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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 5KR9

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/27/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (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
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, HFE NEII 03/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/09/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/19/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245488

March 9, 2015

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

Dear Ms. Grams:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 9, 2015 the above facility is certified for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 skilled nursing facility beds located in rooms.

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 2, 2015

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

RE: Project Number S5488025

Dear Ms. Grams:

On January 16, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 31, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On February 27, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on January 29, 2015 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 December 31, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 9, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 31, 2014, effective February 9, 2015 and therefore remedies outlined in our letter to you dated January 16, 2015, 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
mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697 5488r15

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245488	A. Building B. Wing	2/27/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **02/09/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **02/09/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **02/09/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/09/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **02/09/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **02/09/2015**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **02/09/2015**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	03/02/2015	28035	02/27/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/31/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245488	A. Building B. Wing **01 - 100 MAIN BUILDING**	1/29/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0022	**01/12/2015**	ID Prefix Reg. # **NFPA 101** LSC K0056	**01/12/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	03/02/2015	27200	01/29/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/30/2014

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: 5KR9

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245488**
2.STATE VENDOR OR MEDICAID NO.
(L2) **502043300**

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

4. TYPE OF ACTION: **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 **12/31/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(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 :
Rebecca Haberle, HFE NEII 02/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/13/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 16, 2015

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

RE: Project Number S5488025

Dear Ms. Grams:

On December 31, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 9, 2015, 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 March 31, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 1, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process

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

This request must be sent within the same ten days you have for submitting 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING _____ B. WING _____	12/31/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility'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 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		2/9/15

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

Electronically Signed | 01/26/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING _____ B. WING _____	12/31/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report resident to resident abuse to the State agency for 3 of 4 resident to resident incident reports reviewed which involved five residents (R21, R30, R8, R12, R15). In addition, the facility failed to immediately report and thoroughly investigate potential mistreatment related to injuries of unknown source for 1 of 1 (R9) resident observed with a large skin tear of unknown etiology. Findings include: Resident to Resident altercations: The facility incident report dated 4/14/14, indicated R21 reported to staff that when she approached and attempted to redirect R30 from	F 225	Disclaimer Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manuel. F 225	

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

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F 225	Continued From page 2 going the wrong way in the hall, R30 had grabbed her arm and would not let go. The report also indicated R21 was instructed not to address R30 and to allow the staff to. The report indicated R21 sustained no injuries or pain. Although the administrator was notified of the resident to resident altercation, the Stage agency was not. The facility incident report dated 8/27/14, indicated R8 was having disruptive, aggressive behaviors towards staff while trying to redirect her away from an exit door. Once away from the door, R8 was independently propelling self in the hallway and while passing R30, who was standing in the hallway with his back towards R8, R8 hit R30 in the back flank region. R8 was removed from the area. The report further indicated R30 was not injured, R8's action was not purposeful, R8 became aggressive on occasion and that R30 just happened to be in the hallway. The report also indicated following the incident R8 had a bruise over the right back hand. Although the administrator was notified of the resident to resident altercation, the State agency was not. The facility incident report dated 11/18/14, indicated staff reported R12 had struck R8 across the shoulder and chin while seated at the supper table. The report indicated R8 had stated "she hit me, but i'm ok." The report further indicated R8 denied pain, no injuries were present and the residents were separated. Although the administrator was notified of the resident to resident altercation, the State agency was not. The facility incident report dated 12/21/14,	F 225	1. Reports were turned into the Office of Health Facility Complaints (OHFC) and the Common Entry Point at Crow Wing County regarding allegations of resident to resident incident for resident□s 8, 12, 15, 21, 30 and injury of unknown origin for resident 9. The resident to resident incidents were reported on 12/30/14 and the injury of unknown origin was reported on 1/6/2015. 2. All incident reports for current residents noted to have resident to resident maltreatment and injury of unknown source during the time frame of 2-1-14 to 12-31-14 were reviewed. Review done to determine if any needed to be reported to the appropriate agencies regarding concerns of allegations of maltreatment. All future incidents will be reviewed to determine if they need to be reported according to policy and procedure and state and federal guidelines. 3. All staff were re-educated on definitions of maltreatment per policy and procedure and who to report these to and when. The Interdisciplinary Team and licensed nurses were trained what acts of maltreatment need to be reported per policy and procedure and state and federal definitions. This training occurred on 1/21/2015 and 1/22/2015 at the all nursing home staff survey education meetings. 4. Any new incident report will be audited by director of nursing or designee as they	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 indicated a nursing assistant (NA) reported to a nurse that R15 was hit in the back of the head by another resident who was combative. The NA stated R15 had been coughing when R30 had approached her and struck her in the back of the head and told R15 she should not be doing that. The report further indicated R15 sustained no injuries. Although the administrator was notified of the resident to resident altercation, the State agency was not. On 12/29/14, at 3:23 p.m. registered nurse (RN)-C stated she could report to the State agency if she had to but was new to the facility and did not know what required reporting but could refer to the facility protocol book that was stored nearby in the nursing office is she had to. At 3:30 p.m. RN-A stated facility practice was to report resident to resident altercations to the State agency only if injury occurred. When reviewing R15's above incident report, RN-A stated it was not reportable due to no injuries. On 12/30/14, at 7:21 a.m. licensed practical nurse (LPN)-B stated she could report to the State agency, however, typically on the day shift the director of nursing (DON) or the nurse manager submitted the reports. LPN-B stated resident to resident abuse was reportable and then turned to RN-A and asked her if every resident to resident incident was reportable in which RN-A stated no, only if there was an injury. LPN-B then stated if any questions on reporting she would refer to the DON or RN-A.	F 225	occur for two months, and then random audits weekly times four weeks. The results of the audits will be forwarded to the QAPI (Quality Assurance Performance Improvement) Committee for further recommendations. 5. Date of Completion will be 2/9/2015.	

