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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 3FSZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00322

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245318**

2.STATE VENDOR OR MEDICAID NO.
(L2) **004015100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS**
(L4) **2201 KEENAN DRIVE**
(L5) **INTERNATIONAL FALLS, MN** (L6) **56649**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/19/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Yvonne Switajewski, HFE NEII 05/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/052016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 07/14/2016 Co.
DETERMINATION APPROVAL

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/04/2016
(L33)

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245318

July 5, 2016

Mr. Adam Coe, Administrator
Good Samaritan Society - International Falls
2201 Keenan Drive
International Falls, Minnesota 56649

Dear Mr. Coe:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective April 26, 2016 the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 23, 2016

Mr. Adam Coe, Administrator
Good Samaritan Society - International Falls
2201 Keenan Drive
International Falls, Minnesota 56649

RE: Project Number S5318026

Dear Mr. Coe:

On March 30, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 17, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On May 19, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 2, 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 March 17, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 26, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 17, 2016, effective April 26, 2016 and therefore remedies outlined in our letter to you dated March 30, 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 related to this eNotice.

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245318 Y1	A. Building B. Wing Y2	5/19/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279	Correction	ID Prefix F0281	Correction	ID Prefix F0282	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(i)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	04/26/2016	LSC	04/26/2016	LSC	04/26/2016
ID Prefix F0309	Correction	ID Prefix F0329	Correction	ID Prefix F0428	Correction
Reg. # 483.25	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.60(c)	Completed
LSC	04/26/2016	LSC	04/26/2016	LSC	04/26/2016
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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/17/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245318 (Y1)	A. Building 03 - 2013 BUILDING B. Wing (Y2)	5/2/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0011	Correction Completed 04/26/2016	ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 04/08/2016	ID Prefix Reg. # NFPA 101 LSC K0104	Correction Completed 04/26/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/16/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3FSZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00322

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245318**
2.STATE VENDOR OR MEDICAID NO.
(L2) **004015100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS**
(L4) **2201 KEENAN DRIVE**
(L5) **INTERNATIONAL FALLS, MN** (L6) **56649**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/17/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **54** (L18)
13.Total Certified Beds **54** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Debra Vincent, HFE NEII 04/14/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 05/03/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 30, 2016

Mr. Adam Coe, Administrator
Good Samaritan Society - International Falls
2201 Keenan Drive
International Falls, Minnesota 56649

RE: Project Number S5318026

Dear Mr. Coe:

On March 17, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - 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;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 26, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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

- 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 June 17, 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 September 17, 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 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

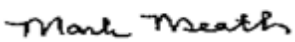
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		4/26/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/08/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a comprehensive care plan to include diabetic care management for 1 of 2 residents (R35) reviewed for diabetes and failed to develop a comprehensive behavior care plan which identified target behaviors and non pharmacological interventions to be attempted for 1 of 1 resident (R24) who received an as needed anti-anxiety medication. In addition, the facility failed to identify mood symptoms/antidepressant use on the care plan for 1 of 2 residents (R22) who was diagnosed with depression and received daily antidepressant medication. Findings include: R35's care plan lacked development of goals and interventions for management of diabetes care. R35's diagnosis report (undated) indicated R35 had diagnoses which included dementia with behavioral disturbance and diabetes. R35's Medication Review Report dated 2/4/10, indicated the physician had ordered for R35 to receive Lantus (insulin) 5 units subcutaneously every night at bedtime. In addition, staff where to monitor R35's blood sugar levels weekly and as needed (PRN). R35's care plan dated 3/16/16, failed to identify R35's diagnosis of diabetes and the development of corresponding interventions which directed staff to observe for signs and symptoms of hyperglycemia (high blood sugar), hypoglycemia	F 279	On 3/16/16 R24's care plan was reviewed and updated to include target behavior(s) and non-pharmacological interventions. On 3/16/16 R35's care plan was reviewed and updated to include diabetic care management. On 3/29/16 R22's care plan was reviewed and updated to include mood symptoms/anti-depressant use. By 4/26/16 all current residents with diabetes will be identified and care plans reviewed to include diabetic care management and updated as needed, all current residents receiving an anti-anxiety medication will be identified and care plans reviewed and updated as needed to include target behavior(s) and non-pharmacological interventions, all current residents receiving an antidepressant will be identified and care plans reviewed and updated as needed to include mood symptoms. As of 4/6/16 nursing staff and non-clinical household leaders have been educated by DNS/DAHL on the development of the care plan to include diabetic care management, target behaviors, mood symptoms, and non-pharmacological interventions. DNS/designee will complete random audits on residents with the diagnosis of diabetes twice weekly for six weeks to ensure the care plan includes diabetic care management. Results to QA for further recommendation. DAHL or designee will complete random audits on residents receiving anti-depressants	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2 (low blood sugar) and other diabetes management interventions. On 3/17/16, at 9:02 a.m. registered nurse (RN)-B confirmed R35's care plan lacked directive regarding diabetes care and management and should have been identified on the care plan. R24 received psychotropic medications and the care plan was not developed to include target behaviors and interventions to be attempted. R24's Medication Review Report, dated 3/16/16, indicated R24 had diagnosis of dementia, anxiety disorder and depressive disorder. In addition, the physician had ordered lorazepam 0.25 milligrams (mg) that could be given every 8 hours as needed (PRN) for anxiety or agitation with a start date of 10/20/15. However, the order had not identified specific target behaviors for the use of the lorazepam. R24's care plan dated 3/16/16, lacked identification of target behaviors for the use of the PRN lorazepam and nonpharmacological interventions to be implemented prior to the administration of the antianxiety medication. R24's PRN Medication Administration history dated 11/1/15-2/28/16, indicated R24 had received lorazepam 0.25 mg on 12/20/15, 12/21/15, 1/19/16, 1/20/16, 1/23/16, 1/24/16, and 2/28/16. R24's record lacked documentation with regards to nonpharmacological interventions attempted prior to the administration of the lorazepam for the aforementioned dates. On 3/16/2016, at 12:26 p.m. RN-B confirmed target behaviors and nonpharmacological	F 279	and/or anti-anxiety medications twice weekly for six weeks to ensure the care plan includes target behaviors, mood symptoms, non-pharmacological interventions, and adverse reactions. Results to QA for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 3	F 279		

interventions had not been specifically identified or documented for the utilization of the PRN lorazepam for R24.

