facility on 2/4/16 to		4.Weekly audits of new residents w	vill be
	Continued From pa timing of the report, with infections were the month and onge completed. RN-B al infection control promechansim for trace their spread and co. A facility policy entiting revised 3/16, directed infection control promechansim for trace their spread and co. A facility policy entiting revised 3/16, directed infection control plated and comfortable enthat the plan "will at state regulations for applicable," but did tracking infections a plan. 483.75(b) COMPLY FEDERAL/STATE/LET The facility must op compliance with all local laws, regulation accepted profession that apply to	PROVIDER OR SUPPLIER AMARITAN SOCIETY - REDWOOD FALLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 timing of the report, the names of the residents with infections were not known until the end of the month and ongoing surveillance could not be completed. RN-B also acknowledged the current infection control program did not have a mechansim for tracking infections to decrease their spread and control outbreaks. A facility policy entitled Infection Control Plan, last revised 3/16, directed that the facility "maintain an infection control plan to provide a safe, sanitary and comfortable environment." It further directed that the plan "will attempt to meet federal and state regulations for infection control where applicable," but did not address surveillance or tracking infections as part of the infection control plan. 483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to give proper notice of non-coverage for 1 of 3 residents (R57) whose Medicare Part A benefits were ending.	A BUILDING 245237 B. WING 245237 B. WING PROVIDER OR SUPPLIER AMARITAN SOCIETY - REDWOOD FALLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 timing of the report, the names of the residents with infections were not known until the end of the month and ongoing surveillance could not be completed. RN-B also acknowledged the current infection control program did not have a mechansim for tracking infections to decrease their spread and control outbreaks. A facility policy entitled Infection Control Plan, last revised 3/16, directed that the facility "maintain an infection control plan to provide a safe, sanitary and comfortable environment." It further directed that the plan "will attempt to meet federal and state regulations for infection control where applicable," but did not address surveillance or tracking infections as part of the infection control plan. 483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to give proper notice of non-coverage for 1 of 3 residents (R57) whose Medicare Part A benefits were ending. Finding include:	PROVIDER OR SUPPLIER AMARITAN SOCIETY - REDWOOD FALLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REDULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 Continued From page 27 timing of the report, the names of the residents with infections were not known until the end of the month and ongoing surveillance could not be completed. RN-B also acknowledged the current infection control program did not have a mechansim for tracking infections to decrease their spread and control outbreaks. A facility policy entitled Infection Control Plan, last revised 3/16, directed that the facility "maintain an infection control plan to provide a safe, sanitary and comfortable environment." If turther directed that the plan "will attempt to meet federal and state regulations for infection control where applicable," but did not address surveillance or tracking infections as part of the infection control plan. 483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to give proper notice of non-coverage for 1 of 3 residents (R57) whose Medicare Part A benefits were ending. Finding include:

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		245237	B. WING _		 	06/	02/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		200 SOUTH DE	SS, CITY, STATE, ZIP CODE KALB STREET ALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTI CORRECTIVE ACTION SHOUL REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 492	a different facility. A denial letter titled Non-Coverage liste would end on 2/4/10 by R57's representathe denial had beer less than 48 hours. During interview on manager stated dento the resident or reasonable to the resident of th		F 49	completed deficiency responsibl Committee change, if	I to prevent reoccurrence x4. DNS, or designee, le for compliance. QA8 e will provide direction of necessary, and will diction or completion of audiance.	will be A or ate	
F 502 SS=D	Requirements, date Medicare Non-Cove days prior to the las 483.75(j)(1) ADMIN The facility must pro	ed 8/12, required the Notice of erage to be give "at least two st covered day." IISTRATION ovide or obtain laboratory	F 50	02			7/12/16
		e needs of its residents. The le for the quality and timeliness					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245237	B. WING		06/	02/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	,	
(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 CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETION DATE
F 502	Continued From pa	age 29	F 50	2		
	by: Based on interview facility failed to provof 5 residents (R11 for anticoagulation Findings include: R11 was admitted to rehab after being hominimum data set of BIMS of 14, was confibrillation (a heart of diagnosis, and recist (blood thinning medical form). The second of the sec	to the facility on 4/13/16 for ospitalized. Her admission (MDS), dated 4/20/16, had a ognitively intact, listed atrial condition) as an active eved anticoagulation therapy dications). Ician orders, dated 4/20/16, blood thinning medication) as) once a day every Tuesday coumadin 2.5 mg once a day Wednesday related to brillation (a heart condition). It		1.Resident R11 lab was complete coagulation therapy. Lab was com on June 2, 2016. 2.All residents have been reviewe ensure lab was completed for coatherapy. 3.All licensed nurses will be retrained June 28, 29, 30 2016 on coagulate therapy and lab procedures. All or received are being double checked licensed personnel. 4.Weekly audits x 4, then Monthly be done by DNS or designee to pure recocurrence of deficiency with coagulation therapy and lab procefor one month. QA&A Committee provide direction or change, if necessary and will dictate continuation or conformal distance.	d to gulation ned on ion ders d by x 2 will revent edures will essary,	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245237	B. WING			06/	02/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DEKALB STREET EDWOOD FALLS, MN 56283		
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 502	- On 5/6/16, INR wa "Hold x2 (for two) date of 5/9/16 On 5/9/16, INR wa "1.25 mg Monday & Recheck 5/12/16 On 5/12/16, INR vo 5/19/16. No docum lab work. No further INR rechement of the INR results were clinic nurse who dadjustment and recommendate the recheck date whowever, there had verified the INR lev. During a follow up in a.m., the anticoagustated R11's last INA that time, R11's had been directed to 2.5 mg Wednesday went on to state R1 been on 5/19/16 and 5/26/16 when the correcheck INR. On 5/10/16 her the INR wowould fax the result clinic had never recommendate the INR wowould fax the result clinic had never recommendate the INR wowould fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works would fax the result clinic had never recommendate the INR works works which works would fax the result fax the INR works works where the INR works works work	as 4.0. Coumadin adjusted to lay 2.5 mg Sunday." Recheck as 2.5. Coumadin adjusted to a Thursday 2.5 mg Wed." vas 1.8. Recheck date entation was provided for this	F 5	02			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245237	B. WING			06/0	02/2016
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		200 S	ET ADDRESS, CITY, STATE, ZIP CODE OUTH DEKALB STREET WOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 502	the results of the te and documention of further directed "A track when labs are Further documenta	ests are in the medical record of physician notification." It process should be in place to	F	02			

PRINTED: 06/28/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A: BUILDING 01 - MAIN BUILDING 01 B. WING 245237 06/02/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 SOUTH DEKALB STREET **GOOD SAMARITAN SOCIETY - REDWOOD FALLS REDWOOD FALLS, MN 56283** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION 1D (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) K 000 INITIAL COMMENTS K 000 **FIRE SAFETY** THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on June 02, 2016. At the time of this survey, Good Samaritan Society Redwood Falls was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to: (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.