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

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F 225	Continued From page 4 At approximately 8:00 a.m. RN-B stated stated she was not sure if resident to resident altercations were reportable or not and would have to ask the DON or RN-A. She added, if a fracture occurred, death within 24 hours of an incident or if a resident care plan was not followed which caused an injury the State agency would be notified. RN-B again stated she was not sure if resident to resident "contact" was reportable or not. At 9:15 a.m. the legal social worker (LSW) stated she had just started with the facility on 12/29/14, but had long term care experience. The LSW stated in her experience, anytime there was any kind of physical contact or injury a report to the State agency would have to be submitted. The LSW added, in most cases resident to resident abuse would be reportable. When reviewing the above incidents, the LSW stated willful intent appeared to be present and that they all should have been reported to the State agency. At 11:17 a.m. the DON stated when a resident to resident altercation occurred he referred to the facility's Resident to Resident Altercations algorithm which directed staff that if the resident was willful and injury occurred the incident would not be reportable. However, at the lower portion of the algorithm, a statement indicated if this algorithm was used it was to be used in conjunction with the federal nursing home regulations. The DON stated he also referred to the facility's Comparison of Federal and State Requirements / Definitions packet for guidance which the State requirement indicated verbal or	F 225		

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F 225	Continued From page 5 physical aggression occurring between residents was not reportable. However, the Federal regulatory guidance indicated each resident had the right to be free from abuse, corporal punishment and involuntary seclusion and directed that each resident must not be subjected to abuse by anyone including other residents. On the same form, Abuse was defined as the willful infliction of injury and physical abuse was defined as hitting, slapping, pinching and kicking. During review of the above incident reports, the DON confirmed they were not reported to the State agency as the facility practice was to report only if injury occurred. At 2:23 p.m. the administrator confirmed the above resident to resident altercations were not reported to the State agency as required and they should have been. Injury of Unknown Origin: The facility's incident report dated 11/4/14, at 3:18 p.m. indicated an unidentified NA noted a "giant" skin tear on R9's leg. The unidentified licensed practical nurse (LPN) measured the area to be 9.0 centimeters (cm) by 6.0 cm. The LPN provided first aide. The LPN also indicated the right shin area had been bruised prior to sustaining the skin tear and R9 may have bumped into an object in her room. The report identified the skin tear as an injury of unknown	F 225		

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F 225	Continued From page 6 origin. The facility administrator was notified of the injury, however, the State agency was not notified and an investigation was not completed to determine the cause of large skin tear and/or rule out abuse. On 12/30/14, at 12:15 p.m. RN-A stated the exact cause of R9's skin tear was unknown. She stated R9 had dementia and was a very small person (66 pounds) and the skin tear of that size would have covered over 50% of R9's leg. She felt that since R9 had the ability to move about in her room independently, the skin tear was not a reportable concern. However, she confirmed injuries of unknown origin were to be reported to the State agency in accordance with the facility policy. The facility's Abuse Definitions form dated 9/12, identified abuse as the willful infliction of injury and physical abuse as hitting, slapping, pinching or kicking. The form also indicated an injury should be classified as an injury of unknown source if the source of the injury was not observed by a person or the source of the injury could not be explained by the resident and the injury was suspicious because of the location of the injury of the number of injuries observed at one particular point in time. The facility's Abuse And Neglect procedure dated 2/13, indicated the purpose was to ensure that	F 225		

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F 225	Continued From page 7 residents were not subjected to abuse by anyone, including but not limited to staff, other residents, family or volunteers. The procedure directed staff to notify the designated agencies in accordance with state law including the state survey and certification agency. The procedure indicated staff may have to report to more than one agency to fulfill both federal and state regulations. The facility's Abuse And Neglect Policy revised 9/13, indicated alleged or suspected violation involving any mistreatment, neglect or abuse including injuries of unknown origin will be reported immediately to the facility administrator and to other officials in accordance with state law, including state survey and certification agency. The policy also indicated the facility would have evidence that all alleged or suspected violations were thoroughly investigated.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to operationalize their abuse policy and procedure related the reporting of 3 of 4 incidents of resident to resident abuse which involved five residents (R21, R30, R8, R12, R15)	F 226	F 226 1. Reports were turned into the Office of Health Facility Complaints (OHFC) and the Common Entry Point at Crow Wing	2/9/15