R22's care plan was not developed to identify the diagnosis of major depressive disorder and the daily usage of an anti-depressant.

R22's quarterly Minimum Data Set (MDS) dated 1/29/16, indicated R22 diagnoses included Parkinson's disease, depression and anemia.

R22's current physician orders indicated Mirtazapine (Remeron) 15 mg give 7.5 mg every evening for major depression and the medication was started on 10/27/15 (date of admission).

R22's Medication Administration Record (MAR) for 3/1/16 - 3/17/16, indicated R22 had received Remeron (antidepressant) 7.5 mg daily.

R22's 3/26/16, care plan lacked identification of R22's major depressive diagnosis or the use of the antidepressant.

On 3/16/16, at 12:00 p.m. R22 was observed eating dinner at the dining table. R22 ate 100% of his meal as he talked with residents and staff. At 1:30 p.m. R22 was observed seated in his wheelchair stationed on the outskirts of the dining room. R22 was alert, calm and watched as other staff and residents passed by.

On 3/17/16, at 8:46 a.m. RN-A verified R22's care plan did not address the the diagnosis of major depressive disorder, mood/behavior symptoms and the use of the anti-depressant Remeron and it's potential for adverse reactions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 4 On 3/17/16, at 9:20 a.m. the house hold leader (HHL) was interviewed and verified the care plan did not address R22's depression diagnosis nor the use of the antidepressant because R22's depression was stable. On 3/17/16, at 11:10 a.m. the director of nursing (DON) verified R22's care plan did not address the use of an antidepressant nor diagnosis of major depressive disorder because R22 was stable. Care Plan policy dated 9/2012, indicated each resident would have an individual comprehensive care plan that would include measurable goals and timetables directed toward achievement and maintenance of the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. The care plan should be driven by identified resident issues/conditions and their unique characteristics, strengths and needs. In addition, when implemented in accordance with standards of good clinical practice, the care plan becomes a powerful, practical tool representing the best approach to provide quality of care and quality of life.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 281	As of 4/6/16 R3, R24, R36, R50, R51 are	4/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 5 review, the facility failed to follow acceptable standards of practice related to medication preparation and administration for 5 of 5 residents (R3, R24, R36, R50, R51) who had their medications pre-set and stored in a cupboard. Findings include: On 3/17/16, at 9:04 a.m. a tour of the Dove Island medication room was conducted with registered nurse (RN)-B. Six clear plastic medicine cups with five different resident names written with a red marking pen on each individual cup were observed in an unlocked cupboard. Four of the five medicine cups held two to nine medication tablets and one cup contained a white powdered substance. RN-B stated licensed practical nurse (LPN)-A must have dished them up and set them in the cupboard. RN-B verified the pre-setting up of medications was not an acceptable practice and stated her best guess was the five medicine cups were for the following residents based on the names written on the medicine cups: R3 - medicine cup contained nine loose tablets R24 - one medicine cup contained a white powdered substance and one medicine cup contained six loose tablets R36 - medicine cup contained eight loose tablets R50 - medicine cup contained two loose tablets R51 - medicine cup contained four and ½ loose tablets On 3/17/16, at 10:17 a.m. LPN-A confirmed he had placed the six medication cups with loose, unidentified medications in the cupboard in the medication room. LPN-A verified the medication which was contained in each resident's medicine	F 281	receiving their medications within acceptable standards of practice related to medication preparation and administration. By 4/26/16 all current residents receiving oral medications will be identified to ensure they are receiving their medications within acceptable standards of practice related to medication preparation and administration. On 3/17/16 nursing staff were informed by the DNS via email to follow standard of practice for medication administration and to not preset medications. As of 4/6/16 nursing staff received education via live in-service by the DNS regarding not pre-setting medications and to follow acceptable standards of practice related to medication preparation and administration. DNS and/or designee will complete random audits on residents receiving oral medications twice weekly for six weeks to ensure that medications are not being preset. Results to QA for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 6 cup and stated he was aware the pre-setting of medications was not the standard of practice. On 3/17/16, at 10:34 a.m. the director of nursing (DON) confirmed staff should not be pre-setting up medications. Medication Administration and Scheduling policy dated 9/15, indicated pre-setting medications was not an acceptable practice.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to report diabetic related hypoglycemic episodes to the health care team as directed by the care plan for 1 of 2 residents (R5) reviewed for diabetes and had hypoglycemic episodes which were not reported to the physician/health care team for review. Findings include: R5's current care plan dated 4/1/14, indicated R5 was diabetic and directed staff to conduct monitoring, document and report signs and symptoms of hypoglycemia (low blood sugar) to R5's health care provider/team.	