TITLE

If continuation sheet Page 1 of 6

06/23/2016

Facility ID: 00063

Electronically Signed

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01	COMPLETED			
		245237	B. WING			/02/2016		
	PROVIDER OR SUPPLIE AMARITAN SOCIET	R Y - REDWOOD FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
K 000	Angela Kappenm <mailto:angela 1.="" 2.="" 3.="" a="" actual,="" addi="" and="" be="" build="" building="" c="" co="" correct="" corridors="" defi="" deficiency="" department="" description="" detection="" determined="" facility="" fire="" following="" for="" fully="" good="" has="" in="" inf="" is="" ka="" mu="" name="" notific<="" o="" of="" one-story="" or="" original="" p="" plan="" prevent="" reoccur="" responsible="" samaritan="" sprinkl="" td="" the="" to="" which="" with=""><td>Pstate.mn.us Initney@state.mn.us> and an@state.mn.us appenman@state.mn.us> ORRECTION FOR EACH IST INCLUDE ALL OF THE FORMATION: If what has been, or will be, done ciency. Oroposed, completion date. Increase of the person orrection and monitoring to orrence of the deficiency. Society Redwood Falls is a g with no basement. The facility er protected, and was of Type II(000) construction. ing was constructed in 1962, tions in 1966 and 1975. If ire alarm system with smoke orridors and spaces open to the monitored for automatic fire cation. The facility has a ds and had a census of 35 at</td><td>K 00</td><td></td><td></td><td></td></mailto:angela>	Pstate.mn.us Initney@state.mn.us> and an@state.mn.us appenman@state.mn.us> ORRECTION FOR EACH IST INCLUDE ALL OF THE FORMATION: If what has been, or will be, done ciency. Oroposed, completion date. Increase of the person orrection and monitoring to orrence of the deficiency. Society Redwood Falls is a g with no basement. The facility er protected, and was of Type II(000) construction. ing was constructed in 1962, tions in 1966 and 1975. If ire alarm system with smoke orridors and spaces open to the monitored for automatic fire cation. The facility has a ds and had a census of 35 at	K 00					
K 025 SS=D	NOT MET as evid NFPA 101 LIFE S Smoke barriers s least a one half h	at 42 CFR, Subpart 483.70(a) is denced by: GAFETY CODE STANDARD hall be constructed to provide at our fire resistance rating and cordance with 8.3. Smoke	K 0:	25		7/12/16		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG 01 - Main Building 01		E SURVEY PLETED
		245237	B. WING		06/	02/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS	STREET ADDRESS, CITY, STATE, ZIP COI 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283			-
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	fire-rated glazing o steel frames. 8.3, 19.3.7.3, 19.3. This STANDARD Smoke barriers sheat a one half ho constructed in accepantium wall. Windo fire-rated glazing o steel frames. 8.3, 19.3.7.3, 19.3. FINDINGS INCLUID During Facility Inspetween the hours observation reveal sprinkler pipe above smoke barrier betwand the Ramp. This deficient pract Maintenance Supen NFPA 101 LIFE SAME One hour fire rated fire-rated doors) or extinguishing system and/or 19.3.5.4 prothe approved autoroption is used, the other spaces by shadoors. Doors are stield-applied protections.	ws shall be protected by r by wired glass panels and 7.5 is not met as evidenced by: hall be constructed to provide at the constructed to terminate at an experiment of the constructed by r by wired glass panels and 7.5 DE: Dection on June 2, 2016, of 10:30 AM and 1:30 PM, and a penetration around a fire the lay-in ceiling in the experiment of the construction of the constr	K 02	1. The penetration around sprinkler pipe above the labetween the East Nurses stramp has been sealed with caulk on 06/21/2016. 2. The safety committee will audits of the facility monthly 3. To ensure this doesn't has safety committee will contimonthly inspections to help safety concerns.	the fire y-in ceiling station and the n fire rated Il complete ly for 90 days. appen again the nue to utilize	7/12/16

PRINTED: 06/28/2016 FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245237	B. WING		06/	02/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		STREET ADDRESS, CITY, STAT 200 SOUTH DEKALB STREE REDWOOD FALLS, MN 5	т		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE	
K 029	fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved autor option is used, the other spaces by sm doors. Doors are sfield-applied protect 48 inches from the permitted. 19.3.2 FINDINGS INCLUID During Facility Inspetween 10:30 AM during the inspection discrepancy with a a.) the door on the was observed without These deficient prafacility Maintenance NFPA 101 LIFE SA Exit access is arranaccessible at all tim 7.1. 19.2.1 This STANDARD is Exit access is arranaccessible at all tim 7.1. 19.2.1 FINDINGS INCLUID FININGS INCLUID FININGS INCLUID FININGS INCLUID FININGS INCLUID FINI	d construction (with o hour an approved automatic fire in in accordance with 8.4.1 stects hazardous areas. When matic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or stive plates that do not exceed bottom of the door are 2.1 DE: Dection on June 2, 2016, and 1:30 PM, observation on revealed the following Hazardous Area: Oxygen Storage Room (S-14) out a self-closing device. Actices were observed by the ce Director. AFETY CODE STANDARD Inged so that exits are readily nes in accordance with section in accordance with	KO	1. A self-closing devioxygen storage room 2. The safety committe audits of the facility m 3. To ensure this does safety committee will monthly inspections to safety concerns.	door on 06/3/2016. see will complete conthly for 90 days. n't happen again the continue to utilize to help identify any the generator room action turn device 06/16/2016. see will complete conthly for 90 days. so't happen again the continue to utilize	7/12/16	