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

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F 226	Continued From page 8 to the State agency. In addition, the facility failed to investigate and immediately report potential mistreatment related to injuries of unknown source for 1 of 1 (R9) resident observed with a large skin tear of unknown etiology. Findings include: Resident to Resident altercations: The facility incident report dated 4/14/14, indicated R21 reported to staff that when she approached and attempted to redirect R30 from going the wrong way in the hall, R30 had grabbed her arm and would not let go. The report also indicated R21 was instructed not to address R30 and to allow the staff to. The report indicated R21 sustained no injuries or pain. Although the administrator was notified of the resident to resident altercation, the Stage agency was not. The facility incident report dated 8/27/14, indicated R8 was having disruptive, aggressive behaviors towards staff while trying to redirect her away from an exit door. Once away from the door, R8 was independently propelling self in the hallway and while passing R30, who was standing in the hallway with his back towards R8, R8 hit R30 in the back flank region. R8 was removed from the area. The report further indicated R30	F 226	County regarding allegations of resident to resident incident for resident□s 8, 12, 15, 21, 30 and injury of unknown origin for resident 9. The resident to resident incidents were reported on 12/30/14 and the injury of unknown origin was reported on 1/6/2015. 2. All incident reports for current residents noted to have resident to resident maltreatment and injury of unknown source during the time frame of 2-1-14 to 12-31-14 were reviewed. Review done to determine if any needed to be reported to the appropriate agencies regarding concerns of allegations of maltreatment. All future incidents will be reviewed to determine if they need to be reported according to policy and procedure and state and federal guidelines. 3. All staff were re-educated on definitions of maltreatment per policy and procedure and who to report these to and when. The Interdisciplinary Team and licensed nurses were trained what acts of maltreatment need to be reported per policy and procedure and state and federal definitions. Re-education on the Abuse Policy and Procedure was provided to staff on 1/21/2015 and 1/22/2015 at the all nursing home staff survey education meetings. All staff will continue to complete training on abuse policy and procedure annually. 4. Any new incident report will be audited by director of nursing or designee as they	

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F 226	Continued From page 9 was not injured, R8's action was not purposeful, R8 became aggressive on occasion and that R30 just happened to be in the hallway. The report also indicated following the incident R8 had a bruise over the right back hand. Although the administrator was notified of the resident to resident altercation, the State agency was not. The facility incident report dated 11/18/14, indicated staff reported R12 had struck R8 across the shoulder and chin while seated at the supper table. The report indicated R8 had stated "she hit me, but i'm ok." The report further indicated R8 denied pain, no injuries were present and the residents were separated. Although the administrator was notified of the resident to resident altercation, the State agency was not. The facility incident report dated 12/21/14, indicated a nursing assistant (NA) reported to a nurse that R15 was hit in the back of the head by another resident who was combative. The NA stated R15 had been coughing when R30 had approached her and struck her in the back of the head and told R15 she should not be doing that. The report further indicated R15 sustained no injuries. Although the administrator was notified of the resident to resident altercation, the State agency was not. On 12/29/14, at 3:23 p.m. registered nurse (RN)-C stated she could report to the State agency if she had to but was not sure what	F 226	occur for two months, then random audits weekly for four weeks. The results of the audits will be forwarded to the QAPI (Quality Assurance Performance Improvement) Committee for further recommendations. 5. Date of Completion will be 2/9/2015.	

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F 226	Continued From page 10	F 226		

required reporting because she was new to the facility but could refer to facility protocol book that was stored nearby in the nursing office is she had to.

At 3:30 p.m. RN-A stated facility practice was to report resident to resident altercations to the State agency only if injury occurred. When reviewing R15's above incident report, RN-A stated it was not reportable due to no injuries.

On 12/30/14, at 7:21 a.m. licensed practical nurse (LPN)-B stated she could report to the State agency, however, typically on the day shift the director of nursing (DON) or the nurse manager submitted the reports. LPN-B stated resident to resident abuse was reportable and then turned to RN-A and asked her if every resident to resident incident was reportable in which RN-A stated no, only if there was an injury. LPN-B then stated if any questions on reporting she would refer to the DON or RN-A.

At approximately 8:00 a.m. RN-B stated she was not sure if resident to resident altercations were reportable or not and would have to ask the DON or RN-A. She added, if a fracture occurred, death within 24 hours of an incident or if a resident care plan was not followed which caused an injury the State agency would be notified. RN-B again stated she was not sure if resident to resident "contact" was reportable or not.

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F 226	Continued From page 11 At 9:15 a.m. the legal social worker (LSW) stated she had just started with the facility on 12/29/14, but had long term care experience. The LSW stated in her experience, anytime there was any kind of physical contact or injury a report to the State agency would have to be submitted. The LSW added, in most cases resident to resident abuse would be reportable. When reviewing the above incidents, the LSW stated willful intent appeared to be present and they all should have been reported to the State agency. At 11:17 a.m. the DON stated when a resident to resident altercation occurred he referred to the facility's Resident to Resident Altercations algorithm which directed staff if the resident was willful and injury occurred the incident would not be reportable. However, at the lower portion of the algorithm, a statement indicated if this algorithm was used it was to be used in conjunction with the federal nursing home regulations. The DON stated he also referred to the facility's Comparison of Federal and State Requirements / Definitions packet for guidance which the State requirement indicated verbal or physical aggression occurring between residents was not reportable. However, the Federal regulatory guidance indicated each resident had the right to be free from abuse, corporal punishment and involuntary seclusion and directed each resident must not be subjected to abuse by anyone including other residents. On the same form, Abuse was defined as the willful infliction of injury and physical abuse was defined as hitting, slapping, pinching and kicking. During review of the above incident reports, the DON confirmed they were not reported to the State agency as the facility practice was to report only if	F 226		