F 282	On 3/17/16 a medication change was made to R5's diabetic intervention. R5's care plan of is being followed as of 3/18/16. By 4/26/16 all diabetic residents care planned to notify physician/healthcare team of hypoglycemic incidents will be identified to ensure their care plan is being followed. On 3/17/16 RN-C educated nursing staff via email of following R5's care plan of reporting hypoglycemic incidents. As of 4/6/16 nursing staff were educated by the DNS on following individualized care plan and notification of the health care team/physician of residents experiencing	4/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 7 R5's Medication Review Report print date 3/17/16, indicated R5 was to receive scheduled lantus insulin daily as well as coverage depending on blood sugar testing results. In addition, R5 was to receive Glucose Gel 40% (medication to treat low blood sugar levels) 15 grams by mouth as needed for blood glucose levels below 70. R5's Medication Record for 3/1/16-3/31/16, indicated on 3/4/16, R5 had a hypoglycemic episode with a blood sugar level of 58 at 2:08 a.m. and was treated with glucose gel 40% 15 grams R5's Medication Record for 2/1/16 - 2/19/16, revealed R5 had hypoglycemic episodes on the following dates and was treated with glucose gel 40% 15 grams each time: -2/14/16, at 12:18 a.m. blood glucose level was 59 -2/19/16, at 4:35 p.m. blood glucose level was 53 -2/22/16, at 2:13 a.m. blood glucose level was 60 -2/25/16, at 7:30 a.m. blood glucose level was 56 -2/29/16, at 4:00 a.m. blood glucose level was 60 R5's nursing progress notes dated 2/1/16, through 3/16/16, lacked documentation of the healthcare team being notified of R5's hypoglycemic episodes and failed to identify the trend of R5's hypoglycemic episodes. R5's 2/16/16, Nursing Home Visit physician progress note indicated R5 was a diabetic with variable blood sugars but overall controlled and to continue the same orders. However, lacked identification of the knowledge regarding R5's trend of hypoglycemic episodes.	F 282	hypoglycemic incidents. DNS/designee will perform random audits 2 times a week for 6 weeks on residents care planned to notify healthcare team/physician of hypoglycemic incidents to ensure their care plan is being followed. Results forwarded to QA for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 8 On 3/16/16, at 8:13 a.m. R5 was observed in own room, seated in a rocker, watching television. R5 was alert and well groomed. At 11:07 a.m. R5 was observed seated at the dining room table visiting with staff and other residents. On 3/17/16, at 9:43 a.m. registered nurse (RN)-C confirmed the above noted low blood sugar readings from 2/29/16, through 3/4/16. RN-C stated she had not been made aware of R5's hypoglycemic episodes and verified R5's care plan directed the staff to notify members of R5's health care team which would have been herself and R5's physician of the episodes. RN-C confirmed R5's care plan was not followed. On 3/17/16, at 10:41 a.m. the director of nursing (DON) stated R5's care plan should have been followed, and was not. Care Plan policy dated 9/2012, indicated each resident would have an individual comprehensive care plan that would include measurable goals and timetables directed toward achievement and maintenance of the resident ' s optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. The care plan should be driven by identified resident issues/conditions and their unique characteristics, strengths and needs. In addition, when implemented in accordance with standards of good clinical practice, the care plan becomes a powerful, practical tool representing the best approach to provide quality of care and quality of life.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		4/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 9 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor and report hypoglycemic episodes to the physician/health care team as directed by the care plan for 1 of 2 residents (R5) reviewed for diabetic management and had recurring episodes of hypoglycemia which required treatment. Findings include: R5's Diagnosis Report (undated) indicated R5 had diagnoses which included diabetes, dementia, and chronic kidney disease. R5's quarterly MDS dated 11/27/15, indicated R5 had no cognitive impairment and received a daily injection of insulin. R5's care plan dated 4/1/14, indicated R5 had diabetes with abnormal glucose levels and was insulin dependent. The plan directed staff to monitor/document and report to R5's health care provider as needed for signs and symptoms of hypoglycemia (low blood sugar). R5's Medication Review Report dated 3/17/16, indicated R5 was scheduled to receive the	F 309	On 3/17/16 a medication change was made to R5's diabetic intervention. As of 3/18/16 R5's hypoglycemic incidents are being monitored and reported to the physician/healthcare team per their plan of care. By 4/26/16 all diabetic residents care planned to notify physician/healthcare team of hypoglycemic incidents will be identified to ensure hypoglycemic incidents are being monitored and reported to the physician/healthcare team per their plan of care. On 3/17/16 RN-C educated nursing staff via email of follow R5's care plan. As of 4/6/16 nursing staff were educated by the DNS on following individualized care plan to monitor and report to the health care team/physician of residents experiencing hypoglycemic incidents. The DNS/designee will complete random chart audits two times a week for six weeks of residents with the diagnosis of diabetes to ensure that the care plan was followed regarding monitoring and reporting to health care team/physician on hypoglycemic incidents, physician orders	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10 following medications/treatments for diabetes: -Lantus (insulin) 20 units subcutaneously (injection into the subcutaneous tissue - SQ) every morning -Lantus 15 units SQ every bedtime -Novolog (insulin) inject 1 unit SQ per 10 grams of carbohydrates after each meal -Novolog sliding scale (scale which directed the amount of insulin to be given based on the blood sugar level) before meals and at bedtime: -For a blood sugar of 150-200 = give 2 units -For a blood sugar of 201 - 250 = give 3 units -For a blood sugar of 251-300 = give 4 units -For a blood sugar of 301 - 350 = give 5 units -For a blood sugar of 351-400 = give 6 units -For a blood sugar of 401-450 = give 7 units -For a blood sugar of 451 - 500 = give 8 units and call the physician for further instruction - Hemoglobin A1C (blood test which indicated how well blood glucose levels have been controlled over the last two - three months) - Blood glucose checks before meals and at bedtime - Glucagon (medication to treat severe low blood sugar levels) 1 milligram (mg) to be injected as needed for blood glucose levels below 45 and unable to swallow - Glucose Gel 40% (medication to treat low blood sugar levels) 15 grams by mouth as needed for blood glucose levels below 70 R5's Medication Record for 3/1/16-3/31/16, revealed on 3/4/16, at 2:02 a.m. R5 had a blood sugar level 58 and was treated with glucose gel 40% 15 grams. R5's Medication Record