Facility ID: 00063

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245237	B. WING _		06/0	02/2016	
	ROVIDER OR SUPPLIER	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP CO 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	ODE		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 038	was observed with door locking mecha operable with no management of the control o	m the Generator Room (153) a "thumb turn device" on the anism. Doors need to be ore than one action. dice was confirmed with the se Director. FETY CODE STANDARD hall be continuously maintained ons or impediments to full ase of fire or other emergency. Corations, or other objects shall ses thereto, egress there from, shall be in accordance with 2.1 is not met as evidenced by: shall be continuously all obstructions or instant use in the case of fire y. No furnishings, decorations, all obstruct exits, access re from, or visibility thereof nce with 7.1.10. 18.2.1, 19.2.1. DE:	K 03		nis area. The that was en removed all I complete of for 90 days. Open again the ue to utilize	7/12/16	
	(floor buffers/carpe within the Northeas Also, Physical Thei	rvation revealed, several items at cleaners)were observed st Exit by the Dining Room. Trapy equipment was observed at door from the Physical nt.					
K 144	Facility Maintenand	tice was confirmed with the ce Director. FETY CODE STANDARD	K 14	4		7/12/16	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - Main Building 01	(X3) DATE SURVEY COMPLETED	
		245237	B. WING			06/0	2/2016
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DEKALB STREET EDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 144 SS=D	under load for 30 min accordance with 3-4.4.1 and 8-4.2 (I 110) This STANDARD in Generators inspect under load for 30 min accordance with 3-4.4.1 and 8-4.2 (I 110) FINDINGS INCLUIT During documental between the hours following was discontained in the transfer time are being documented load test. During do revealed that the transfer time are being documented load test. During do revealed that the transfer time are documented on the Generator Test Reference in the second se	ted weekly and exercised ninutes per month and shall be NFPA 99 and NFPA 110. NFPA 99), Chapter 6 (NFPA is not met as evidenced by: ited weekly and exercised ninutes per month and shall be NFPA 99 and NFPA 110. NFPA 99), Chapter 6 (NFPA is not review on June 2, 2016, of 10:30 AM and 1:30 PM, the overed: Ithat there was no assurance that there was no assurance is supplied to the emergency es. Also, it was observed that not cool down time was not during the monthly generator occumentation review, it was ansfer time from normal to and cool down time was not is Monthly Emergency port.	K	144	1. The assurance letter will be obt from the natural gas supplier on/or 07/11/2016. The monthly generate test will be for 30 minutes with a 1 minute cool down period. Our polic been updated on 06/03/2016. 2. The safety committee will compaudits of the facility monthly for 90 3. To ensure this doesn't happen as safety committee will continue to umonthly inspections to help identify safety concerns.	before r load 0 cy has lete days. gain the tilize	

Facility ID: 00063



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 14, 2016

Mr.. Marcus Parence, Administrator Good Samaritan Society - Redwood Falls 200 South Dekalb Street Redwood Falls, MN 56283

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5237023

Dear Mr.. Parence:

The above facility was surveyed on May 31, 2016 through June 2, 2016 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, Health Regulation 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.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

Good Samaritan Society - Redwood Falls June 14, 2016 Page 2

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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss at (651) 201-3793 or email: susanne.reuss@state.mn.us.

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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 07/06/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00063 06/02/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET **GOOD SAMARITAN SOCIETY - REDWOOD FAL** REDWOOD FALLS, MN 56283 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

notice of assessment for non-compliance.

the Minnesota Department of Health Informational Bulletin 14-01, available at

obul.htm The State licensing orders are delineated on the attached Minnesota

You have agreed to participate in the electronic receipt of State licensure orders consistent with

http://www.health.state.mn.us/divs/fpc/profinfo/inf

INITIAL COMMENTS:

Electronically Signed

STATE FORM If continuation sheet 1 of 33 2CLO11

TITLE

(X6) DATE

06/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	MDED. ` ´	MULTIPLE JILDING: _	CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
	00063	B. WI	NG		06/0	2/2016
NAME OF PROVIDER OR SUPF		STREET ADDRESS 200 SOUTH DEI REDWOOD FAL	KALB S	TREET		
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY OR LSC IDENTIFYING INFORMA	FULL PRI	ID EFIX AG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
you electronical is necessary for enter the word text. You must State licensure completion dat corrected prior Minnesota Deput of this Department provider and the issued. Please indicate correction that and identify the Minnesota Deput he State Licent federal software assigned to Min Nursing Home The assigned to column entitled statute/rule our "Summary State and replaces the correction order findings which after the statent evidence by." If are the Suggest Time period for PLEASE DISR FOURTH COLUMN "PROVIDER'S"	Health orders being subrilly. Although no plan of or State Statutes/Rules, p "corrected" in the box avithen indicate in the electroress, under the header, the date your orders with to electronically submitting artment of Health. The 1, and June 2, 2016 states are following correction orders in your electronic plan of you have reviewed these of date when they will be considered as the statutes of compliance is listed in the states of compliance is listed in the ement of Deficiencies of the To Comply" portion of the states of the color of	correction lease ailable for ronic ling ill be ng to the urveyors ove ders are for completed. Lumenting sing en les for le far left ate n the olumn of the des the te statute et as andings n and OF THE N." THIS	00			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00063	<u>I</u>		06/0	2/2016
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S TH DEKALB	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			7/12/16
		omprehensive plan of care I personnel involved in the i.				
	by: Based on observati review the facility fa interventions to pre	ent is not met as evidenced ion, interview and document alled to implement vent further falls for 1 of 3 iewed for accidents.		Corrected		
	Findings include:					
	2/18/16, indicated F impairment and nee transfer. The MDS diagnoses cancer, mellitus, osteoporos cataracts. The MDS	inimum Data Set (MDS) dated R54 had severe memory eded extensive assistance to identified the following hypertension, diabetes sis, fracture, dementia and S further indicated R54 had a to admission with a fracture r to admission.				
	was at risk for falls impulsive behavior	ted 5/6/16, directed staff R54 related to confusion and and would attempt unsafe self ions included remind the				

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00063	B. WING		06/0	2/2016
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	TH DEKALB D FALLS, M			
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	resident to not benditems, encourage the for assistance, encourage the for assistance, encountered activities that prome activity, ensure approom, monitor resides gait and mobility, in blood pressures (lypressures to check by a change in posidays and then updated as a change in posidays and then updated and the posidays and the posidays and then updated and the posidays and then updated and the pos	d over and pick up dropped he use of the grabber or call burage to participate in ote exercise and physical ropriate footwear, night light in lent for significant changes in ursing to check orthostatic ing, sitting, standing blood for low blood pressure caused tion) twice a day for three ate the physician. dministration record and blood re reviewed for twice daily essure (BP) documentation shift and ending 5/14/16 on acked any documentation of o.m. shift lacked any nostatic BP's. a.m. a sitting BP of 126/16 acked a record of lying and p.m. shift lacked any rthostatic BP's standing BP of 126/74, lying itting BP of 94/53 were	2 565			

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00063	B. WING		06/0	2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	H DEKALB : D FALLS, M			
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 4	2 565			
	registered nurse (R BP's were not docu	on 6/2/16, at 11:49 a.m. N)-C verified the orthostatic mented as completed. on 6/2/16, at 12:22 p.m. the				
	director of nursing s	services (DNS) stated she ned interventions to be				
	R54 did not have a	p.m. the DNS verified that night light in his bedroom or ould have been placed in ce.				
	A policy on care pla received.	ins was requested and not				
	The director of nurs to assure the plan of interventions implei	THOD OF CORRECTION: sing or designee could monitor of care is followed and mented to assure residents ent care to prevent falls.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 570	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			7/12/16
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal representative at least				