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F 226	Continued From page 12 injury occurred. At 2:23 p.m. the administrator confirmed the above resident to resident altercations were not reported to the State agency as required and they should have been. Injury of unknown origin: The facility's incident report dated 11/4/14, at 3:18 p.m. indicated an unidentified NA noted a "giant" skin tear on R9's leg. The unidentified licensed practical nurse (LPN) measured the area to be 9 centimeters (cm) by 6 cm. The LPN provided first aide. The LPN also indicated the right shin area had been bruised prior to sustaining the skin tear and R9 may have bumped into an object in her room. The report identified the skin tear as an injury of unknown origin. The facility administrator was notified of the injury, however, the State agency was not notified and an investigation was not completed to determine the cause of large skin tear and/or rule out abuse. On 12/30/14, at 12:15 p.m. RN-A stated the exact cause of R9's skin tear was unknown. She stated R9 had dementia and was a very small person (66 pounds) and the skin tear of that size would have covered over 50% of R9's leg. She felt that since R9 had the ability to move about in her room independently, the skin tear was not a	F 226		

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	245488	A. BUILDING _____ B. WING _____	12/31/2014

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

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F 226	Continued From page 13 reportable concern. However, she confirmed injuries of unknown origin were to be reported to the State agency in accordance with the facility policy. The facility's Abuse Definitions form dated 9/12, identified abuse as the willful infliction of injury and physical abuse as hitting, slapping, pinching or kicking. The form also indicated an injury should be classified as an injury of unknown source if the source of the injury was not observed by a person or the source of the injury could not be explained by the resident and the injury was suspicious because of the location of the injury of the number of injuries observed at one particular point in time. The facility's Abuse And Neglect procedure dated 2/13, indicated the purpose was to ensure that residents were not subjected to abuse by anyone, including but not limited to staff, other residents, family or volunteers. The procedure directed staff to notify the designated agencies in accordance with state law including the state survey and certification agency. The procedure indicated staff may have to report to more than one agency to fulfill both federal and state regulations. The facility's Abuse And Neglect Policy revised 9/13, indicated alleged or suspected violation involving any mistreatment, neglect or abuse	F 226		

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F 226	Continued From page 14 including injuries of unknown origin will be reported immediately to the facility administrator and to other officials in accordance with state law, including state survey and certification agency. The policy also indicated the facility would have evidence that all alleged or suspected violations were thoroughly investigated.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 1 of 1 resident (R12) who requested to change dining seating. Findings include: R12's significant change Minimum Data Set (MDS) dated 10/13/14, indicated R12 was diagnosed with Alzheimer's disease and required limited to extensive assistance with all activities of daily living. R12's care plan dated 10/10/14, indicated R12 had impaired cognition, anxiety and was able to	F 241	F 241 1. Resident #12 was offered optional dining arrangements to provide a dignified dining experience on 12/31/14 which the resident declined. Social Worker will check with resident weekly for 4 weeks and then quarterly thereafter for one year. If resident appears to get agitated during the dining experience, staff to offer redirection through verbal cues, reorientation and supervision and offer the resident an alternate seating arrangement as resident requests. 2. All residents were reminded about resident bill of rights with emphasis on resident dignity and choice at the resident council meeting on 1/20/2015. Anyone not in attendance received a copy of the bill of	2/9/15

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F 241	Continued From page 15 verbalize needs. The care plan directed staff to redirect R12 through verbal cues, reorientation and supervision. On 12/30/14, at 5:25 p.m. R12 was observed seated in the dining room at a table with R8. - At 5:27 p.m. R8 was observed to begin to tap her silverware on the table next to R12. - At 5:27 p.m. the activity director was observed to walk over to R8 and remove the silverware from R8's hand. - At 5:28 p.m. R8 picked up the silverware and again began to pound the table. - At 5:28 p.m. the activity director was observed to remove the silverware from R8's hands and handed R8 a glass of water. - At 5:38 p.m. R8 was observed to pound the glass of water on the table, causing it to spill. At this time, R12 was observed to become agitated and attempted to redirect R8 and told R8 not to make a mess. - At 5:40 p.m. the activity director was observed to redirect R8 and clean the table of the spilled liquids. At that time, registered nurse (RN)-D was observed to administer R12's medications. R12 was heard to ask RN-D if she could move to another table. RN-D replied "I am not in charge of the table assignments, you will have to talk to the authorities." RN-D then returned to the medication cart. - At 5:42 p.m. RN-D confirmed R12 had asked if she could move to another table. She explained R12 was seated at her assigned table and that is where she would be receiving her evening meal. - At 5:45 p.m. R12 asked the State Agency staff if she could move to a different table and pointed to an empty table. R12 stated R8 was pounding on the table, moving the table cloths and it was	F 241	rights. All future admissions will continue to receive the Bill of Rights upon admission. Through the next Resident Council meetings will be reviewing the Bill of Rights with emphasis on a dignified dining experience for the next two quarters. Anytime a resident requests a dining table change due to a disruptive tablemate we will accommodate by offering alternatives. 3. All staff were re-educated at the all nursing home staff survey education meetings on 1/21/2015 and 1/22/2015 about resident□s rights, dignity and choice and accommodating resident□s requests. This re-education included the choice of where the resident would like to sit in the dining room. 4. Audits will be done at weekly care conferences for 1 quarter to ensure residents rights, dignity to respect their individuality and choice are being accommodated. The results of the audits will be forwarded to the QAPI (Quality Assurance Performance Improvement) Committee for further recommendations. 5.Date of completion will be 2/9/2015.	