for 2/1/16 - 2/19/16, revealed the following low blood sugar levels in	F 309	include treatment of hypoglycemia and parameters for when treatment should be initiated, and incidents and actions taken for hypoglycemic incidents documentation. Result to QA for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11 which R5 was treated with glucose gel 40% 15 grams: -2/14/16, at 12:18 a.m. blood glucose level was 59 -2/19/16, at 4:35 p.m. blood glucose level was 53 -2/22/16, at 2:13 a.m. blood glucose level was 60 -2/25/16, at 7:30 a.m. blood glucose level was 56 -2/29/16, at 4:00 a.m. blood glucose level was 60 R5's A1C results were: -2/3/16, 6.7 - value identified as being high (reference range 4.6-6.2) -3/2/16, 7.1 - value identified as being high (reference range 4.6-6.2) R5's 2/16/16, Nursing Home Visit physician progress note indicated R5 was a diabetic with variable blood sugars but overall controlled and to continue the same orders. However, lacked identification of the knowledge regarding R5's trend of hypoglycemic episodes. R5's nursing progress note dated 3/14/16, indicated R5's A1C was 7.1, which was adequate control per the physician. R5's diabetes was managed with insulin sliding scale and carb counting of meals. The progress note lacked identification of R5's trend of hyperglycemic episodes. R5's nursing progress notes dated 2/1/16, through 3/16/16, lacked documentation of the healthcare team being notified of R5's hypoglycemic episodes and failed to identify the trend of R5's hypoglycemic episodes. R5's consulting pharmacist medication review from 12/3/15 - 3/3/16, indicated no new suggestions with regards to R5's medication	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 regime. On 3/16/16, at 8:13 a.m. R5 was observed in own room watching television. R5 was alert and well groomed. At 11:07 a.m. R5 was seated at the dining room table visiting with staff and other residents. On 3/17/16, at 9:43 a.m. registered nurse (RN)-C confirmed the above noted low blood sugar readings from 2/29/16, through 3/4/16. RN-C stated she had not been made aware of R5's hypoglycemic episodes. RN-C stated if she had been aware that R5 had needed repeated treatment for the low blood sugar readings RN-C would have notified the physician and he probably would have decreased R5's dose of Lantus insulin. RN-C verified R5's care plan directed the staff to notify members of the health care team which would have been herself and the physician of hypoglycemic episodes. RN-C confirmed this had not been done. On 3/17/16, at 10:41 a.m. the director of nursing (DON) confirmed R5's care plan should have been followed. Hypoglycemic Incidents policy dated 12/15, indicated when a resident had a diagnosis of diabetes, an individual physician's order should be obtained for treatment of hypoglycemia and parameters for when treatment should be initiated. In addition, incidents and actions taken for episodes of hypoglycemia should be documented in the progress notes.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		4/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 13 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure target symptoms/behaviors, non pharmacological interventions and/or adequate justification of use was identified for 3 of 4 residents (R35, R24, R22) who received psychotropic medications. Findings include: R35 received Risperdal (antipsychotic) without adequate justification for its use identified.	F 329	On 4/4/16 Consultant Pharmacist review of R35 indicates an AIMS was completed 3/14/16. On 4/5/16 R35's primary physician completed a medication review and no changes were made. On 3/16/16 R24's care plan was reviewed and updated to include target behavior(s) and non-pharmacological interventions. On 3/29/16 R22's care plan was reviewed and updated to include mood/behavior symptoms, adverse reactions and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 14 R35's diagnosis report (undated) indicated R35 had diagnoses which included dementia with behavioral disturbance, orthostatic hypotension, fatigue, diabetes and joint pain. R35's quarterly Minimum Data Set dated 12/16/15, indicated R35's cognition was intact, had no signs or symptoms of delirium or psychosis, had not exhibited behaviors towards self or others and had not wandered nor rejected cares. R35's Risperdal medication physician orders included: -Initial physician order dated 2/4/16, indicated Risperdal 0.5 milligrams (mg) at bedtime (HS) as needed for agitation, wandering or aggressive behavior -On 2/17/16, a telephone order from the physician was obtained to increase the Risperdal to 0.5 mg once a day (scheduled dose instead of the PRN) -On 2/22/16, a telephone order from the physician was obtained to give Risperdal 1.0 mg one time only and then give 0.5 mg twice a day for unspecified dementia with behavioral disturbances R35's medication administration record indicated R35 had received Risperdal 0.5 mg twice a day since 2/22/16. R35's progress notes related to mood/behavior dated 2/14/16 - 3/9/16, indicated R35 had eight episodes of wanting to leave, or had been outside with staff and had not wanted to return into the facility. However, for all the episodes, the notes indicated R35 was cooperative and able to be	F 329	non-pharmacological interventions. By 4/26/16 all current residents receiving an antipsychotic, antianxiety and/or an antidepressant will be identified to ensure target mood/behaviors symptoms, non-pharmacological interventions and/or adequate justification of use are identified. As of 4/6/16 nursing staff and non-clinical household leaders have been educated by the DNS / DAHL on the development of the care plan to ensure target mood/behaviors symptoms, non-pharmacological interventions and/or adequate justification of use identified for residents who receive anti-psychotic, anti-anxiety, anti-depressant medications. DNS and/or designee will complete random audits on residents receiving an antipsychotic twice weekly for six weeks to ensure adequate justification of use is identified. Results to QA for further recommendation. DAHL/designee will complete random audits on residents receiving antipsychotic, antidepressants and/or antianxiety medications twice weekly for six weeks to ensure the care plan includes target behaviors, mood symptoms, non-pharmacological interventions and adverse reactions. Results to QA for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 15	F 329		