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU		` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00063		B. WING		06/0	02/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FAL	200 SOUT	DRESS, CITY, S TH DEKALB D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 570	quarterly and within the comprehensive by part 4658.0400, This MN Requirement by: Based on observation review, the facility for 1 of 3 residents (R3 Findings include: R30's quarterly min 5/20/16, indicated so impairment. R30's dated 11/13/15, indicated so im	in seven days of the resident assessmer subpart 3, item B. ent is not met as even, interview, and deailed to revise the case on, who was reviewed in the severe cognition of the severe care assessment in the severe c	idenced idenced coument are plan for id for falls. S), dated itive nt (CAA), ik for falls sion and e floor next is fall increasing are floor fall air. he floor fall air. he floor fall idence foor fall idence floor fall idence floo	2 570	Corrected		
	Later that night at 6	:59 p.m., NA-D state	ed she				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00063		B. WING		06/	02/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FAI	00 SOUT	DRESS, CITY, S H DEKALB S D FALLS, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 570	was aware that R30 had a bed alarm to out of bed. During an interview was unable to state further stated she wfor fall interventions Later that day at 8:1 being transferred in During the observation the reason for the filstated the fall matiwas a "fall risk." NA had Dysem in her wislipping out; however the R30's wheelchad Dysem in R30's wheelchad Dysem in R30's whose intervention, to "remore exit building unation address putting prevent falls. On 6/2/16, at 8:20 a stated the facility had thought R30 no long interview, RN-C correct a bed alarm and RN should be taken off unable to find any of fall prevention on R	on 6/2/16, at 7:34 a.m. on 6/2/16, at 7:34 a.m. fall interventions for R3 yould check R30's care in the bed by NA-E and NA tion, NA-E was not awalloor mat; however, NA-was on the floor because F went on to state R30 yheelchair to prevent heer, when she went to chair, she stated there was eelchair. careplan, revised 10/29 at alarm as a current hind resident not to startended." R30's care pland gone alarm free and ger had a bed alarm. Defirmed that R30 did now B stated the intervent the care plan. RN-B was ther interventions relate 30's care plan.	yetting , NA-E 30, but plan ved A-F. are of F se R30 0 also er from neck on sn't any 9/15, and up an did air to I)-B uring t have ion as ed for	2 570			
	The director of nurs	HOD OF CORRECTIC sing (DON) or designee nent policies and proce	, could				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILDING.			
		00063	B. WING		06/0	2/2016
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	TH DEKALB D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT 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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 7	2 570			
	designee, could pro staff related to the t revisions. The quali	revisions. The DON or ovide training for all nursing timeliness of care plan ity assessment and assurance erform random audits to				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			7/12/16
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident				
	by: Based on observati review the facility fa and/or implement ir falls for 2 of 3 resid accidents and failed	ent is not met as evidenced ion, interview and document ailed to fully investigate a fall nterventions to prevent further ents (R54, R30) reviewed for d to monitor bruises for 1 of 3 o were reviewed for non in conditions.		Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						(3) DATE SURVEY COMPLETED	
		00063		B. WING		06/0	02/2016
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAL		H DEKALB : D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 8		2 830			
	R54's admission Mi 2/18/16, indicated Fimpairment and neetransfer. The MDS diagnoses: cancer, mellitus, osteoporos cataracts. The MDS history of falls prior related to a fall prior R54's fall Care Area 2/24/16, indicated Find during transitions at and diuretics. The Crisk factors: osteopodepression, loss of and visual impairmed was at high risk for developed to decreating transitions and the diuretics of the composition of the with physical and or impaired balance. R54's care plan datat risk for falls related behavior and would Interventions includibend over and pick the use of the grabble encourage to partice exercise and physic footwear, night light significant changes to check orthostatic	nimum Data Set (MI R54 had severe memeded extensive assisted identified the following hypertension, diabetts fracture, demention and the state of th	dated ance pressants owing airment, atinence ted R54 would be with the orking due to R54 was mpulsive transfers. Int to not incourage ince, to promote opropriate sident for nursing ing,				
		sed by a change in p e days and then upda					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00063	B. WING		06/0)2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	UTH DEKALB OOD FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 9	2 830			
	R54's Fall Tools we dates:	ere completed on the following	9			
	- 2/11/16 on admiss fall risk	sion and indicated a medium				
	- 3/6/16 following a fall risk	fall and indicated a medium				
	- 3/14/16 following fall risk	a fall and indicated a mediur	n			
	- 3/27/16 following fall risk	a fall and indicated a mediur	n			
	- 3/29/16 following fall risk	a fall and indicated a mediur	n			
	- 4/6/16 following a fall risk	a fall and indicated a medium				
	- 4/20/16 following fall risk	a fall and indicated a mediur	n			
	- 5/6/16 following a fall risk	a fall and indicated a medium				
	- 5/11/16 following risk	a fall and indicated a low fall				
	R54's fall investigate the following falls:	tion forms indicated R54 had				
	bathroom sitting on next to the toilet an stated that the floor out from under him	.m. R54 was found in the the wheelchair foot pedals d the call light was on. R54 was slippery and his foot slippery and his foot slippery and blood sugars were no)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMP		
		00063	B. WING		06/0	2/2016
GOOD SAMARITAN SOCIETY - REDWOOD FAI			DRESS, CITY, S TH DEKALB OF THE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 830	documented. Bathr R54 did not receive have a walking boo fibula fracture. Interencourage R54 to versiting in the doorwate slipped out of the trying to get up. Vita not documented. Rater meals and dual bedtime, care plan - 3/6/16, at 3:50 a.r. in his room. Vital sonot documented. Rater meals and dual bedtime, care plan - 3/6/16, at 3:50 a.r. in his room. Vital sonot documented. Rater meals and dual bedtime, care plan - 3/6/16, at 3:50 a.r. in his room. Vital sonot documented. Rater meals and dual bedtime, care plan - 3/6/16, at 3:50 a.r. in his room. Vital sonot documented. Rater meals and documented. Rater meals and documented and injury and the second injury and the second injury. Intervention singury. Intervention resident shirt 3/27/16, at 2:30 pagars were not documented and injury. Intervention singury and place to his second sugars were receive an injury. Intervention in	oom floor noted to not be wet. an injury. R54 was noted to t on his right foot due to a revention added was to wait for help due to weakness. m. R54 was found on the floor ay of the bathroom. R54 stated e wheelchair when he was al signs and blood sugars were 54 did not receive an injury. was to encourage R54 to toilet ring the morning and at was updated. n. R54 was found on the floor igns and blood sugars were 54 did not receive an injury. led remind R54 to use his call lasfer and added a sign to his m to ask for assistance. R54 c for an urinary tract infection. m. R54 was found on the floor call light within reach. was attempting to transfer to bed. Vital signs and blood cumented. R54 did not receive on added clip call light to m. was found sitting on the liner. resident stated he was bed and fell. Vital signs and not documented. R54 did not utervention listed was R54 al and occupational therapy	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00063		B. WING		06/	02/2016
	F PROVIDER OR SUPPLIER SAMARITAN SOCIETY	- REDWOOD FAL	200 SOUT	DRESS, CITY, S TH DEKALB S D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	floor of the TV room him tipped over. R5 needed to sit down. were not document injury. Intervention receiving therapy a discontinued on 4/1 work with therapy for ambulation. - 4/6/16, at 9:00 a.m. in the middle of his trying to get to his rugars were not do an injury. Intervention receiving therapy a boot. R54 has a his due to cognitive important and boods and the didn't know signs and blood sugars and blood sugars and blood sugars and resident will be four hours promptly hydrochlorothiazide blood pressure) due - 5/6/16, at 3:15 a.m. the floor with his can he was coming back Sugar 125, BP 115/16 temperature 97.7 a 96%. No injury was was a night light plant of the side	n and his walker was a stated he got lost. Vital signs and blocked. R54 did not receincluded was R54 wand his walking boot v 2/16. R54 will continor strengthening and m. R54 was found or room. R54 stated he ecliner. Vital signs a cumented. R54 did nons's included R54 vind continues to weather of unsafe self troairments. p.m. R54 was found found an injury. Intervention an injury. Intervention ation, toileting plan retoileted after meals	and od sugars sive an as still was to be nue to I the floor e was and blood not receive was still ra cam ansfers on the ding. R54 g. Vital nented. ons added eviewed and every trolling ures. ting on 4 stated ations 18, a level added on the on the	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				A. BOILDING.			
		00063		B. WING		06/0	2/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - REDWOOD FAI				H DEKALB : D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 12		2 830			
	documented. R54 c	did not receive an inju was for nursing to ob essures twice daily fo	tain				
	pressure record we orthostatic blood pr	dministration record are reviewed for twice essure (BP) docume the p.m. shift and end shift.	daily ntation				
	-5/11/16 p.m. shift lorthostatic BP's	acked any document	ation of				
	-5/12/16 a.m. and p documenting of orth	o.m. shift lacked any nostatic BP's.					
	- 5/13/16, at 10:44 a.m. a sitting BP of 126/16 was recorded at but lacked a record of lying and standing BP's. The p.m. shift lacked any documentation of orthostatic BP's						
	- 5/14/16, at 4:08 a standing BP of 126/74, lying BP of 122/60 and sitting BP of 94/53 were recorded.						
	physician that ortho	l lacked any notificationstatic BP's were not orthostatic BP's that 16.					
	was observed transhis room. NA-A ask the bathroom and Fasked R54 if he wa R54 stated yes. NA wheelchair to the si the wheelchair foot	o.m. nursing assistant porting R54 via where R54 if he needed R54 stated no. NA-A inted to sit in his recliptoral recommendation of the recliner, respectals, placed a tranand then placed R54 in the and then placed R54 in the placed R54 in the placed R54 in the placed R54	elchair to to use then ner and moved nsfer belt				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 13		2 830			
	R54 used the walke and sat down. NA- gave R54 his call lig if he needed assista		recliner belt and n to use it				
	had a lot of falls and him back from mea and then transfer h self transfer himsel his call light and co on. NA-A further sta	p.m. NA-A stated that d that staff needed to als right way, offer to als right way, offer to the first of the that the recliner or high that the stated R54 rand and that they didn't contain the fall other than toileting	b bring toilet him ne would arely used ever being hange				
	On 6/2/16, at 7:48 a.m. NA-B stated the aids are informed of fall interventions in report and that R54's fall interventions were to toilet before and after meals and to check on him every hour.						
	stated that after a fithe staff that are we from where they fel pain and injury. RN resident has care p not make changes for a fall. RN-D state left in the case mar paperwork and upon RN-D stated that R	a.m. registered nurse all they do a fall hudo orking, assess the reall, check for range of I-D further stated that planned interventions unless there is a new ted that the fall paper nagers box and they plate the care plan if notes to walk but shouldn't be to walk but shouldn't all they walk but shouldn't be to walk but	Ile with sident motion, if a they do v reason work is review the eeded.				
		a.m. R54's room was as not observed to be om.					
	When interviewed	on 6/2/16, at 11:49 a.	m.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X3) DATE COMP		SURVEY LETED	
		00063	B. WING		06/0	2/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FAL 200 SOUT	DRESS, CITY, S TH DEKALB : D FALLS, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	occupational theraga a fall committee bu of the meeting. The communicate if sor fall or if they have a seen due to falls. To many interventions many were not such and vision. The OT approached her regressed that the next the fall and possible during stand up mereminders to use his interventions were removed from his wand that the facility interventions and the have another fall. Eshould be done followed in the station but his power or change record orthostatic BP's we completed. When interviewed of director of nursing sexpectations follow to notify herself and	oist (OT) stated the facility has at the therapists are not a part of OT stated that the facility will meone is in therapy and has a referral for someone to be the OT further stated they tried with R54 while in therapy and cessful due to his cognition stated that the facility had not garding fall interventions for	2 830			
	incident report and stated that following	cossible injury, complete an fall investigation. The DNS g a fall nursing is to put a new use and then management is				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
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NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - REDWOOD FAI			TH DEKALB D FALLS, M			
(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 APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	to review the report any needed change DNS stated that wit were accurate to th care planned interv DNS further stated should be assessed sugar level if some On 6/2/16, at 12:51 R54 did not have a bathroom, and it sh there by maintenan	s and interventions and make es to the interventions. The h each fall the interventions e scenario, however expected entions to be followed. The that absolutely vital signs d with every fall and a blood one is diabetic. p.m. the DNS verified that night light in his bedroom or ould have been placed in	2 830			
	5/20/16, indicated simpairment. R30's of dated 11/13/15, indicated simpairment. R30's of dated 11/13/15, indicated simpairment. R30's of dated 11/13/15, indicated simpaired hearing, and the use R30 had the following and the wheelchair. It included placing a R30's toileting schells of the conformation of the simpairment of the conformation of the simpairment of the conformation of the	ng falls: as found lying on the floor next nterventions after this fall personal alarm and increasing				