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F 241	Continued From page 16 making her "nervous." At this time, as nursing assistant (NA)-F approached R12, she stated, "I will be the bigger person" and proceeded to firmly tell R12 the evening meal would be served soon and then R8 would not pound on the table anymore. She told R12 she was not able to move for she was at her assigned seat. NA-F then walked away. - At 5:47 p.m. R8 began to pound on the table with her hands and was again redirected by the activity director. - At 5:56 p.m. R8 and R12 were served the evening meal. The activity director sat at the table and assisted R8 with the meal. R12 was observed to quietly eat her meal at the same assigned table. On 12/30/14, at 6:00 p.m. RN-C, (the evening charge nurse) verified R8 exhibited behaviors daily during the evening meal. RN-C stated the behaviors ranged from yelling, pounding on the table, moving table cloths, mixing her food items together and/or spilling items. RN-C stated she was aware R8's behaviors irritated other residents around her however, the other resident were allowed to freely move in the dining room as they wished. She stated she was not aware R12 was bothered by R8's behaviors but she could easily be moved to a different area of the dining room. On 12/30/14, at 6:10 p.m. the kitchen manager stated the residents were able to be moved if there was an open chair at the table. She confirmed there currently were several open areas in the dining room. She stated R12 had recently moved to R8's table to help direct R8 in	F 241		

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F 241	Continued From page 17 the evening. She stated she was not aware R12 was irritated by R8's behaviors. On 12/31/14, at 7:40 a.m. RN-A stated the dining room seating assignment had been arranged between the nursing and dietary departments along with the resident and/or a family request. She stated there were no rules regarding changing tables and any resident was able to move to a different table, at any time. She stated the staff members should have moved R12 upon her request and should not have told her she was to stay in her assigned seat. On 12/31/14, at 8:05 a.m. the director of nurses and the facility administrator were interviewed. They concurred the residents were to be treated in a dignified manner in the dining room and if they made a request for alternative seating, the staff members were to assist with enhancing the dining experience for all of the residents. The administrator stated the facility was currently working on enhancing the dining experience and the staff members should have assisted R12 to move to a different table verses telling her to stay in her assigned seat. The facility Resident Rights policy dated 2/2013, stated the facility must promote care for residents in a manner and in an environment that maintains or enhances each resents dignity and respect in recognition of his or her individuality.	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		2/9/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 18 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely turning and repositioning for 1 of 3 residents (R1) as directed by the individual plan of care. Findings include: R1's care plan dated 10/14/14, identified R1 had a potential for skin impairment and directed staff to turn and reposition R1 every three hours when in the chair or bed. R1's Diagnosis Report dated 10/16/14, identified R1's diagnoses as aftercare healing from a fractured right elbow and hip, anxiety and dementia. On 12/30/14, during continual observation from 7:05 a.m. until 11:30 a.m. the following was observed: - At 7:05 a.m. R1 was observed seated in her wheelchair in the activity room. - At 7:50 a.m. R1 was observed to remain seated in her wheelchair and was transported into the large dining room and stationed at her table for breakfast. - At 8:52 a.m. upon completion of her breakfast meal, a nursing assistant (NA)-A transported R1 back into the activity room. R1 was observed to	F 282	F 282 1. Resident #1 was re-assessed for proper positioning. There were no changes noted to the residents care plan. Resident is being repositioned according to care plan. Staff member that was involved in care was re-educated on how to re-approach residents if refuse repositioning on 12/30/2014. 2. All residents who need assistance with repositioning are potentially at risk for this deficient practice. Review of all current care plans completed and staff are repositioning residents according to their individualized plan of care. 3. Nursing staff re-educated on the importance of timely repositioning and following the care plan. This training occurred on 1/21/2015 and 1/22/2015 at the all nursing home staff survey education meetings. 4. Random audits on repositioning will occur daily on varied shifts for 4weeks and then three times per week for 4 weeks and then monthly times one month. The results of the audits will be forwarded to the QAPI (Quality Assurance	

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F 282	Continued From page 19 remain seated in her wheelchair while in the activity room until 11:30 a.m. (4 hours and 25 minutes) during which time she participated in a ball exercise, had snack, sang and dozed while seated in her wheelchair. At no time during this observation was R1 repositioned or offloaded (relieve the pressure to an area for one full minute) nor was R1 offered to be repositioned of offloaded. On 12/30/14, at 11:16 a.m. NA-A stated R1 should be repositioned every two hours. NA-A agreed for R1 to remain in the same position from 7:05 a.m. until now 11:16 a.m. was too long. NA-A stated she would go and get R1 now and bring her to the bathroom. On 12/30/14, at 11:30 a.m. NA-A was observed to transport R1 back to her room and assisted R1 onto the toilet. R1's brief was dry; however the skin around R1's coccyx (tailbone) and both buttock cheeks were reddened. On 12/30/14, at 11:34 a.m. registered nurse (RN)-A verified R1's care plan directed staff to reposition R1 every three hours. RN-A stated it was her expectation that if a resident refused to be repositioned the staff member would re-approach the resident in 30 minutes and encouraged repositioning again. On 12/30/14, at 11:35 a.m. licensed practical nurse (LPN)-B confirmed R1 should be repositioned every 2-3 hours. LPN-B confirmed for R1 to wait four hours and 25 minutes to be	F 282	Performance Improvement) Committee for further recommendations. 5. Date of completion will be 2/9/2015.	