redirected when staff intervened and redirected.

R35's Consultant Pharmacist's Medication Regime Review from dated 3/3/16 indicated R35 had been started on Risperdal with no baseline Abnormal Involuntary Movement Scale (AIMS - a rating scale to measure involuntary movements that can sometimes develop as a side effect of long-term treatment with antipsychotic medication) and recommended the facility perform the assessment within 30 day of the initiation of the medication and at least every six months thereafter in or to monitor for adverse reactions to the medication. In addition, the form indicated R35 had already had several falls and was classified as a high fall risk which needed to be brought to the attention of the physician to either reduce the dose of Risperdal or change the drug to one that caused less orthostatic hypotension and resulting dizziness which could lead to falling. Although the recommendation was signed by the director of nursing (DON), the follow-through section of the form was blank. R35's Medication Regimen Review documentation form note dated 3/3/16, also indicated R35 was put on Risperdal and no baseline AIMS was performed.

On 3/16/16, at 8:01 a.m. R35 was observed seated in the dining room independently eating breakfast. R35 was well groomed and visited with tablemates.

On 3/17/16, at 8:20 a.m. R35 was observed to propel his wheelchair from the dining room area directly to own room, no wandering or exit seeking behavior observed.

On 3/17/16, at 8:42 a.m. registered nurse (RN)-B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 16	F 329		

confirmed R35 had received Risperdal 0.5 mg twice a day since 2/22/16, and stated R35 had been started on the Risperdal because of his behaviors such as wandering, verbal aggression towards staff, angry with another resident on a different unit and had made a statement once about wanting to harm himself. RN-B stated R35 had been moved over to her unit on 2/12/16, and since the move, the household staff have found that if they kept R35's pain under control and kept R35 busy doing the things he liked, R35's behaviors were much better. RN-B stated the more the staff worked with R35, the more she questioned if Risperdal was an appropriate medication choice for him. RN-B stated R35 had not exhibited signs or symptoms of delirium, psychosis, delusions or hallucinations.

On 3/17/16, at 11:00 a.m. the consulting pharmacist (CP) stated even though he had not conducted R35's 3/16, medication regime review, he interpreted the recommendation for conducting a baseline AIMS as the pharmacists way of beginning to address the issue for questioning the appropriateness of the Risperdal medication for R35.

Psychopharmacological Medications and Sedative/Hypnotic policy dated 8/14, indicated each resident's drug regime would be free from unnecessary drugs. In addition, residents who have not used antipsychotic drugs should not be given these drugs unless antipsychotic drug therapy was necessary to treat a specific condition as diagnosed and documented in the clinical record.

R24 received as needed (PRN) lorazepam (antianxiety medication) and target behaviors and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 17	F 329		

nonpharmacological interventions had not been identified or consistently implemented.

R24's Admission Record dated 3/16/16, indicated R24 was diagnosed with dementia, anxiety disorder and depression.

R24's quarterly MDS dated 12/28/15, indicated R24 had severe cognitive impairment, showed no signs of psychosis or behavior towards self or others and had received daily doses of antianxiety medication. R24's Psychotropic Drug Use Care Area Assessment (CAA) dated 7/10/15, indicated R24 had diagnosis of anxiety and received antianxiety medication. The note also indicated R24 had x2 failed dose reductions of the medication conducted with R24 becoming more restless, elopement attempts and verbal aggression.

R24's care plan dated 3/16/16, indicated R24 had impaired cognitive function/dementia. However, the care plan lacked indication of the R24's anxiety diagnosis, symptoms of anxiety and identification of target behaviors related to the use of the PRN lorazepam and nonpharmacological interventions to be implemented prior to the administration of the antianxiety medication in an attempt to avoid the use.

R24's Medication Review Report dated 3/16/16, indicated an order started on 2/16/16, for Ativan (lorazepam) 0.25 mg every eight hours as needed for anxiety or agitation related to anxiety state. In addition, an order for Ativan 0.25 mg daily related to anxiety state which was started on 2/16/16. The orders had not identified specific target behaviors which warranted the use of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 18 lorazepam. R24's Medication Review Report form dated 10/19/15, indicated orders which were started on 11/18/14, for lorazepam 0.5 mg PRN every eight hours as needed for anxiety or agitation and lorazepam 0.5 mg daily due to anxiety state. The form lacked identification of target behaviors which warranted the use of the medication. A hand written order at the bottom of the form and dated 10/20/15, indicated to decrease bedtime ativan from 0.5 mg to 0.25 mg. R24's PRN Medication Administration forms dated 11/1/15-2/28/16, indicated R24 had PRN lorazepam 0.25 mg started on 10/20/15, and received on 12/2/15, 12/20/15, 12/21/15, 1/19/16, 1/20/16, 1/23/16, 1/24/16, and 2/28/16. R24's February Medication Administration history indicated lorazepam 0.5 mg every eight hours PRN was started 2/6/16. R24's medication forms lacked identified target behaviors which warranted the use of the medication and nonpharmacological interventions to be attempted or were attempted prior to the administration of the lorazepam in an attempt to avoid the use of the psychotropic medication. R24's CP Medication Regimen Review form for dates 3/9/15, through 2/10/16, indicated on 11/5/15, addition of Ativan 0.25 mg every eight hours as needed anxiety. The last written note dated 2/10/16, recommended a dose reduction of Zoloft use. The form lacked identification of the lack of target behaviors and nonpharmacological interventions for the use of the lorazepam. On 3/16/2016, at 12:26 p.m. RN-B confirmed target behaviors and nonpharmacological	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 19 interventions had not been specifically identified or documented for the use of the lorazepam. On 03/16/2016, 1:51 p.m. the DON stated it was her expectation nursing followed the facilities policy's and provided quality medication administration and monitoring. On 03/17/2016, 11:27 a.m. the consulting pharmacist (CP) confirmed target behaviors and nonpharmacological interventions should have been identified. The CP stated we typically looked at the whole picture but typically did not look at target behaviors and nonpharmacological interventions to ensure they were identified. R22 received an antidepressant medication without the identification of target mood/behavior symptoms and lacked a comprehensive care plan related to the depression diagnosis, use of an antidepressant medication and target mood symptoms to monitor for. R22's quarterly Minimum Data Set (MDS) dated 1/29/16, indicated R22's diagnoses included Parkinson's disease, depression and anemia. the MDS also indicated R22 had the presence of feelings of tiredness and having little energy. R22's overall mood score was zero. R22's current physician orders indicated Mirtazapine (Remeron), an antidepressant, 7.5 mg every evening for major depression which was started on 10/27/15. R22's care plan dated 3/16/16, lacked indication of R22's major depressive diagnosis, use of the antidepressant, target mood symptoms and signs and symptoms of adverse reaction. In addition,	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 20	F 329		

R22's medical record lacked indication or target mood/behavior symptoms.

R22's Medication Administration Record for 3/1/16 - 3/17/16, indicated R22 had received Remeron 7.5 mg daily.