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	E SURVEY IPLETED
00063 B. WING 06	/02/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FAL REDWOOD FALLS, MN 56283	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PRECEDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830 Continued From page 16 On 6/1/16, at 6:49 p.m., R30 was observed being transferred into bed and repositioned by nursing assistant (NA)-D. A floor mat was observed lying on the ground beside R30's bed. Later that night at 6:59 p.m., NA-D stated she was aware that R30 had a history of falling and had a bed alarm to notify staff if R30 was getting out of bed. During an interview on 6/2/16, at 7:34 a.m., NA-E was unable to state fall interventions for R30, but further stated she would check R30's care plan for fall interventions. Later that day at 8:15 a.m., R30 was observed being transferred into bed by NA-E and NA-F. During the observation, NA-E was not aware of the reason for the floor mat; however, NA-F stated the fall mat was on the floor because R30 was a "fall risk." NA-F went on to state R30 also had Dysem in her wheelchair to prevent her from slipping out; however, when she went to check on the R30's wheelchair, she stated their wasn't any Dysem in R30's wheelchair. R30's most current careplan listed a personal bed alarm as a current intervention, last revised on 10/29/15, to "remind resident not to stand up or exit building unattended." The care plan did direct for R30 to have a low bed, floor mat, and to offer tolleting. R30's care plan did not address putting Dysem in her wheelchair to prevent falls. On 6/2/16, at 8:20 a.m., register nurse (RN)-B stated the facility had gone alarm free and thought R30 no longer had a bed alarm. During interview. RN-C confirmed that R30 did not have	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00063		B. WING		06/	02/2016
	GOOD SAMARITAN SOCIETY - REDWOOD FAI				STATE, ZIP CODE STREET N 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	unable to find any of fall prevention on R R11 was admitted to rehab after being he minimum data set (BIMS of 14 and was admission care are listed her as needing bed mobility causing related skin condition. R11's current physical listed coumadin (a limit 1.25 mg (milligram and Thursday and cevery Monday and unspecified atrial filt. During observation three quarter size bouring observation three quarter size bounded on the top of one had hurt her but appear." On 6/1/16, at 6:38 go noted on R11 and, if have a new bruise to approximately the sagain, R11 stated in didn't have to do an She went on to stat the staff had never was observed wear making the bruises. During an interview.	other interventions related 30's care plan. o the facility on 4/13/10 ospitalized. Her admis MDS), dated 4/20/16, is cognitively intact. Rate assessment, dated ag extensive assistance gher to be at risk for poss. cian orders, dated 4/2 olood thinning medical solood thinning the bruises "they just the bruises "just e she took a blood thinning a short sleeve nig visible. Iater that evening, at	6 for ssion had a 11's 4/26/16, se with pressure 20/16, stion) uesday e a day dition). 7:14	2 830			
		ation aide (TMA)-A sta					