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F 282	Continued From page 20 repositioned was too long. On 12/30/14, at 2:48 p.m. the director of nursing (DON) verified his expectations were that the care plans would be followed with regards to turning and repositioning residents. In addition, if the NA attempted to reposition a resident and they were unsuccessful, the DON expected the NA to reattempt repositioning at a different time, and if they were still unsuccessful the NA should notify the nurse. The DON confirmed for R1 to wait four hours and 25 minutes to be repositioned was too long for someone who had been identified at risk for the development of a pressure ulcer. The facility's Skin Assessment and Pressure Ulcer Prevention policy dated 6/2014, indicated residents who are unable to reposition themselves independently should be repositioned as often as directed by the care plan.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 provide coordinated hospice care and services for 1 of 1 resident	F 309	F 309 1.Interdisciplinary team met with Hospice	2/9/15

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F 309	Continued From page 21 (R53) reviewed who was receiving hospice services. Findings include: R53's quarterly Minimum Data Set (MDS) dated 11/3/14, indicated R53 was diagnosed with hypertension, anxiety and stomach disorders. The MDS also indicated R53 required extensive assistance with all activities of daily living and was receiving hospice services. R53's Activities of Daily Living (ADLs) Care Area Assessment (CAA) dated 5/22/14, indicated R53 received hospice services. R53's care plan dated 5/14/14, indicated R53 received hospice serves and required extensive assistance with all ADLs. The plan repeatedly directed staff to ask for guidance from the hospice provider if questions regarding R53's care were identified. However, the plan did not indicate what type of services hospice was providing R53. R53's hospice care plan dated 10/6/14, directed hospice staff to provide R53 with personal cares including full baths two times a week, socialization, repositioning and spiritual needs. On 12/29/14, at 3:44 p.m. nursing assistant (NA)-H stated she was R53's primary care giver for the evening shift. When questioned when the hospice staff members would be visiting R53 or	F 309	RN director on 1/2/2015 to review the care plan for resident #53 to ensure coordinated care and services. Care plan updated to direct staff to look at hospice binder for the hospice care plan. The hospice binder shows which services are provided and the calendar of scheduled visits. 2.All future residents requiring Hospice Services will have Plan of Care communicated per facility procedure that explains delineation of Center/ Hospice staff roles and responsibilities to ensure collaboration between the Nursing Home and the Hospice agency. 3.All nursing staff were re-educated on the policy and procedure for hospice services and delineation of roles and responsibilities and where to find current communication for Hospice services at the all nursing home staff survey education meeting on 1/21/2015 and 1/22/2015. 4.Audit will be done on all residents receiving hospice services weekly for two months and then every other week times 2 months. Results will be reviewed at the QAPI (Quality Assurance Performance Improvement) committee meeting for further recommendations. 5.Date of completion will be 2/9/2015.	

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F 309	Continued From page 22	F 309		

what services they provided, she stated she did not know and was not aware R53 was receiving hospice services.

On 12/29/14, at 3:50 p.m. licensed practical nurse (LPN)-C confirmed R53 received hospice services but stated she was not aware or what days, what time or what services hospice provided R53 during the visits. She stated hospice staff members usually contacted the facility the day before the visits and she was not aware of when they would be coming to the facility.

On 12/30/14, at 7:10 a.m. R53 was observed resting in bed, fully dressed and appeared well groomed.

On 12/30/14, at 7:33 a.m. hospice NA-A arrived at the facility. Hospice NA-A stated she visited the facility twice a week to assist R53 with morning cares. She stated was at the facility to provide R53 with a partial bath and to assist her to dress.

On 12/30/14, at 7:40 a.m. NA-G stated she had already assisted R53 with morning cares around 6:30 a.m. She verified R53 received hospice services but she did not know when the hospice staff would be at the facility or what type of services they would provide R53. NA-G then pulled out the NA Group Assignment sheets for 12/30/14, and explained the assignment sheets identified which residents she was assigned. When asked how the sheet identified when

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	245488	A. BUILDING _____ B. WING _____	12/31/2014

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

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F 309	Continued From page 23	F 309		

hospice staff would be at the facility to care for R53 or what they would be providing, NA-G stated the assignment sheet did not give her this information.

On 12/30/14, at 7:47 a.m. the hospice NA-A approached the State agency staff and asked if R53 had already received morning cares. She reported she would not be completing cares, as the facility staff had already done so.

On 12/30/14, at 7:50 a.m. registered nurse (RN)-A stated hospice staff visit R53 two days a week and would be completing this morning's cares. When questioned how the direct care staff would know when hospice staff members would be visiting the facility and what cares they would be providing for R53, RN-A stated they were to receive that information in report as the hospice staff members called the facility the day before the visit to inform us.

On 12/30/14, at 7:55 a.m. RN-B, the wing nurse for R53, stated she had attended morning report and was not made aware the hospice staff would be providing cares for R53.

On 12/30/14, at 8:00 a.m. RN-A approached NA-G and informed her hospice staff members should have performed cares for R53. NA-G stated she was unaware of the hospice schedule.