R22's Medication Review Report dated 3/17/16, indicated R22 received Mirtazapine 7.5 mg in the evening for major depressive disorder.

R22's consultant pharmacy reports 11/6/15, 12/3/15, 1/14/16, 2/10/16, and 3/3/16, had no recommendations or guidance regarding the use of Remeron or the lack of identification of the target symptoms.

On 3/16/16, at 12:00 p.m. R22 was observed eating dinner in the dining room. R22 consumed 100% of his meal as he talked with residents and staff. At 1:30 p.m. R22 was observed seated in his wheelchair stationed on the outskirts of the dining room. R22 was alert, calm and watched as other staff and residents passed by.

On 3/17/16, at 8:46 a.m. RN-A stated R22 was admitted to the facility with the medication order. RN-A verified no target mood symptoms/behaviors had been identified and R22's care plan did not address the diagnosis of depression, the use of the antidepressant, target mood symptoms and potential adverse reactions. RN-A stated the facility CP advised the staff if a resident's condition was stable, the resident's care plan did not have to identify the issue. RN-A stated since R22 was admitted, there had been no concerns regarding the depression.

On 3/17/16, at 9:20 a.m. the household leader

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 21 (HHL) stated R22 did not have any symptoms of depression and verified no target behavior/symptoms had been identified and a care plan which identified the target mood/behavior symptoms and use of the medication had not been developed. HHL stated R22's depression was not identified on the care plan because it had been stable. On 3/17/16, at 11:10 a.m. the DON verified the facility had not identified any mood/behavior indicators related to R22's diagnosis of major depression and subsequent use of the antidepressant and stated R22's spouse would be contacted to find out why R22 was on the antidepressant medication. At 1:00 p.m. the DON stated R22's wife had been contacted and she stated she did not know that R22 had been receiving an antidepressant medication. The DON stated R22's physician would be contacted regarding why R22 was ever started on the antidepressant medication. The facility policy Psychopharmacological Medications and Sedative / Hypnotics, revised 8/14, indicated the purpose was to evaluate behavior interventions and alternatives before using psychopharmacological medications. Psychopharmacological medication is any medication used for managing behavior, stabilizing mood or treating psychiatric disorders and individualized non-pharmacological approaches that were provided as part of a supportive physical and psychosocial environment and are directed toward preventing, relieving and/or accommodating a residents' distressed behavior.	F 329		
F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428		4/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428 SS=D	Continued From page 22 IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility consulting pharmacist failed to identify hypoglycemic episodes which required treatment in order to make appropriate recommendations for 1 of 1 resident (R5) who had repeat hypoglycemic episodes. In addition, the consulting pharmacist failed to identify the lack of target symptoms/behaviors and non-pharmacological interventions for 2 of 4 residents (R24, R22) who received psychotropic medication without target symptoms/behaviors and non-pharmacological interventions to be implemented identified in order to avoid its use. Findings include: R5's Diagnosis Report (undated) indicated R5 had diagnoses which included diabetes, dementia, and chronic kidney disease. R5's quarterly MDS dated 11/27/15, indicated R5 had no cognitive impairment and received a daily injection of insulin.	F 428	On 4/4/16 consulting pharmacist completed a chart review on R5, R22, and R24. On 3/17/16 a medication change was made to R5's diabetic intervention to address their hypoglycemic episodes. On 3/29/16 R22's care plan was reviewed and updated to include mood/behavior symptoms, adverse reactions and non-pharmacological interventions. 3/16/16 R24's care plan was reviewed and updated to include target behavior(s) and non-pharmacological interventions. On 4/4/16 the consultant pharmacist completed a chart review on all residents to identify any lack of target symptoms/behaviors and non-pharmacological interventions for residents receiving psychotropic medications and for any repeat hypoglycemic episodes. On 4/7/15 consultant pharmacist was educated by the pharmacies manager of clinical operations on providing quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 23 R5's care plan dated 4/1/14, indicated R5 had diabetes with abnormal glucose levels and was insulin dependent. The plan directed staff to monitor/document and report to R5's health care provider as needed for signs and symptoms of hypoglycemia (low blood sugar). R5's Medication Review Report dated 3/17/16, indicated R5 was scheduled to receive the following medications/treatments for diabetes: -Lantus (insulin) 20 units subcutaneously (injection into the subcutaneous tissue - SQ) every morning -Lantus 15 units SQ every bedtime -Novolog (insulin) inject 1 unit SQ per 10 grams of carbohydrates after each meal -Novolog sliding scale (scale which directed the amount of insulin to be given based on the blood sugar level) before meals and at bedtime: -For a blood sugar of 150-200 = give 2 units -For a blood sugar of 201 - 250 = give 3 units -For a blood sugar of 251-300 = give 4 units -For a blood sugar of 301 - 350 = give 5 units -For a blood sugar of 351-400 = give 6 units -For a blood sugar of 401-450 = give 7 units -For a blood sugar of 451 - 500 = give 8 units and call the physician for further instruction - Hemoglobin A1C (blood test which indicated how well blood glucose levels have been controlled over the last two - three months) - Blood glucose checks before meals and at bedtime - Glucagon (medication to treat severe low blood sugar levels) 1 milligram (mg) to be injected as needed for blood glucose levels below 45 and unable to swallow - Glucose Gel 40% (medication to treat low	F 428	drug regimen reviews and reporting irregularities to the physician and DNS. As well as performing the reviews according to PharMerica's standard for drug regimen review. The manager of clinical operations/designee will perform audits for two months on consulting pharmacist's medication regimen review findings. Results forwarded for QA for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 24 blood sugar levels) 15 grams by mouth as needed for blood glucose levels below 70 R5's Medication Record for 3/1/16-3/31/16, revealed on 3/4/16, at 2:02 a.m. R5 had a blood sugar level 58 and was treated with glucose gel 40% 15 grams. R5's Medication Record for 2/1/16 - 2/19/16, revealed the following low blood sugar levels in which R5 was treated with glucose gel 40% 15 grams: -2/14/16, at 12:18 a.m. blood glucose level was 59 -2/19/16, at 4:35 p.m. blood glucose level was 53 -2/22/16, at 2:13 a.m. blood glucose level was 60 -2/25/16, at 7:30 a.m. blood glucose level was 56 -2/29/16, at 4:00 a.m. blood glucose level was 60 R5's A1C results were: -2/3/16, 6.7 - value identified as being high (reference range 4.6-6.2) -3/2/16, 7.1 - value identified as being high (reference range 4.6-6.2) R5's 2/16/16, Nursing Home Visit physician progress note indicated R5 was a diabetic with variable blood sugars but overall controlled and to continue the same orders. However, lacked identification of the knowledge regarding R5's trend of hypoglycemic episodes. R5's nursing progress note dated 3/14/16, indicated R5's A1C was 7.1, which was adequate control per the physician. R5's diabetes was managed with insulin sliding scale and carb counting of meals. The progress note lacked	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 25	F 428		