Minnesota Department of Health

	(X3) DATE SURVEY COMPLETED	
00063 B. WING 06	02/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
baths. The nurses would fill out the skin observation sheet if there were any skin concerns and scan it into the electronic medical record. She also stated new bruises were reported to the charge nurse, case manager, administrator, and resident's family. Then were investigated. Furthermore, TMA-A stated she was not aware of R11 having any bruises recently. Later that same evening, 7:29 p.m., registered nurse (RN)-A stated bruises were documented in the progress notes, investigated, and monitored by verbally telling staff member to staff member. She further stated staff could document a progress note if a bruise healing or getting worse, but mainly would "keep an eyo nit" via verbal report. RN-A was unaware of R11's bruises stating she was never informed of them but R11 was on coumadin. She also stated she wouldn't know if the bruises were healing without reporting or documentation. During an interview on 6/2/16, at 2:05 p.m., RN-B stated the nurses were expected to monitor for bruise and skin conditions on bath days, but further stated there had been a "breakdown" in communication regarding the monitoring. She also stated she was unaware of R11's bruises and, if she had been aware, would've notified the coumadin clinic nurse for further instruction. R11's progress notes were reviewed from admission. The progress notes did not mention any bruises or skin concerns. R11's "daily skilled notes" were reviewed from admission. The notes did not mention any skin concerns and noted R11's skin was normal.		

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP		
			A. BUILDING	:		
		00063	B. WING		06/0	2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	JTH DEKALB OOD FALLS, M			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 19	2 830			
		ission. The assessments conditions observed."				
		plan, initiated on 4/22/16, did in related concerns and did n interventions.	ot			
	Director of Nursing polices and proced monitoring non-pre The Director of Nur educate staff on the The Director of Nur	THOD OF CORRECTION: The or her designee could develoures regarding assessing and ssure related skin conditions. It is is policies and procedures. It is is got her designee could be policies and procedures. It is is got her designee could be system to ensue residents riate care.	p I			
	TIME FRAME FOR (21) Days	CORRECTION: Twenty One				
21375	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	21375			7/12/16
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on interview facility failed to dev infection control prosurveilance and tra	ent is not met as evidenced and document review, the elop a comprehensive ogram that included ongoing cking of infections. This had ct all 34 residents residing in		Corrected		

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Minnesota Department of Health

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00063		B. WING		06/	02/2016
	GOOD SAMARITAN SOCIETY - REDWOOD FAI			DRESS, CITY, S TH DEKALB : D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21375	Continued From pa	ge 20		21375			
	Control Reports from infections were ider in facility) urinary tradequired urinary tradequired urinary tradeper/lower respirations community acquired infections, 35 nosof types, and 9 common varying types. The Infections in Center infection, site of infection, site of infections in Center infection, all infections addition, all infections were treated with a During an interview registered nurse (R	on 6/2/16, at 2:31 p. N)-B a report was pu	ollowing al (aquired munity ocomial 2 atory tract earying ons of esident date of t a culture en, and st any n thly report m., ulled from				
	the computer of all the first of the mont With that report, RN Infection Control Reinfections, type of ir infections were nos aquired, and the infmonth. She also staresidents with infect to fill out the Month Infections in Center awknowledged due names of the reside known until the end surveillance could rawknowledged the	infections in the facility to the end of the many of the completed. Recurrent infection converse many of the many	ity from nonth. hthly er of e ty r that e that report t s report, the vere not ngoing N-B also trol				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '			SURVEY
			A. BOILDING.			
		00063	B. WING		06/0	2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	TH DEKALB D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 21	21375			
	infections to decrea	ase their spread and control				
	revised 3/16, direct infection control pla and comfortable en that the plan "will at state regulations fo applicable," but did	tled Infection Control Plan, last ed that the facility "maintain an in to provide a safe, sanitary evironment." It further directed ttempt to meet federal and r infection control where not address surveillance or as part of the infection control				
	The Director of Nur review and revise in procedures to ensu- trending of resident ensure the infection resident infections symptom tracking, provide training to i assurance team co	THOD OF CORRECTION: rsing (DON) or designee could affection control policies and are adequate tracking and an infections. The DON could a control program analyzed adentifying patterns and trends, and antibiotic stewardship and involved staff. The quality all audit the system to ensure compliance with the infection				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21385	MN Rule 4658.0800 Staff assistance	0 Subp. 3 Infection Control;	21385			7/12/16
	Personnel must be infection control pro the residents and n	istance with infection control. assigned to assist with the ogram, based on the needs of ursing home, to implement ocedures of the infection				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00063		B. WING		06/0	02/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAL		TH DEKALB D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21385	Continued From pa	ge 22		21385			
	by: Based on observati review the facility fa hygiene while perso	ent is not met as evion, interview and docuiled to ensure propeonal cares were performal cares were during a	cument r hand ormed for		Corrected		
	Findings include:						
	assessment dated cognitively intact an	imum Data Set (MDS 5/2/16, indicated R47 of required extensive sfers, toilet use, and p	was				
	that R47 had weaking all transfers with as	t revised on 5/12/16, ness, used a sit-to-st sistance of one staff for toileting on the co	and lift for , and				
	was observed assist commode in her room NA-E gave R47 the call when finished. It came on. NA-E enter gloves, and used the up from the commodused several disposal clean R47's peri are the trash can. NA-E "Large," bowel moves oiled gloves, NA-E from the bed and prepants, adjust R47's	a.m., nursing assistant ating R47 to transfer from, using the sit-to-secal light and instruct At 8:53 a.m., R47's dered R47's room, do se sit-to-stand lift to reach and then threw the stold R47 that she has ement. Without remost picked up a disposation to R47, pulled up shirt, pushed the conget the handles, and the	onto the stand lift. ted her to sall light nned aise R47 d, NA-E ackage to em into ad a, oving her able brief p R47's mmode				

Minnesota Department of Health

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-	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00063	B. WING		06/0	2/2016
NAME OF		OTDEET AD		CTATE ZID CODE		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	H DEKALB			
		REDWOO	D FALLS, M	N 56283		1
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		DATE
		,		DEFICIENCY)		
21385	Continued From pa	ao 22	21385			
21303	Continued From pa	.ge 23	21303			
		nandles of the sit-to-stand lift				
		her motorized wheelchair.				
		o-stand remote to lower R47				
		and then used the remote				
		up to readjust her placement				
		Still without removing the				
		unhooked the sling from the both hands on the handles				
		placed R47's feet onto the				
		elchair, pulled up her own				
		d on the package that held the				
		nd moved the package,				
		hing, latched R47's seat belt,				
		the garbage can, opened the				
		ouching the door handle,				
		for the garbage and placed it				
	into the can, and th	en took off the soiled gloves				
		nds. NA-E then pushed the				
		of R47's room with both hands				
		the storage area across the				
		er lifts were stored, and placed				
		ad used for R47 across the				
		ceeded to move the commode				
		donned clean gloves, and				
		ode. After completion of R47's				
	,	terviewed and stated she				
		ed the soiled gloves and				
		after cleaning R47's peri area,				
		uipment and other items, and ed the sit-to-stand lift before				
	considered ready for	orage area where it was				
	Considered ready it	л use.				
	During an interview	on 6/2/16, at 2:32 p.m., the				
		stated her expectation was for				
		e facility's policy and				
		hygiene and glove use. DON				
		d change their gloves.There's				
		s contamination. That's my				
	expectaton."					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00063		B. WING		06/	02/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FAL	200 SOUT	DRESS, CITY, S TH DEKALB D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21385	Continued From pa	ge 24		21385			
	Handwashing proce	ity's Hand Hygiene a edure, revised 3/16, or hand hygiene with	did not				
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control			21390			7/12/16
	control program muprocedures which pare collection to identify residents; B. a system for control of outbreaks. C. isolation and reduce risk of trans. D. in-service exprevention and con. E. a resident he immunization progrationed in part 465 procedures of resident the prevention and. F. the development of the procedures, including defined in part 4656. G. a system for the products which affed disinfectants, antised incontinence product. I. methods for a current standards of the procedures of the products which affed disinfectants, antised incontinence products.	ealth program included am, a tuberculosis particles and policies to treatment of infection and implement olicies and infection a tuberculosis programment and evaluation of the control, septics, gloves, and maintaining awareness of practice in infection of the control of the c	and ving: c data ons in tion, and ses; ns to s agents; ling an orogram as and o assist in ns; ation of control ram as a use; ion of such as				
	This MN Requireme	ent is not met as ev	idenced				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00063		B. WING		06/0	02/2016
	PROVIDER OR SUPPLIER	- REDWOOD FAL	200 SOUT	DRESS, CITY, S TH DEKALB D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21390	by: Based on interview facility failed to deve infection control prosurveilance and tracthe potential to affethe facility. Findings include: During review of the Control Reports fro infections were ider in facility) urinary tracquired urinary tracquired urinary tracommunity acquired infections, 35 nosotypes, and 9 comm varying types. The Infections in Center infection, site of infewas obtained, a cauthe antibiotic treatm symptoms contributed addition, all infection were treated with a survey in the control of	and document reviewelop a comprehensive orgam that included of cking of infections. The ct all 34 residents research facility's Monthly Inform 5/15 to 4/16, the footified: 25 nosocomial act infections, 2 comment infections, 15 nosotory tract infections, 2d upper/lower respirate comial infections of valunity acquired infection Monthly Report of Research is the residents, whether or not usative agent if known the composition of the infection. It is listed on the month intibiotics.	engoing nis had iding in ection llowing (aquired nunity comial etory tract arying ons of sident date of a culture n, and est any nenly report	21390	Corrected		
	registered nurse (R the computer of all the first of the mont With that report, RN Infection Control Re infections, type of ir infections were nos aquired, and the inf month. She also sta residents with infec	on 6/2/16, at 2:31 p.r N)-B a report was pulinfections in the facility to the end of the months. B filled out the Months with the number occurrence or community ection control rate for ated the names of the tons were taken off the port of Resident.	lled from by from conth. chly er of y that				

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DAT A. BUILDING: CON		
			A. BUILDING.	·		
		00063	B. WING		06/0	2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	TH DEKALB OD FALLS, M			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
21390	Continued From pa	ge 26	21390			
	awknowledged due names of the reside known until the end surveillance could r awknowledged the program did not hav	r. Furthermore, RN-B to the timing of the report, the ents with infections were not l of the month and ongoing not be completed. RN-B also current infection control we a mechansim for tracking ase their spread and control				
	revised 3/16, direct infection control pla and comfortable en that the plan "will at state regulations for applicable," but did	tled Infection Control Plan, lassed that the facility "maintain and to provide a safe, sanitary exironment." It further directed thempt to meet federal and refection control where not address surveillance or as part of the infection control				
	The Director of Nur develop, review and procedures to ensu are maintained. The DON or design appropriate staff on	THOD OF CORRECTION: rsing (DON) or designee could d/or revise policies and are infection control procedures nee could educate all a the policies/procedures, and aitoring systems to ensure e.				
	TIME PERIOD FOR Twenty-One (21) Da					
21426	MN St. Statute 144 Prevention And Cor	A.04 Subd. 3 Tuberculosis ntrol	21426			7/12/16
		e provider must establish and nensive tuberculosis				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		.	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING	•		
		00063	B. WING		06/0	2/2016
NAME OF	PROVIDER OR SUPPLIER	STR	EET ADDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	SOUTH DEKALB DWOOD FALLS, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	infection control pro- current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimir Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement	ogram according to the mean infection control guidelined States Centers for Disection (CDC), Division of the nation, as published in CD ality Weekly Report (MMV) include a tuberculosis an that covers all paid and contractors, students, nteers. The Department of the technical assistance intation of the guidelines.	nes ase PC's VR).			
	by: Based on interview facility failed to adm within the appropria employees (NA-C) R28) who worked a Findings include: The Facility Tubero Worksheet for Hea the Minnesota Dep completed 4/4/16, i for TB infections. A facility policy entit and Screening for B	ent is not met as evidence and document review, the ninister the tuberculin skir ate timeframe for 1 of 5 and 2 or 5 residents (R21 and resided in the facility. Stulosis (TB) Risk Assessmulth Care Settings License artment of Health (MDH), identified the facility as low the setting the setting the setting the facility as low the setting the facility be setting to the setting	e i test , nent d by v risk Plan S,	corrected		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00063		B. WING		06/	02/2016
	OVIDER OR SUPPLIER	- REDWOOD FAL	200 SOUT	DRESS, CITY, S TH DEKALB S D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
te tv po bi (() a RCT e E N o M fin D o pi Li a pi tr ca vi hi o A fot bi T tii a a m	wo step tuberculing olicy further directed aseline TB screen in Center for Disease and guideline." Recommendations are Workers" state in the second state in the second state in the second second second second in the second in	d for TB upon hire uskin test (TST) method "new employees ing according to cure Control) recommer from the CDC "Test es baseline testing (st) should be given per reviewed for the faNA)-C file was had ar, her Employee/Caraire (symptom screen completed until 3/1/1 on 6/2/16, at 12:14 ed NA-C had been ing the nurses at the faked to work as a nurseen hired on after the leted. Office managularited working and ents until 3/16; howe the shadow experient of residents' rooms led: Tuberculosis Cowed 3/16, indicated sion, residents will resuberculin skin test (Topolicy did not indicated culosis screening presidents screening presidents will applicated screening presidents will result of the shadow experient of residents will result of the shadow experient of the shadow ex	nod. The will have rent CDC nodations ing Health two step prior to acility. In hire date endidate en) and 6. p.m., In a school acility. It is eschool er stated doing ever, she ence, NA-C is control Plan that "prior eceive a TST) or a ste any ior to or	21426			

6899

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00063	B. WING		06/0	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	H DEKALB : D FALLS, M			
(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 APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	R21 was admitted to symptom screen for 2/8/16. R21's first T 2/9/16 (over 72 hour R21 were not provid R28 was admitted to symptom screen for 1/10/16. R28's first until 1/12/16 (almost positive with 4 mm when read. A subset ordered. During interview on registered nurse (R to be given on the consecond TST adminification weeks later, but not She further stated to given and read wer calendar. She verification screenings had been given their administration of the consecution of the consecution of the director of nurse revise policies and surveillance. The Dappropriate staff on The DON could mot TB screening to ensure the consecution of	o the facility on 2/5/16. A ractive TB was completed on ST was not administered until rs later). Physician orders for ded. o the facility on 1/7/16. A ractive TB was completed TST was not administered at a week later) and appeared (millimeters) of induration equent chest X-ray was 6/2/16, at 2:24 p.m., N)-B stated the first TST was lay of admission with the stered approximately two a before the month was up. That the dates the TST's were be suppose to be placed on the led R21 and R28's baseline en given late and should have mission date. THOD FOR CORRECTION: sing (DON) could review and	21426			
22000	MN St. Statute 626	5.557 Subd. 14 (a)-(c) tment of Vulnerable Adults	22000			7/12/16

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00063		B. WING		06/0	02/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDR 200 SOUTH					DDRESS, CITY, STATE, ZIP CODE TH DEKALB STREET DD FALLS, MN 56283			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
22000	Subd. 14. Abuse facility, except hom personal care atten establish and enfor prevention plan. The assessment of the environment, and it factors which may eand a statement of to minimize the risk comply with any rull promulgated by the (b) Each facility, agency and person providers, shall dev prevention plan for residing there or reaction the plan shall contrassessment of: (1) abuse by other indivulnerable adults; (c) other vulnerable adults; (c) other vulnerable adults. For the purperm "abuse include (c) If the facility, and personal care a knows that the vuln violent crime or an toward others, the iplan must detail the minimize the risk the reasonably be expefacility and persons unsupervised. Undof a vulnerable adults.	prevention plans. (a) e health agencies an dant services providue an ongoing writter ne plan shall contain aphysical plant, its sepoulation identifying encourage or permit a specific measures to of abuse. The plans ses governing the plans licensing agency, including a home heal care attendant services from ain an individual abuse ach vulnerable adulceiving services from ain an individualized the person's susceptiduals, including othe (2) the person's risk oults; and (3) statement obe taken to minimize the person and other versons of this paragra	d ers, shall a abuse an an ang abuse, be taken shall a lath care vices use t them. tibility to er f abusing ants of the ze the ulnerable ph, the agencies oviders, amitted a ession ention en to alt might ors to the late with the late of the ention	22000				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00063	B. WING		06/0	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	TH DEKALB STREET DD FALLS, MN 56283			
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	(X5) COMPLETE DATE	
22000	authority or through another facility, and	ge 31 om a law enforcement a medical record prepared by ther health care provider, or g assessments of the	22000			
	This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to conduct reference checks and background study for 1 of 5 newly hired employee (nursing assistant (NA)-C) whose position included direct contact with residents. Findings include:			Corrected		
	The facility Abuse a 9/13, included, "The employ individuals abusing, neglecting court of law or have					
	procedure, revised employment shall be successful complet and criminal background personal and professing other pre-employments assessments.	ound Investigations policy and 4/16, included, "All offers of the conditioned on the sion of the federal exclusion found check, the results of the sional reference checks and the opening of the sional requirements such as the state-specific criminal or screens for illegal drugs				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00063		B. WING		06/	02/2016	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FAL STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMA	-ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
22000	During an interview office manager stat 1/19/16, after obser program and then of the facility. On 12/1, authorization for the office manager was completed backgroevidence of completed buring an interview administrator verification.	ge 32 on 6/2/16, at 2:26 p.red NA-C was hired or ving through a schoolecided she wanted to /15, NA-C signed the background check, a unable to locate the und check and lacked ting reference checks on 6/2/16, at 3:15 p.red NA-C's background ks could not be located.	n or work at but the diss.	22000				

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