R53's "hospice binder" included a calendar which indicated what day and which hospice staff

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F 309	Continued From page 24 member would be visiting R53. However, the calendar did not indicate the time or what type of cares the hospice staff would provide R53. On 12/30/14, at 12:40 a.m. RN-A confirmed the facility did not have a system in place to inform the direct care staff of the hospice services scheduled or services provided for R53. She stated she had been in contact with the hospice provider and was working on ways to enhance communication between the hospice provider and the facility. On 12/30/14, at 1:10 p.m. the director of nurses stated he was not aware of any concerns related to communication between the facility and the hospice provider. The Hospice Services Provided in a Skilled Nursing Facility policy dated 9/2012, directed the hospice team and the center staff to communicate with each other to ensure cohesive care.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		2/9/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING _____ B. WING _____	12/31/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a 1 of 3 residents (R1) identified at risk for pressure ulcers was repositioned in a timely manner in an effort to prevent the development of pressure ulcers. Findings include: R1's Diagnosis Report dated 10/16/14, identified R1's diagnoses as aftercare healing from a fractured right elbow and hip, anxiety, dementia and depression. R1's care plan dated 10/14/14, indicated R1 had a potential for skin impairment and directed staff to turn and reposition R1 every three hours when she was in her chair or bed. R1's admission Minimum Data Set (MDS) dated 10/21/14, indicated R1 had severe cognitive impairment and required extensive assist with bed mobility, transferring, locomotion on and off the unit, toileting and personal hygiene. In addition, the MDS identified R1 to be at risk for the development of a pressure ulcer and recommended a turning and repositioning program be in place. R1's Pressure Ulcer Care Area Assessment	F 314	F 314 1. Resident #1 was re-assessed for proper positioning. There were no changes noted to the residents care plan. Resident is being repositioned according to care plan. Staff member that was involved in care was re-educated on how to re-approach residents if refuse repositioning on 12/30/2014. 2. All residents who need assistance with repositioning are potentially at risk for this deficient practice. Review of all current care plans completed and staff are repositioning residents according to their individualized plan of care. 3. Nursing staff re-educated on the importance of timely repositioning and following the care plan. This training occurred on 1/21/2015 and 1/22/2015 at the all nursing home staff survey education meetings. 4. Random audits on repositioning will occur daily on varied shifts for 4weeks and then three times per week for 4 weeks and then monthly times one month. The results of the audits will be forwarded to the QAPI (Quality Assurance Performance Improvement) Committee for further recommendations. 5. Date of Completion will be 2/9/2015.	

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F 314	Continued From page 26	F 314		

(CAA) dated 10/21/14, identified R1 as being at risk for the development of pressure related skin breakdown and indicated R1 required a regular schedule for turning.

R1's Positioning Assessment and Evaluation dated 10/23/14, indicated R1 was able to tolerate up to three hours in sitting or lying positions. The evaluation indicated staff was to assist R1 with repositioning.

R1's Braden Scale for Predicting Pressure Sore Risk dated 11/5/14, indicated R1 was at risk for the development of a pressure ulcer and the intervention guide recommended R1 be turned frequently (e.g., every two hours).

On 12/30/14, during continual observation from 7:05 a.m. until 11:30 a.m. the following was observed:
- At 7:05 a.m. R1 was observed seated in her wheelchair in the activity room.
- At 7:50 a.m. R1 was observed to remain seated in her wheelchair and was transported into the large dining room and stationed at her table for breakfast.
- At 8:52 a.m. upon completion of her breakfast meal, a nursing assistant (NA)-A transported R1 back into the activity room. R1 was observed to remain seated in her wheelchair while in the activity room until 11:30 a.m. (4 hours and 25 minutes) during which time she participated in a ball exercise, had snack, sang and dozed while seated in her wheelchair. At no time during this observation was R1 repositioned or offloaded (relieve the pressure to an area) nor was R1

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F 314	Continued From page 27 offered to be repositioned of offloaded. On 12/30/14, at 11:16 a.m. NA-A stated R1 should be repositioned every two hours. NA-A agreed for R1 to remain in the same position from 7:05 a.m. until now 11:16 a.m. was too long. NA-A stated she would go and get R1 now and bring her to the bathroom. On 12/30/14, at 11:30 a.m. NA-A was observed to transport R1 back to her room and assisted R1 onto the toilet. R1's brief was dry; however the skin around R1's coccyx (tailbone) and both buttock cheeks were reddened. On 12/30/14, at 11:34 a.m. registered nurse (RN)-A verified R1's care plan directed staff to reposition R1 every three hours. RN-A stated it was her expectation that if a resident refused to be repositioned the staff member would re-approach the resident in 30 minutes and encouraged repositioning again. On 12/30/14, at 11:35 a.m. licensed practical nurse (LPN)-B confirmed R1 should be repositioned every 2-3 hours. LPN-B confirmed for R1 to wait four hours and 25 minutes to be repositioned was too long. On 12/30/14, at 2:48 p.m. the director of nursing (DON) verified his expectations were that the care plans would be followed with regards to turning and repositioning residents. In addition, if the NA attempted to reposition a resident and	F 314		

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F 314	Continued From page 28 they were unsuccessful, the DON expected the NA to reattempt repositioning at a different time, and if they were still unsuccessful the NA should notify the nurse. The DON confirmed for R1 to wait four hours and 25 minutes to be repositioned was too long for someone who had been identified at risk for the development of a pressure ulcer. The facility's Skin Assessment and Pressure Ulcer Prevention policy dated 6/2014, indicated residents who are unable to reposition themselves independently should be repositioned as often as directed by the care plan. The policy also indicated the development of an individualized repositioning schedule was recommended and should be communicated to the nursing assistants.	F 314		
F 334 SS=C	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	F 334		2/9/15

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F 334	Continued From page 29 documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second	F 334		

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F 334	Continued From page 30 pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 5 residents (R28, R30, R24, R31, R4) or their legal representative had received the required education regarding the benefits and potential side effects of the influenza immunization prior to administering it. Findings include: On 12/30/14, at 4:05 p.m. the director of nursing (DON) provided a letter dated 9/25/14, which he stated was mailed to all residents / family representatives. The letter addressed the upcoming influenza immunizations along with the education regarding the benefits and potential side effects of the immunization. On 12/31/14, at 8:34 a.m. the DON stated the letter instructed residents / family representatives to notify the facility by 10/8/14, if they were declining the immunization. The DON stated R4 refused the influenza immunization on 10/13/14, however verified there was no documentation in	F 334	F 334 1. Residents 4, 24, 28, 30, 31 and/or legal representatives were re-educated on the benefits and potential side effects of the influenza immunization. This education was documented in each chart. 2. All current residents were reviewed to ensure they received the proper education on the potential side effects of the influenza immunization and that this education had been documented in their medical record. Any new residents that are receiving immunizations will have the education documented in their chart. 3. Licensed nurses were re-educated at the all nursing home staff survey education meetings on 1/21/2015 and 1/22/2015 on the correct method of documentation within the electronic medical record when educating residents or legal representatives when giving an immunization. 4. Random audits will be done on residents receiving immunizations to	

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F 334	Continued From page 31 R4's medical record identifying this refusal and stated there should have been a progress note written in R4's medical record to identify R4 had received the immunization education prior to refusing the immunization. During review of the immunization form with the DON, a check box which if checked indicated the resident or legal representative had received the education prior to the administration of the immunization. The DON verified the box was not checked for R28, R30, R24, and R31. In addition, the DON stated he was not aware of the education check box on the immunization form and verified the facility policy for resident immunizations was not followed. R28's Influenza Immunization form indicated R28 received the vaccination on 10/13/14. The check box which indicated the required education was provided to the resident and / or representative prior to the administration of the immunization was blank. R30's Influenza Immunization form indicated R30 received the vaccination on 10/13/14. The check box which indicated the required education was provided to the resident and / or representative prior to the administration of the immunization was blank. R24's Influenza Immunization form indicated R24 received the vaccination on 10/13/14. The check box which indicated the required education was	F 334	ensure education occurred and was documented weekly for one month, every other week times one month and monthly for one month. Results will be reviewed at the QAPI (Quality Assurance Performance Improvement) committee meeting for further recommendations. 5. Date of completion will be 2/9/2015.	

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F 334	Continued From page 32 provided to the resident and / or representative prior to the administration of the immunization was blank. R31's Influenza Immunization form indicated R31 received the vaccination on 10/13/14. The check box which indicated the required education was provided to the resident and / or representative prior to the administration of the immunization was blank. The facility's Immunizations For Residents procedure revised 11/14, indicated prior to the vaccination, the resident or resident's legal representative would be provided the Centers for Disease Control (CDC) information and education regarding the benefits and potential side effects of the influenza vaccine. The procedure also indicated the section of the education form which indicated education was provided to the resident and / or representative would be checked documenting that the educational information was provided.	F 334		

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	245488	A. BUILDING **01 - 100 MAIN BUILDING** B. WING _____	**12/30/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. At the time of this survey, Good Samaritan Society, Woodland 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 19 Existing 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 St. Paul, MN 55101 Or by e-mail to:	K 000	EPOC	

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

Electronically Signed | 01/26/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Good Samaritan Society, Woodland is a 1-story building without a basement. The building was constructed in 1982 and was determined to be of Type V(111) construction. The building is separated from the apartment building with a 2-hour fire barrier and is divided into 3 smoke zones with 1-hour fire barriers. The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 42 beds and had a census of 40 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 022	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to properly identify 3 of several non-required doors leading to the exterior that do not lead to the public way in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.1.7 and 7.10.8.1 These deficient practices could negatively affect residents, staff and visitors, by causing confusion in locating an exit from the building to the public way in the event of an emergency. Findings include: On facility tour between 10:30 AM to 1:30 PM on	K 022	K022 1.Added appropriate signage to east day room, west day room and courtyard doors. 2.Date of completion was 1/12/2015. 3.Rich Nelson, Maintenance Director	1/12/15

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	245488	A. BUILDING **01 - 100 MAIN BUILDING** B. WING _____	**12/30/2014**

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K 022	Continued From page 3 12/30/2014, observations revealed that the west day room, east day room, and the courtyard doors were not marked as "NO EXIT". These doors are not part of a required exits and need to display a sign that reads as follows: NO EXIT. The word "NO" shall be in letters 2 inches in height and with a stroke width of 3/8 inch, and the word "EXIT" in letters 1 inch in height located directly below the word "NO". This deficient practice was verified by the Maintenance staff member (AJ).	K 022		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain	K 056	K056 1.Added 2 drop sprinkler heads to cover the area obstructed by the duct work in c137. We replaced all 9 sprinkler heads in	1/12/15

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K 056	Continued From page 4 the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 10:30 AM to 1:30 PM on 12/30/2014, observations have revealed the following deficient conditions that are affecting the facilities fire sprinkler coverage: 1) The mechanical room C137 had HVAC duct work that is 63 inches in width that is blocking the fire sprinkler coverage for that room. Fire Sprinkler coverage needs to be provided below that HVAC duct work obstruction. 2) There is a sprinkler head that is located in the clean side of the dish washer that is heavily corroded which can affect the sprinkler heads ability to activate in the event of a fire emergency. This deficient practice was verified by the Maintenance staff member (AJ).	K 056	kitchen area with new non-corrosive heads to prevent future problems. 2.Completion date 1/12/2015. 3.Rich Nelson, Maintenance Director	