identification of R5's trend of hypoglycemic episodes. R5's nursing progress notes dated 2/1/16, through 3/16/16, lacked documentation of the healthcare team being notified of R5's hypoglycemic episodes and failed to identify the trend of R5's hypoglycemic episodes.

R5's consulting pharmacist medication review from 12/3/15 - 3/3/16, indicated no new suggestions with regards to R5's medication regime.

On 3/16/16, at 8:13 a.m. R5 was observed in own room watching television. R5 was alert and well groomed. At 11:07 a.m. R5 was seated at the dining room table visiting with staff and other residents.

On 3/17/16, at 9:43 a.m. registered nurse (RN)-C confirmed the above noted low blood sugar readings from 2/29/16, through 3/4/16. RN-C stated she had not been made aware of R5's hypoglycemic episodes. RN-C stated if she had been aware that R5 had needed repeated treatment for the low blood sugar readings RN-C would have notified the physician and he probably would have decreased R5's dose of Lantus insulin. RN-C verified R5's care plan directed the staff to notify members of the health care team which would have been herself and the physician of hypoglycemic episodes. RN-C confirmed this had not been done.

On 3/17/16, at 10:41 a.m. the director of nursing (DON) confirmed R5's care plan should have been followed in regards to the physician and healthcare team notification of the hypoglycemic episodes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 26 On 3/17/16, at 11:17 a.m. the consulting pharmacist (CP) stated for a diabetic resident who was on several coverages of insulin, the CP would have expected the CP who had reviewed R5's medication regimen to review the resident's insulin usage, investigate episodes of blood sugar fluctuations, and provide appropriate recommendations based on this review. The CP verified R5's monthly medication regime review from 12/3/15 - 3/3/16, had not identified R5's recent trend of hypoglycemic episodes. Hypoglycemic Incidents policy dated 12/15, indicated when a resident had a diagnosis of diabetes, an individual physician's order should be obtained for treatment of hypoglycemia and parameters for when treatment should be initiated. In addition, incidents and actions taken for episodes of hypoglycemia should be documented in the progress notes. R24 received PRN (as needed) lorazepam (antianxiety medication) without target behaviors for the use of the medication identified nor non pharmacological interventions to be attempted prior to the administration of the medication. R24's quarterly MDS dated 12/28/15, indicated R24 had severe cognitive impairment, showed no signs of psychosis or behavior towards self or others. R49 had received 7 doses of antianxiety medication during the seven day observation period of this assessment. R24's care plan dated 3/16/16, lacked identification of target behaviors for the use of the PRN lorazepam and nonpharmacological interventions to be implemented prior to the	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 27 administration of the antianxiety medication. R24's Medication Review Report dated 3/16/16, indicated R24 had diagnosis of dementia, anxiety disorder, and depressive disorder. In addition, the physician had ordered lorazepam 0.25 milligrams (mg) that could be given every 8 hours PRN for anxiety or agitation (start date 10/20/15). However, the order had not identified specific target behaviors for the use of the lorazepam. R24's PRN Medication Administration history dated 11/1/15-2/28/16, indicated R24 had lorazepam 0.25 mg on 12/20/15, 12/21/15, 1/19/16, 1/20/16, 1/23/16, 1/24/16, and 2/28/16. R24's record lacked documentation with regards to nonpharmacological interventions attempted prior to the administration of the lorazepam for the aforementioned dates. Review of the pharmacists monthly medication review for R24, from 11/15-3/16, lacked mention of the need for identification of target behaviors and nonpharmacological interventions for the utilization of R24's PRN lorazepam. On 3/16/2016, at 12:26 p.m. RN-B confirmed target behaviors and nonpharmacological interventions had not been specifically identified or documented for the utilization of the PRN lorazepam for R24. On 03/17/2016, 11:27 a.m. the CP confirmed target behaviors and nonpharmacological interventions should have been identified. The CP stated we typically look at the whole picture but we typically do not look at target behaviors and nonpharmacological interventions.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 28	F 428		

R22 received an antidepressant medication without the identification of target mood/behavior symptoms and lacked a comprehensive care plan related to the depression diagnosis, use of an antidepressant medication and target mood symptoms to monitor for.

R22's quarterly Minimum Data Set (MDS) dated 1/29/16, indicated R22's diagnoses included Parkinson's disease, depression and anemia. the MDS also indicated R22 had the presence of feelings of tiredness and having little energy. R22's overall mood score was zero.

R22's current physician orders indicated Mirtazapine (Remeron), an antidepressant, 7.5 mg every evening for major depression which was started on 10/27/15.

R22's care plan dated 3/16/16, lacked indication of R22's major depressive diagnosis, use of the antidepressant, target mood symptoms and signs and symptoms of adverse reaction. In addition, R22's medical record lacked indication or target mood/behavior symptoms.

R22's Medication Administration Record for 3/1/16 - 3/17/16, indicated R22 had received Remeron 7.5 mg daily.

R22's Medication Review Report dated 3/17/16, indicated R22 received Mirtazapine 7.5 mg in the evening for major depressive disorder.

R22's consultant pharmacy reports 11/6/15, 12/3/15, 1/14/16, 2/10/16, and 3/3/16, had no recommendations or guidance regarding the use of Remeron or the lack of identification of the target symptoms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 29	F 428		

On 3/16/16, at 12:00 p.m. R22 was observed eating dinner in the dining room. R22 consumed 100% of his meal as he talked with residents and staff. At 1:30 p.m. R22 was observed seated in his wheelchair stationed on the outskirts of the dining room. R22 was alert, calm and watched as other staff and residents passed by.

On 3/17/16, at 8:46 a.m. RN-A stated R22 was admitted to the facility with the medication order. RN-A verified no target mood symptoms/behaviors had been identified and R22's care plan did not address the diagnosis of depression, the use of the antidepressant, target mood symptoms and potential adverse reactions. RN-A stated the facility CP advised the staff if a resident's condition was stable, the resident's care plan did not have to identify the issue. RN-A stated since R22 was admitted, there had been no concerns regarding the depression.

On 3/17/16, at 9:20 a.m. the household leader (HHL) stated R22 did not have any symptoms of depression and verified no target behavior/symptoms had been identified and a care plan which identified the target mood/behavior symptoms and use of the medication had not been developed. HHL stated R22's depression was not identified on the care plan because it had been stable.

On 3/17/16, at 11:10 a.m. the DON verified the facility had not identified any mood/behavior indicators related to R22's diagnosis of major depression and subsequent use of the antidepressant and stated R22's spouse would be contacted to find out why R22 was on the antidepressant medication. At 1:00 p.m. the DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 30	F 428		

stated R22's wife had been contacted and she stated she did not know that R22 had been receiving an antidepressant medication. The DON stated R22's physician would be contacted regarding why R22 was ever started on the antidepressant medication.

The facility policy Psychopharmacological Medications and Sedative / Hypnotics, revised 8/14, indicated the purpose was to evaluate behavior interventions and alternatives before using psychopharmacological medications. Psychopharmacological medication is any medication used for managing behavior, stabilizing mood or treating psychiatric disorders and individualized non-pharmacological approaches that were provided as part of a supportive physical and psychosocial environment and are directed toward preventing, relieving and/or accommodating a residents' distressed behavior. Each residents medication regime would be free from unnecessary drugs, which included in the presence of adverse consequences that indicated the dose of the medication should be reduced or discontinued.

The Pharmaceutical Services policy dated 9/12, indicated pharmacy services would be provided to meet the needs of each resident. In addition, each resident's medication regime would be reviewed monthly and any irregularities would be reported to the attending physician or the director of nursing services or both.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING **03 - 2013 BUILDING** B. WING _____	**03/16/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	**2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society - International Falls was found not 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 18 New Health Care. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/08/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING **03 - 2013 BUILDING** B. WING _____	**03/16/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	**2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Good Samaritan Society International Falls is a new 1-story building, no basement, and was determined to be Type V (111) construction. The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition) with quick response sprinkler heads. The building is separated from the new assisted living building with a 2-hour fire barrier. The facility has automatic smoke detectors that are on the fire alarm system, throughout the corridor system, in all areas open to the corridor and in all sleeping rooms. It is installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition) and the Minnesota State Fire Code 2007 edition. The fire alarm system is monitored for automatic fire department	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING **03 - 2013 BUILDING** B. WING _____	**03/16/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	**2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 notification. The building is divided into 3 smoke compartments by 1-hour smoke barriers and 2-hour fire barriers. The facility has a capacity of 54 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 011 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 11/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Observations revealed a gap between the double doors in 1 of 1 door assemblies in the 2-hour fire barriers located throughout the facility are not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 18.1.1.4.3,. This deficient practice could allow the products of combustion to travel from one building to another, which could negatively impact 47 of 47 residents, staff and visitors of the facility. Findings include: On facility tour between 12:30 PM to 3:30 PM on 03/16/2016, revealed that the meeting edges on the double doors in the 2-hour fire barrier separating the Nursing home from the Assisted Living facility had a gap that was greater than a	K 011	The double doors in the two hour fire barrier separating the SNF from the Assisted Living facility were adjusted and fitted with a smoke seal. To be completed by 4-26-16 Gary Hooker Facilities Director	4/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING **03 - 2013 BUILDING** B. WING _____	**03/16/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	**2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 011	Continued From page 3 1/4 of an inch midway down the doors when measured. This deficient condition was verified by a Maintenance Supervisor.	K 011		
K 054 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code 1999 edition, section 7-3.2.1. This deficient practice could affect 47 of 47 residents, visitors, and staff. Findings include: On facility tour between 12:30 PM to 3:30 PM on 03/16/2016, a review of the facility's available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient condition was verified by a Maintenance Supervisor.	K 054	Documentation of sensitivity testing was not available at the time of the inspection. We have since obtained documentation that all smoke sensors were tested on 11-12-2014 and were in the safe range. The next testing date is due by November of 2016. Gary Hooker Facilities Director	4/8/16
K 104	NFPA 101 LIFE SAFETY CODE STANDARD	K 104		4/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING **03 - 2013 BUILDING** B. WING _____	**03/16/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	**2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 104 SS=D	Continued From page 4 Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 5-1.2 and 5.2. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect 47 of 47 residents, visitors, and staff in the event of a fire. Findings include: On facility tour between 12:30 PM to 3:30 PM on 03/16/2016, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Maintenance Supervisor, that the facility had failed to provide documentation verifying that the fire and smoke dampers has been acceptance tested after installation or function tested/inspected prior to occupancy in 2013. This deficient condition was verified by a Maintenance Supervisor.	K 104	On documentation that the smoke dampers had been acceptance tested we have found the Fire Alarm Inspection report from 8-26-13 in which the damper controls were documented as functioning properly. The dampers shall also be inspected and tested with documentation by April 26, 2016. Gary Hooker Facilities Director	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING **03 - 2013 BUILDING** B. WING _____	**03/16/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	**2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE