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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: BJBK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00063

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245237**

2.STATE VENDOR OR MEDICAID NO.
(L2) **385318700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - REDWOOD FALLS**
(L4) **200 SOUTH DEKALB STREET**
(L5) **REDWOOD FALLS, MN** (L6) **56283**

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 **06/01/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **43** (L18)

13.Total Certified Beds **43** (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
	43			
(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 :
LoAnn DeGagne, HFE NE II — 06/01/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 06/28/2017 (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
04/14/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 07/14/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/06/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245237
June 28, 2017

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

Dear Mr. Parence:

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

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

Effective June 1, 2017 the above facility is certified for or recommended for:

43 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 28, 2017

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

RE: Project Number S5237024

Dear Mr. Parence:

On May 10, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 15, 2017. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on April 21, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On June 1, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR), and on June 14, 2017 the Minnesota Department of Public Safety completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 21, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 27, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 21, 2017, as of June 1, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 1, 2017.

However, as we notified you in our letter of May 10, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 21, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the recommended remedies in their letter of May 10, 2017:

- Civil money penalty will remain recommended. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: BJBK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00063

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(L1) **245237**

2.STATE VENDOR OR MEDICAID NO.
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(L4) **200 SOUTH DEKALB STREET**
(L5) **REDWOOD FALLS, MN** (L6) **56283**

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 **06/01/2017** (L34)

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0 Unaccredited 1 TJC
2 AOA 3 Other

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01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
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FISCAL YEAR ENDING DATE: (L35)
12/31

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To (b) :

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Compliance Based On:
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And/Or Approved Waivers Of The Following Requirements:
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___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

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18 SNF	18/19 SNF	19 SNF	ICF	IID
	43			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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17. SURVEYOR SIGNATURE — Date :
LoAnn DeGagne, HFE NE II — 06/01/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 06/28/2017 (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
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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04/14/1981
(L24)

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A. Suspension of Admissions:
(L44)
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26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
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04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
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28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 07/14/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/06/2017
(L33)

DETERMINATION APPROVAL

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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245237
June 28, 2017

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200 South Dekalb Street
Redwood Falls, MN 56283

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

Please contact me if you have any questions.

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Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 28, 2017

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Good Samaritan Society - Redwood Falls
200 South Dekalb Street
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RE: Project Number S5237024

Dear Mr. Parence:

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Sincerely,

Kate JohnsTon, Program Specialist
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DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: BJBK

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(L4) **200 SOUTH DEKALB STREET**
(L5) **REDWOOD FALLS, MN** (L6) **56283**

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 **04/21/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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18 SNF	18/19 SNF	19 SNF	ICF	IID
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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 :
Christine Bodick-Nord, HFE NE II 05/25/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 05/31/2017 (L20)

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

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28. TERMINATION DATE:
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29. INTERMEDIARY/CARRIER NO.
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30. REMARKS
Posted 06/06/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
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DETERMINATION APPROVAL

MDH
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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 10, 2017

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

RE: Project Number S5237024

Dear Mr. Parence:

On April 21, 2017, 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 constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criteria and remedies will be imposed immediately. Therefore, this

Department is imposing the following remedy:

- State Monitoring effective May 15, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will

recommend to the CMS Region V Office that one or more of the following remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

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 July 21, 2017 (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 October 21, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal

regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	**200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable 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 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;	F 156		5/27/17

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

Electronically Signed | 05/20/2017

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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F 156	Continued From page 1 (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and	F 156		

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F 156	Continued From page 2 as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email),	F 156		

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F 156	Continued From page 3	F 156		

and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

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F 156	Continued From page 4 (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	F 156		

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F 156	Continued From page 5 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the appropriate liability notice to 2 of 3 residents (R5, R7) reviewed who were discharged from Medicare services. Findings include:	F 156	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	

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F 156	Continued From page 6 R5's Admission Record, dated 6/23/16, indicated she admitted to the facility on 6/23/16. A review of the medical record indicated R5 no longer qualified for Medicare covered services beginning 1/7/17. R5 remained in the facility following discontinuation of Medicare benefits. There was no indication that R5 was provided the Center Medicare Service (CMS) 10123, or generic notice, (a document which explains a resident's right to an expedited review of Medicare benefits) prior to the end of her Medicare stay as required. However, R5 was provided, and her beneficiary signed, the facility's SNF Determination on Continued Stay (a document which explains a resident's financial obligations when Medicare benefits end) on 1/3/17. R7's Admission Record, dated 4/13/16, indicated she admitted to the facility on 4/13/16. A review of the medical record indicated R7 no longer qualified for Medicare covered services beginning 3/14/17. R7 remained in the facility following discontinuation of Medicare benefits. There was no indication that R7 was provided the CMS 10123, or generic notice, prior to the end of her Medicare stay as required. However, R7 was provided and signed the facility's SNF Determination on Continued Stay on 3/13/17. During an interview on 4/18/17, at 3:31 p.m., registered nurse (RN)-A stated she was responsible for providing residents with the appropriate notices when Medicare services were ending, but stated she did not fully understand the process. RN-A referred to a guide sheet as to when the notices were to be given and which	F 156	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 Manual. 1.Residents R5 and R7 both received CMS10123 form notifying them of their rights on May 19th 2017. 2.All residents in the last three months who were discharge from Medicare but remained in the facility were issued a notice of non-coverage denial per GSS procedure. 3.MDS coordinator and business office manager have been re-educated on when to give proper notice on May 17th 2017 4.Audits will be conducted by DNS or designee of all residents having been discharged from Medicare Part A stay to ensure proper notifications were made weekly X 4, monthly X 2. Audit results will be reviewed by Quality Committee for further recommendations.	

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F 156	Continued From page 7 ones were needed. RN-A stated, "I have 48 hours to get that out [the notices] once I'm given notice that services are ending." RN-A further stated was not aware of the requirement that notices were to be provided to the resident two days prior to the last covered day. Review of the facility's policy, Medicare Part A Non-Coverage Notifications, SNF Beneficiary Notice Scenarios, dated 2/13, included, "Liability notices are issued to notify Medicare Part A residents of their financial liability for services when skilled criteria are not met." It also included, "Coverage/Appeal notices are issued to notify traditional Medicare (Part A and Part B) and Medicare Advantage/Replacement plan beneficiaries of their right to an expedited appeal by a Quality Improvement Organization (QIO) when skilled coverage is ending." The policy lacked direction for the timeframe that notices were to be provided to the resident when services were ending.	F 156		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or	F 225		5/27/17

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F 225	Continued From page 8 (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities 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. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the	F 225		

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F 225	Continued From page 9 investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 notify the administrator and report an adverse event/ and possible neglect of care to the state agency (SA) when a staff member failed to lock a tub chair resulting in a fall for 1 of 5 residents (R31) reviewed for accidents. Findings include: R31's annual Minimum Data Set (MDS) dated 2/23/17, indicated R31 was cognitively intact, and required physical assistance with bathing. R31's care plan dated 3/16/17, indicated he was at risk for falls related to left sided weakness. During interview on 4/18/17, at 12:50 p.m. R31 stated about the first week of September 2016, he was receiving his bath, and the lock gave way. He stated the chair went backwards and he fell into the tub. R31 stated he had a sore wrist a couple days later. The wrist was Xrayed and not broken. R31 stated the incident occurred in the old bathtub and stated a new tub was installed a couple of months ago. During a subsequent interview on 4/19/17, at 1:58 p.m. R31 identified nursing assistant (NA)-C as the NA who assisting him the day of the incident. R31 stated NA-C received assistance from two other staff to assist	F 225	1.R31 incident has been reported to appropriate state agency. 2.All incidents occurring in the past 3 months have been reviewed to ensure proper notification to administrator and state agency was done as appropriate. 3.All staff In-servicing was conducted by Administrator on GSS policy and procedure for abuse, neglect, and mandated reporting was completed on May 17th, 2017. 4.Social Service director, or her designee, will audit progress notes and incidents to ensure proper notification was made to the administrator and state agency daily x2 weeks, weekly x 4, then monthly x 2. Results will be reported to Quality committee for further recommendations.	

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F 225	Continued From page 10	F 225		

him up and back into the tub chair and ensure the chair was locked into place.

Review of R31's progress notes dated 6/2/16 through 4/19/17, lacked evidence an investigation had been completed related to his fall in the bath tub, nor was there evidence the administrator or SA had been notified of the potential neglect of care.

During interview on 4/19/17, at 11:43 a.m. the administrator stated he was not aware R31 sustained a fall in the bathtub. On 4/20/17, at 10:05 a.m. the administrator stated an incident report had not been completed on this fall. He stated the fall had not reported to him and an investigation had not been completed.

During an interview on 4/19/17, at 2:38 p.m. NA-C stated R31 fell in the bathtub in September 2016. NA-C stated while assisting R31 into the chair, the chair slid back and R31 fell into the bottom of the tub. NA-C stated she called for assistance, and the (former) director of nursing (DON) and registered nurse (RN)-A entered to help. She stated R31 was assisted to stand, the tub chair was locked into place and he was assisted to sit back down. NA-C stated she did not report the incident because the DON was present and aware of the incident. She stated the DON provided her education on use of the tub chair.

When interviewed on 4/20/17, at 8:50 a.m. RN-A stated she assisted NA-C and the DON after R31's fall. RN-A stated an incident report should have been completed for this incident, but she was unable to locate one.

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(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 11 A facility policy for Abuse and Neglect, revised 11/16, indicated the purpose of the policy as follows: "To prevent future injuries...If there is an allegation of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, and/or there is serious bodily injury, than it will be reported not later than two hours after the allegation is made to the administrator, and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long - term care centers) in accordance with state law." The facility Abuse Definitions policy revised 11/16, defined neglects as "Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." The policy did not address an adverse event (an untoward , undesirable, and usually unanticipated event that causes death or serious injury, or risk thereof).	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and	F 226		5/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226	Continued From page 12 (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their abuse prevention policy and procedures to report possible neglect of care when a staff member failed to lock a tub chair resulting in a fall to the administrator and state agency (SA) for 1 of 5 residents (R31) reviewed for accidents. Findings include: A facility policy for Abuse and Neglect, revised 11/16, indicated the purpose of the policy as follows: "To prevent future injuries...If there is an allegation of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, and/or there is serious bodily injury, than it will be	F 226	1.R31 incident was reported to appropriate state agency. 2.All incidents occurring in the past 3 months have been reviewed to ensure proper notification to administrator and state agency was done as appropriate. 3.All staff In-servicing was conducted by Administrator on GSS policy and procedure for abuse, neglect, and mandated reporting and for the centers policy on notifying administrator and leadership was completed on May 17th, 2017. 4.Audits will be conducted by the Social Service Director, or her designee to ensure proper notifications of incidents were made weekly X4, monthly X 2.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226	Continued From page 13 reported not later than two hours after the allegation is made to the administrator, and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long - term care centers) in accordance with state law." The facility Abuse Definitions policy revised 11/16, defined neglects as "Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." The policy did not address an adverse event (an untoward , undesirable, and usually unanticipated event that causes death or serious injury, or risk thereof). R31's annual Minimum Data Set (MDS) dated 2/23/17, indicated R31 was cognitively intact, and required physical assistance with bathing. R31's care plan dated 3/16/17, indicated he was at risk for falls related to left sided weakness. During interview on 4/18/17, at 12:50 p.m. R31 stated about the first week of September 2016, he was receiving his bath, and the lock gave way. He stated the chair went backwards and he fell into the tub. R31 stated he had a sore wrist a couple days later. The wrist was Xrayed and not broken. R31 stated the incident occurred in the old bathtub and stated a new tub was installed a couple of months ago. During a subsequent interview on 4/19/17, at 1:58 p.m. R31 identified nursing assistant (NA)-C as the NA who assisting him the day of the incident. R31 stated NA-C received assistance from two other staff to assist him up and back into the tub chair and ensure the chair was locked into place.	F 226	Results will be reported to Quality Committee for further recommendations.	

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	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

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F 226	Continued From page 14 Review of R31's progress notes dated 6/2/16 through 4/19/17, lacked evidence an investigation had been completed related to his fall in the bath tub, nor was there evidence the administrator or SA had been notified of the potential neglect of care. During interview on 4/19/17, at 11:43 a.m. the administrator stated he was not aware R31 sustained a fall in the bathtub. On 4/20/17, at 10:05 a.m. the administrator stated an incident report had not been completed on this fall. He stated the fall had not reported to him and an investigation had not been completed. During an interview on 4/19/17, at 2:38 p.m. NA-C stated R31 fell in the bathtub in September 2016. NA-C stated while assisting R31 into the chair, the chair slid back and R31 fell into the bottom of the tub. NA-C stated she called for assistance, and the (former) director of nursing (DON) and registered nurse (RN)-A entered to help. She stated R31 was assisted to stand, the tub chair was locked into place and he was assisted to sit back down. NA-C stated she did not report the incident because the DON was present and aware of the incident. She stated the DON provided her education on use of the tub chair. When interviewed on 4/20/17, at 8:50 a.m. RN-A stated she assisted NA-C and the DON after R31's fall. RN-A stated an incident report should have been completed for this incident, but she was unable to locate one.	F 226		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		5/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 241	Continued From page 15 (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff provided a dignified rising experience for 1 of 3 residents (R19) who required staff assistance for activities of daily living (ADLs). In addition, the facility failed to provide a dignified dining experience in 1 of 1 resident dining rooms. Findings include: R19's annual Minimum Data Set (MDS), dated 1/27/17, indicated R19 was severely cognitively impaired, required extensive assistance for all ADLs and was frequently incontinent of bowel and bladder. During an observation on 4/19/17, at 8:49 a.m., nursing assistant (NA)-B entered R19's room, turned on the room lights, closed the door, and announced to R19 that it was time to get ready for the day. NA-B pulled back R19's comforter. R19 was lying on her right side facing the door and was dressed in a blouse, slacks, and socks. R19's slacks and her brief were pulled down to just above her knees, exposing her bare lower abdomen, perineal area, and upper thighs. While NA-B gathered supplies, R19 tugged at the waist band of her slacks multiple times, attempting to pull up her slacks. NA-B returned to R19's bedside, used a washcloth to wipe R19's face and then cleaned her peri area. The bed linens	F 241	1.Care plan reviewed and updated for resident R19 for resident preferences. 2.All residents care plans needing assistance with ADL have been reviewed for the appropriate interventions 3.Re-education for all nursing staff regarding standard of care, that clothing is appropriately placed and comfortable for all residents and liens are changed when soling is noted on May 17th 2017 by DNS and Administrator. All nursing staff educated that residents have the right to choose when they would like to get up and be put to bed on May 17th 2017. Dietary staff was educated on ensuring they ask the residents if it is ok to clear dishes and if so remove dishes from table and scraped off away from residents in order to provide a dignified dining experience on May 17th 2017. 4.Random weekly audits of a resident dignified rising experience will be completed x 4 weeks, monthly x 2. The DNS, or designee, will be responsible for compliance. Random weekly audits of a dignified resident dining experience will be completed x4 weeks, monthly x2. The Dietary Manager or designee will be responsible for compliance. Audit results will be reviewed by Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

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GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 241	Continued From page 16	F 241		

under R19 were observed with stool and were wet with urine. When finished, NA-B assisted R19 to transfer to the wheelchair and wheeled her to the dining room for breakfast.

During an interview on 4/19/17, at 9:10 a.m., NA-B stated the night shift staff would usually get R19 dressed and put her back to bed before their shift ended and stated they [over night staff] were trying to help the day shift by getting residents ready for the day. NA-B stated, "It's probably not very comfortable because her pants were down half way." NA-B stated the bed linens were soiled and wet because R19's brief and pants were pulled down to her knees and stated, "I didn't even think she had a brief on, I'm not sure why they did that."

When interviewed on 4/20/17, at 7:36 a.m., registered nurse (RN)-A stated the night shift staff were directed to get up a couple residents before their shift was over, however, she stated getting residents up to dress them and putting them back to bed with their slacks pulled down was not dignified. RN-A stated, "I would not be comfortable with that. I know the residents don't like that."

DINING ROOM

During an observation on 4/19/17, at 11:53 a.m., residents were seated at tables in the main dining room, eating their lunch meal, sipping coffee, and/or visiting. As residents finished their meal, they left the dining room either independently or escorted by staff. At 12:07 p.m., fifteen residents remained in the dining room eating their meal. Two kitchen staff, Cook(C)-A and C-B, each pushed a three tiered cart utilized for bussing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 241	Continued From page 17	F 241		

dishes. C-A and C-B went from table to table with their carts and were hurriedly removing dishes from the tables, including tables where residents were still eating. C-A collected dirty beverage glasses and cups and C-B collected dirty dishes and silverware. C-B used a spatula to scrape remaining food into an uncovered pail, stacking the dirty dishes, and tossing the dirty silverware onto the second shelf into a gray slotted plastic bin. While stacking the dishes on the cart and tossing the silverware into the bin, loud clanking and clattering noises were evident.

During an interview on 4/19/17, at 12:48 p.m., nursing assistant (NA)-A stated, clearing tables of dirty dishes in the dining room while residents continued to eat was common practice. NA-A stated, "They [kitchen staff] have to be out by a certain time due to the low census."

When interviewed on 4/19/17, at 12:52 p.m., the director of food and nutrition stated, "It would be better if they removed the dishes from the tables and scraped them elsewhere."

During an interview on 4/20/17, at 7:18 a.m., registered nurse (RN)-A stated residents felt rushed when tables were cleared while they were still eating and stated they often wanted to leave the dining room instead of eating their meal. RN-A stated the kitchen staff start clearing tables as residents finish eating because, "There's pressure to cut back on hours. There's not enough residents."

When interviewed on 4/21/17, at 8:44 a.m., C-A stated, "If we don't start bussing tables until all of the residents are finished eating, we would never finish our shift on time." C-A indicated when the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 18 census was below 36, kitchen staff were directed to finish their shift by 12:45 p.m., so they had to clean tables as residents finished eating, even if others at the table were still eating. C-A stated it probably would be better to "walk" the dirty dishes to a different area and clean them, away from the residents that were still eating. A facility policy titled Good Samaritan Society, Dining Service Standards, dated 11/16, directed staff to "Limit employee generated noise to ensure a pleasant dining environment (e.g., medication crushing/pounding, clanging dishes, talking over residents' heads and across the dining area)." The policy further indicated, "Clear table settings only with permission of other residents seated at the same table who are still eating."	F 241		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes	F 279		5/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 19 to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 20 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure comprehensive care plans were developed for 1 of 3 residents (R17) reviewed for pressure ulcers. Findings include: R17's annual Minimum Data Set (MDS), dated 11/30/16, identified a severe cognitive impairment due to a diagnosis of Alzheimer's disease, with physical and verbal behaviors which interfered with his care, and rejection of cares. It further identified R17 needed extensive assistance with transfers, bed mobility, and toileting. Furthermore, it identified R17 was at risk for pressure ulcer development, and currently had one Stage 2 partial thickness pressure ulcer, identifying a pressure reducing device for his chair, nutrition and hydration interventions, and pressure ulcer care as R17's current skin treatments. R17's quarterly MDS, dated 2/23/17, identified he continued to have one Stage 2 pressure ulcer. In addition, the MDS indicated R17 had acquired one new Stage 3 pressure ulcer and one new Unstageable pressure ulcer since his annual MDS. R17's Progress Notes indicated the following: - On 8/24/16, at 3:18 a.m. staff used a sit to stand lift to transfer R17 into a recliner. The note indicated "Approx [approximately] 20 min [minutes] later he wanted to get out of the recliner stating "it hurts my butt too much." There was no additional documentation this was addressed.	F 279	1.Care plan reviewed and interventions for pressures ulcers put into place for R17. 2.All residents with wounds were reviewed for prevention and treatment interventions. All residents are assessed upon admission, quarterly and after a change in condition for pressure sore risk using the Braden Scale for Predicting Pressure Sore Risk. 3.Re-education of all licensed staff was completed GSS policy and procedures for pressure ulcers on May 17th 2017 by DNS. 4.Audits of residents at risk for pressure sores will be completed weekly X4 weeks, monthly x2 to ensure compliance. DNS, or designee, will be responsible for compliance.Audit results will be reviewed by Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 21	F 279		

- On 9/4/16 at 10:15 p.m. staff noted "[R17] has let staff toilet him without behaviors. [R17] has been complaining of butt pain so we have been trying to get repositioned out of wheelchair as frequently as possible and put barrier cream on bottom."

R17's Wound RN (registered nurse) Assessments (a formalized assessment with staging, evidence of healing, and interventions) and Wound Data Collection (which contained measurements daily monitoring, and wound bed characteristics):
- On 10/24/16 Wound Data Collection measured the coccyx ulcer 2 cm x 1 cm x 0.5 cm depth, noting the area was improving but was now open again with small areas that were beginning to open and "[R17] complained that it hurt when doing cares."
- On 10/28/16 Wound RN Assessment continued to assess the coccyx ulcer as a Stage 2, was observed with "no healing over the past week." At that time, the assessment noted treatment would be changed to calcium alginate daily and would address pain by asking for an increase in Tylenol.

R17's current physician orders, dated 4/20/17, indicated he took hydrocodone-acetaminophen (narcotic pain reliever) 5-325 mg (milligrams) once a day as needed for pain, acetaminophen (non narcotic pain reliever) 325 mg three time a day scheduled for pain, and a lidoderm patch (topical patch with a numbing medication) was applied to his lower back on a day for pain. In addition, R17's orders included pressure relieving boots as needed when in bed, pressure relieving foam boots on at all times, and daily dressing changes with Aquacel to the right heel and coccyx.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 22	F 279		

R17's current care plan, dated 11/6/16, identified an "alteration in coccyx with gluteal abrasions R/T [related to] Resistance to cares, Incontinence," and the following interventions had been added to the care plan: "Refer to RN wound assessment/Wound Data assessment for tx [treatment] plan. Observe response and consult with MD [doctor] as needed," "Reposition/offload/turning every 2 hours in bed and chair. Attempt to re approach if resistive," "Provide pressure relieving cushion in chair," "Notify nurse immediately of any new areas of skin breakdown," and "House supplement and Arginaid for increased protein."

R17's Bedside Kardex, undated, directed staff to reposition every two hours with re-approaching if necessary, pressure reducing cushion in wheelchair, and to check and change R17 every two hours. For comfort, the Kardex directed "Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM (range of motion), withdrawal or resistance to care."

R17's care plan and Bedside Kardex lacked diagnoses and interventions regarding R17's bilateral heel ulcers or the pressure reduction boots. In addition, it lacked a diagnosis of pain with associated pharmacological and non pharmacological interventions used to address pain.

During observation on 4/19/17, at 10:19 a.m. NA-A asked R17 if he needed to use the bathroom and brought R17 into his room. While in his room, NA-A and NA-E used a sit to stand lift to assist R17 into a upright position, R17 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 279	Continued From page 23	F 279		

"ow my back," as he was lifted into a standing position, then quickly changed his brief. R17 swore and hollered at them during the change, but made no further exclamations of pain. R17 was observed to have the blue foam boots on while standing with the lift. Due to his behaviors, R17 was not laid down at that time, instead NA-A and NA-E assisted R17 back into the wheelchair. There were no further verbal or non verbal signs of pain observed.

During interview on 4/19/17, at 10:19 a.m. NA-A stated R17 had occasional back pain, but only complained about it with movement. NA-A further stated R17 never reported pain in his feet or heels, but was aware R17 had sores on his heels.

During interview on 4/19/17, at 11:55 a.m. licensed practical nurse (LPN)-B stated R17 had chronic back pain and slept in the recliner at home. LPN-B stated his chronic back pain was treated with the lidoderm patch. LPN-B reported R17 would report having pain but could not state where the pain was. LPN-B further reported R17 rarely yelled out, verbalized pain, or showed facial grimacing during dressing changes, but was treated with daily as needed hydrocodone. LPN-B further stated staff would distract R17 with jelly toast and coffee/water or singing as well. LPN-B was aware of R17 had a current pressure ulcer on his left heel, and wore blue foam boots at all times for the right heel. In addition, she stated staff were to put appropriate foot wear with grips on when using the sit to stand lift.

During observation on 4/19/17, at 1:55 p.m. R17 was observed lying in bed as his dressings to the coccyx and right heel were changed. NA-A assisted to turn R17 to his right side as LPN-B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 279	Continued From page 24	F 279		

sprayed wound cleanser on a 4 x 4 gauze and patted open coccyx ulcer. R17 stated "ow goddamn it that is sore!" as LPN-B cleansed the wound. LPN-B proceeded to cut a piece of Aquacel Ag and placed it over the ulcer, then covered it with a foam Mepilex dressing. NA-A assisted R17 to lie on his back while LPN-B changed the right heel dressing. R17 was observed not wearing the foam boots, which were sitting in a chair across the room. Instead, he was wearing gray boots with a hard rubber sole and white fur insides. LPN-B took off the right boot, cleansed the area with 4 x 4 gauze and wound cleanser, measured the heel, and placed Aquacel Ag over the ulcer covered with a foam Mepilex dressing. LPN-B placed the gray boot on R17's right foot, instructing NA-A R17 was "only to have the gray slippers on for short transfers" reminding NA-A to replace them with the blue foam boots. LPN-B left the room, while NA-A assisted R17 with the sit to stand lift to the commode. R17 had no further verbal or non verbal signs of pain during cares or dressing change.

During interview on 4/20/17, at 9:59 a.m. registered nurse (RN)-A stated R17 was suppose to wear the blue foam boots at all times. RN-A further stated some staff change out the blue boots to his regular gray boots when using the sit to stand lift, which was okay as long as staff remembered to change R17 back into his blue foam boots afterward "which is a necessity." RN-A acknowledged she had not put any interventions pertaining to R17's heels on the care plan or Kardex, stating she had communicated to staff the blue foam boots needed to be on him in his wheelchair and at all times. RN-A stated R17 had chronic back pain and received scheduled Tylenol and hydrocodone

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	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 25 as needed once a day. RN-A further stated there should be something on the care plan regarding pain. In addition, she reported she would have included something on the care plan about pain related to R17's lower back, made a goal R17 would not have discomfort or complications related to the side effects of analgesia through the review date, and would have put in appropriate interventions including to observe and report changes in usual routine and report withdrawal or resistance to care. A facility policy entitled Care Plan, revised 11/16, directed care plans were reviewed quarterly, and were "reviewed, evaluated and updated when there is a significant change in the resident's condition. This plan of care will be modified to reflect the care currently required/provided for the resident."	F 279		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 ensure care planned interventions for repositioning and toileting schedules were implemented for 2 of 3 residents (R17, R10) reviewed for pressure ulcers.	F 282	1. Positioning Assessment & Evaluation and bladder assessment and evaluation completed for R10 and R17. Care plan updated to reflect current toileting, reposition program and interventions. 2.All current residents have been	5/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 282	Continued From page 26 Findings include: R17's quarterly MDS, dated 2/23/17, indicated he was severely cognitively impaired, required assist of two staff for transfers, toileting and bed mobiliy, and was frequently incontinent of urine and frequently incontinent of bowel. R17's annual Minimum Data Set (MDS), dated 11/30/16, indicated he was always incontinent of urine, but continent of bowel. R17's Care Area Assessment (CAA), dated 12/1/16, identified urinary incontinence related to immobility and urinary urgency and indicated "Refusal for help at times. Have to re-approach several times per shift." R17's urinary incontinence CAA was not completed, and lacked care plan considerations including an overall goal, complications, or risk factors for incontinence. R17's current care plan, dated 11/6/16, identified an ADL (activities of daily living) deficit related to confusion and weakness. The care plan indicated R17 was on a check and change program for incontinence every three hours until 2/28/17, when it had been revised to every two hours and as needed. The care plan further indicated R17 had "alteration in coccyx with gluteal abrasions R/T (related to) Resistance to cares, Incontinence," and directed staff to reposition/offload/turn every 2 hours in bed and chair and attempt to re approach if resistive. R17's Bedside Kardex, undated, directed staff to reposition every two hours with re-approaching if necessary, pressure reducing cushion in wheelchair, and to check and change R17 every two hours. During continuous observation on 4/19/17, at	F 282	reviewed for current bladder assessment and reassessed as needed for current incontinence and catheter needs. Care plans reviewed and updated to reflect current incontinence retraining or management programs. All current residents have been reviewed for current positioning assessment & evaluation and reassessed as needed for current positioning. Care plans reviewed and updated to reflect current repositioning schedules. All residents, upon admission, will be observed for 72 hours for bladder incontinence and continued catheter use, if present. RN will complete Bladder Assessment, and appropriate incontinence program will be initiated based of evaluation of assessment. Bladder Assessment will be reviewed quarterly and with each Change of Condition to identify changes in incontinence and modification of program will be made as needed. 3. All Licensed staff will be retrained on GSS policies and procedures regarding planned interventions for repositioning and toileting schedules on May 17th 2017 by DNS. 4. Audits will be completed on residents for bowel and bladder assessments and interventions for toileting and repositioning to ensure compliance weekly x 4, monthly x2 .DNS, or designee, will be responsible for compliance. Audit results will be reviewed by Quality Committee for further recommendations.	

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	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 282	Continued From page 27	F 282		

7:06 a.m. R17 was observed sitting in his wheelchair in his room, his head was bent forward, eye shut and was observed sleeping; it appeared morning cares had been completed as he was dressed and was wearing bilateral blue foam boots to his lower extremities, which were resting on his foot pedals. At 7:34 a.m. an unidentified staff member came to take R17 to breakfast, and asked if he wanted to use the bathroom before breakfast, which he refused. R17 was observed eating breakfast until 8:55 a.m., at which time licensed practical nurse (LPN)-B brought R17 back into his room, stated she would be right back, and returned a few minutes later to adjust R17's bedside table and water pitcher within reach. R17 was overheard yelling "get the hell out," and LPN-B left the room. There were no offers of repositioning at this time. R17 was observed sitting in the wheelchair in the same position and continued to wear the bilateral blue foam boots until 9:28 a.m., when LPN-B brought R17 out to play an activity. R17 was observed to play the activity until 10:01 a.m. when it was brought to nursing assistant (NA)-A's attention that R17 had not been offered repositioning for three hours and had not been offered toileting in over two hours.

During interview on 4/19/17, at 10:07 a.m. NA-A reported she was not sure when R17 was last toileted or repositioned since another nursing assistant could have offered and they usually communicated verbally one another. NA-A went over to the wall computer stating they were suppose to chart in Point of Care when they re-approached/offered toileting and repositioning, further stating R17 was scheduled to be toileted at 9:00 a.m., and she usually checked at 2:00 p.m. before she left. NA-A reported R17 had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 282	Continued From page 28	F 282		

repositioned last when he got up at 5:00 a.m. and was last toileted at 5:34 a.m., stating R17 had been up when NA- had gotten to work at 6:00 am., so he "should be checked here shortly." NA-A reported R17 was toileted and repositioned every three hours or "when he is deciding to move on us," because he had a reoccurring wound on the coccyx and wound on the heels.

During observation on 4/19/17, at 10:19 a.m. NA-A asked R17 if he needed to use the bathroom and brought R17 into his room. While in his room, NA-A and NA-E used a sit to stand lift to assist R17 into a upright position, then quickly changed his brief. R17 swore and hollered at them during the change. R17 was observed to have the blue foam boots on while standing with the lift. NA-A called LPN-B into the room to observe R17's coccyx ulcer; however, LPN-B stated R17 had to be in bed to do the dressing changed and would complete it later in the afternoon. Due to his behaviors, R17 was not laid down at that time, instead NA-A and NA-E assisted R17 back into the wheelchair. LPN-B instructed NA-A and NA-E to re-approach R17 later. NA-A stated R17's brief was dry; however, she changed it because he had been in it for a while. NA-A further stated R17 was usually incontinent of bladder but was usually continent of bowel and could sit on the commode to have a bowel movement. R17 was observed to wear the blue foam boots during the entire observation.

During observation on 4/19/17, at 1:55 p.m. R17 was observed lying in bed as his dressings to the coccyx and right heel were changed. At that time, R17 was observed to have incontinence episode with urine and R17 verbalized needing go the the bathroom. NA-A assisted R17 with the sit to stand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 282	Continued From page 29	F 282		

lift to the commode to have a bowel movement. At that time, NA-A stated R17 had a medium amount of urine in his brief.

During interview on 4/19/17, at 2:34 p.m. NA-A stated, to her knowledge, R17 had last been offered toileting around 9:00 a.m., when she had last checked on him. Meaning almost four hours had went by before R17 had been offered toileting.

During interview on 4/20/17, at 7:53 a.m. NA-D stated R17 was repositioned and toileted every two hours and if he refused they would re-approach. NA-D further stated R17 had days he was unwilling to cooperate and days he was very cooperative, staff tried the best they could.

During interview on 4/20/17, at 9:59 a.m. and again at 2:44 p.m. RN-A state R17 was at risk for pressure ulcers due to his behaviors, during which he would fight, kick, and yell, and staff would attempt to re-approach him later; however, he could go a whole shift without being changed or laid down, which is the reason the coccyx ulcer had not healed. RN-A stated R17 was suppose to be repositioned every two hours and nursing assistants were expected to reposition residents from side to side as part of their standard protocol whenever they entered a room. RN-A stated R17's toileting schedule had been revised from every three hours to every two hours and had been communicated to staff on the care plan. She further stated his toileting scheduled had been revised because he was constantly incontinent of urine.

During interview on 4/21/17, at 1:09 p.m. the Director of Nursing Services (DNS) stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 282	Continued From page 30 would expect staff to follow the care plan on R17's toileting and repositioning schedules, and if resident needed to go more often, would expect staff to take him. DNS further stated she would expect staff to re-approach if repositioning was refused, with maybe a new staff member or nurse offering. In there was no repositioning scheduled, then residents were to be repositioned every two hours and as needed as a standard. R10's quarterly MDS, dated 3/5/17, indicated R10 had diagnoses which included hemiplegia, diabetes mellitus, heart failure, hyperlipidemia, and hypertension. The MDS identified R10 was severely cognitively impaired, required extensive assistance with activities of daily living (ADL), and was totally dependent on staff assistance for bed mobility and transfers. The MDS indicated R10 had no stage 1 or greater or unhealed pressure ulcer. Also, the MDS identified R10 was at risk for pressure ulcers. R10 annual Care Area Assessments(CAA), dated 9/20/16, indicated R10 required extensive assistance of two for bed mobility. Also indicated R10 unable to ambulate and required extensive assist of two with full body lift for out of bed transfers. It indicated R10 is frequently incontinent of bladder and wore incontinence briefs. The CAA further indicated R10 was at risk of developing pressure ulcers.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 282	Continued From page 31 R10's care plan last reviewed 3/6/17, identified R10 was at risk for skin impairment related to diabetes. R10 care plan identified goal was to remain free of breakdown. Interventions listed included reposition resident from side to side every three hours and as needed, offload out of wheelchair every three hours and as needed. Also identified R10 had pressure reducing cushion on wheelchair. Care plan failed to identify a pressure reducing mattress for R10 bed. R10 Kardex report dated 4/20/17 identified reposition resident from side to side every three hours and as needed, offload out of wheelcahir every three hours and as needed. Resident has pressure reducing cushion in wheelchair. Kardex failed to identify a pressure reducing mattress. R10 Braden scale for predicting Pressure Sore Risk dated 3/2/17, indicated resident was at risk of developing pressure sore. Reviewed R10 pharmacy orders dated, 11/15/16, which identified sensicare ointment three times a day and as needed if soiled. During an observation on 4/20/17, at 10:25 a.m. of RN-A assessing wound, RN-A stated no zinc oxide ointment was applied today. RN-A described wound as 0.3 x 0.5 x 0.1 open area on left buttock near gluteal folds. RN-A described other area on coccyx as quarter sized area pink, no open area. RN-A applied zinc oxide cream to wound area. RN-A stated she expected cream to be applied by staff with every incontinence. There was no pressure reducing mattress observed on R10 bed.	F 282		
F 314	483.25(b)(1) TREATMENT/SVCS TO	F 314		5/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 314 SS=G	Continued From page 32 PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, monitor, and treat pressure ulcers in order to heal current pressure ulcers and prevent further development of others for 3 or 3 residents (R17, R1, R10) who developed pressure ulcers while residing in the facility. This resulted in actual harm to R17 who developed new pressure ulcers to the heels and had worsening of a chronic coccyx pressure ulcer. Findings include: R17 developed facility acquired pressure ulcers to the coccyx area and bilateral heels without a comprehensive pressure ulcer skin assessment to determine appropriate interventions. R17 was at further risk for development and worsening of pressure ulcers due to refusal of cares. However,	F 314	1. R1, R10, and R17 have been reassessed using the Braden scale and care plan have been update with current interventions for ongoing assessments, monitoring and treatment. 2. All residents at risk for pressure ulcers per their Braden Scale for Predicting Pressure Sore Risk were reviewed and care plan updated as appropriate. All residents, upon admission, will have Braden Scale for Predicting Pressure Sore Risk completed. 3.All Licensed staff will be retrained on GSS policies and procedures regarding comprehensively assess, monitor, and treat pressure ulcers in order to heal current pressure ulcers and prevent further development of others on May 3rd	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 33 the facility did not implement timely recommended support surfaces to reduce pressure to the pressure ulcers. R17 did not have weekly pressure ulcer assessments completed from nursing staff, and care planned interventions of repositioning and application of boots to the heels were not implemented consistently. R17's annual Minimum Data Set (MDS) dated 11/30/16, identified a severe cognitive impairment due to Alzheimer's disease, with physical and verbal behaviors which interfered with his care, and rejection of cares. It further identified R17 needed extensive assistance with transfers, bed mobility, and toileting, indicating he was always incontinent of urine and continent of bowel. Furthermore, the MDS identified R17 was at risk for pressure ulcer development, and currently had one Stage 2 (partial-thickness loss of skin with exposed dermis) pressure ulcer, identifying current skin treatments of a pressure reducing device for his chair, nutrition and hydration interventions, and pressure ulcer care. R17's Pressure Ulcer Care Area Assessments (CAA) dated 12/2/16, indicated R17 had a Stage 2 pressure ulcer on his coccyx containing granulation tissue and was at risk for further impairments. It further indicated current treatments included dressing changes with calcium Ag silver, nutritional supplements and vitamins, repositioning every two hours day and night, a pressure reducing mattress and cushion in wheelchair. The CAA identified R17 received routine toileting for incontinence related to immobility and urinary urgency. R17's CAA also identified a decreased nutritional intake and being resistive to cares for contributing factors to his pressure ulcer development. The CAA further	F 314	2017 by DNS. 4.Audits will be completed on residents at risk for pressure sore to prevent reoccurrence of deficiency weekly x 4, monthly x2. DNS, or designee, will be responsible for compliance Audit results will be reviewed by Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 34	F 314		

identified, "During resistive episodes, staff do re-approach resident with repositioning and toileting/cares," and directed to the care plan for more information. The goal of treatment at the time was to improve healing and minimize the risk of development. R17's Behavioral CAA completed 12/2/16, identified R17 was not always easily redirected, staff had to re-approach and fatigue, sleep disturbance, delirium, and dementia contributed to the behaviors. The Behavioral CAA lacked identification of the nature of the behaviors including things such as antecedents, effective/ineffective interventions, illnesses/conditions contributing to behavioral symptoms, and an overall goal. There was no description of how the behaviors impacted R17 and simply indicated, "will proceed to care plan due to behaviors."

R17's quarterly MDS dated 2/23/17, identified he continued to have one Stage 2 pressure ulcer. In addition, the MDS indicated R17 had acquired one new Stage 3 (Full-thickness loss of skin, in which fat is visible in the ulcer and granulation tissue and rolled wound edges are often present) pressure ulcer and one new unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) pressure ulcer since his annual MDS. Although the Stage 3 and unstageable pressure ulcers were clearly acquired after R17 had been a resident in the facility, his MDS did not identify any pressure ulcers as being facility acquired since his last annual assessment. The interventions listed to treat R17's current ulcers included a pressure reducing device for chair and pressure ulcer care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 35	F 314		

R17's undated Bedside Kardex, directed staff to reposition every two hours with re-approaching if necessary, pressure reducing cushion in wheelchair, and to check and change R17 every two hours.

During continuous observation on 4/19/17, at 7:06 a.m. R17 was observed sitting in his wheelchair in his room, his head bent forward, eyes shut and was observed sleeping. R17 was dressed and wearing bilateral blue foam boots to his lower extremities, which were resting on his foot pedals. At 7:34 a.m. an unidentified staff member came to take R17 to breakfast, and asked if he wanted to use the bathroom before breakfast, which he refused. R17 was observed eating breakfast until 8:55 a.m., at which time licensed practical nurse (LPN)-B brought R17 back into his room. LPN-B returned a few minutes later to adjust R17's bedside table and water pitcher within reach. R17 was overheard yelling "get the hell out," and LPN-B left the room. There were no offers of repositioning at this time. R17 was observed sitting in the wheelchair in the same position and continued to wear the bilateral blue foam boots until 9:28 a.m., when LPN-B brought R17 out to an activity. R17 was observed in the activity until 10:01 a.m. when the surveyor informed nursing assistant (NA)-A that R17 had not been offered repositioning for three hours and had not been offered toileting in over two hours.

On 4/19/17, at 10:07 a.m. NA-A reported she was not sure when R17 was last toileted or repositioned since another nursing assistant could have offered and they usually communicated verbally with one another. NA-A went over to the wall computer stating they were suppose to chart in Point of Care when they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

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GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 314	Continued From page 36	F 314		

re-approached/offered toileting and repositioning, further stating R17 was scheduled to be toileted at 9:00 a.m. NA-A usually checked at 2:00 p.m. before she left. NA-A reported R17 had been repositioned last when he got up at 5:00 a.m. and was last toileted at 5:34 a.m., stating R17 had been up when NA-A had gotten to work at 6:00 am., so he "should be checked here shortly." NA-A reported R17 was toileted and repositioned every three hours or "when he is deciding to move on us," because he had a reoccurring wound on the coccyx and wound on the heels. She further stated they repositioned him to get him off his heels.

During observation on 4/19/17, at 10:19 a.m. NA-A asked R17 if he needed to use the bathroom and brought R17 into his room. While in his room, NA-A and NA-E used a sit to stand lift to assist R17 into a upright position, then quickly changed his brief. R17 swore and hollered during the change. R17 was observed to have the blue foam boots on while standing with the lift. NA-A called LPN-B into the room to observe R17's coccyx ulcer, however, LPN-B stated R17 had to be in bed to do the dressing change and would complete it later in the afternoon. Due to his behaviors, R17 was not laid down at that time, instead NA-A and NA-E assisted R17 back into the wheelchair. LPN-B instructed NA-A and NA-E to re-approach R17 later. NA-A stated R17's brief was dry, however, she changed it because he had been in it for a while. NA-A further stated R17 was usually incontinent of bladder but was usually continent of bowel and could sit on the commode to have a bowel movement. R17 was observed to wear the blue foam boots during the entire observation. R17 was not offered/provided repositioning from 5:34 a.m. to 10:19 a.m. (4.75

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 314	Continued From page 37 hours). On 4/19/17, at 11:55 a.m. LPN-B stated R17 was repositioned when he allowed staff to assist. He had a pressure reducing cushion in his wheelchair for his coccyx ulcer, and wore the blue foam boots at all times for the right heel. In addition, she stated staff was to put appropriate foot wear with grips on when using the sit to stand lift. LPN-B reported R17 had the foam boots since the right heel wound started, then stated he had had the foam boots at night before the heel wound, however, R17 refused to wear them. The physician ordered them as needed when R17 allowed staff to put them on. She further stated R17 wouldn't allow staff to prop his feet up or float his heels even after staff re-approached him. LPN-B confirmed R17 was now wearing the foam boots all the time. LPN-B stated R17 was seen by the wound nurse who took measurements, wounds were measured "for sure once a week and when allowed," and could be documented in both the Wound Data Collection sheets or the Wound RN Assessment. She further stated the Wound Data Collections could be done by an LPN or RN, and were completed everyday to every other day. During interview on 4/19/17, at 12:39 p.m. occupational therapist (OT)-A stated about a month ago, OT had called in a separate agency to perform pressure mapping of R17's wheelchair. OT-A stated she performed an evaluation of R17's wheelchair/cushion, trialed different wheelchair cushions and ordered a pressure reducing cushion. During the interview, OT-A observed R17's wheelchair cushion and confirmed it had been ordered for pressure reduction.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 314	Continued From page 38 On 4/19/17, at 1:55 p.m. R17 was observed lying in bed as his dressings to the coccyx and right heel were changed. NA-A assisted to turn R17 to his right side as LPN-B sprayed wound cleanser on a 4 x 4 gauze and patted the open coccyx ulcer. R17 stated, "Oow goddamn it that is sore!" as LPN-B cleansed the wound. LPN-B cut a piece of Aquacel Ag and placed it over the ulcer, then covered it with a foam Mepilex dressing. LPN-B stated the coccyx contained a small opening which was pink with drainage that could have been from his incontinence brief. LPN-B stated she forgot to measure the coccyx and would measure it later that night. NA-A assisted R17 to lie on his back while LPN-B changed the right heel dressing. R17 was observed not wearing the foam boots, which were sitting in a chair across the room. Instead, he was wearing gray boots with a hard rubber sole and white fur inside. LPN-B took off the right boot, cleansed the area with 4 x 4 gauze and wound cleanser, measured the heel ulcer 3.5 cm x 2.5 cm, and placed Aquacel Ag over the ulcer covered with a foam Mepilex dressing. The wound bed appeared to have pink and red tissue, however, LPN-B stated the wound bed had been "yellow." LPN-B placed the gray boot on R17 right foot, instructing NA-A that R17 was "only to have the gray slippers on for short transfers" NA-A was reminded to replace them with the blue foam boots. LPN-B left the room, while NA-A assisted R17 with the sit to stand lift to the commode to have a bowel movement. At that time, NA-A stated R17 had a medium amount of urine in his brief. R17 had no further verbal or non verbal signs of pain during cares or dressing change. On 4/19/17, at 2:34 p.m. NA-A stated, to her	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 314	Continued From page 39	F 314		

knowledge, R17 had last been offered toileting around 9:00 a.m., when she had last checked on him, which meant almost four hours had gone by before R17 had been offered toileting.

On 3/13/16, a Wound RN (registered nurse) Assessment indicated R17 had a stage 2 coccyx pressure ulcer, which had completely healed with no open areas or redness.

R17's Skin Observation, dated 8/10/16, identified the resident had a "soft reddened open area to coccyx."

PROGRESS NOTES:
R17's progress notes indicated the following:

- 8/13/16, at 12:53 p.m. R17 had behaviors and refused toileting in the morning, but allowed staff to dress him and allowed staff to toilet him after lunch.
- 8/13/16, at 7:52 p.m. staff attempted to apply a 2 x 2 Mepilex (foam) dressing to R17's right buttock for "Open sore." R17 refused.

During the week of 8/14/16 - 8/20/16, the coccyx ulcer was not assessed nor were any measurements documented. The National Pressure Ulcer Advisory Panel (NPUAP) indicates a pressure ulcer assessment should contain: stage, location, size (length x width x depth) , undermining/tunneling, wound bed tissue (granular, non-viable, eschar), and exudate (amount, color, odor). On 8/19/16, at 9:44 p.m. staff applied a 2 x 2 Mepilex dressing to R17's right buttocks.

During the week of 8/21/16 - 8/27/16, the coccyx ulcer was not assessed nor were any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 40	F 314		

measurements documented. On 8/22/16, at 8:26 p.m. staff recorded that the 2 x 2 Mepilex dressing had not been changed, and at 11:28 p.m. the open area on the coccyx was noted and house cream was applied. The note indicated the open area would be addressed with the physician. On 8/23/16, at 2:08 a.m. two staff transferred R17 from his bed into wheelchair, and the notes indicated R17 had been incontinent at the time. The note further indicated, "Area on buttocks assessed by nurse. Barrier cream applied." However, there was no documentation of the assessment. The note from 8/24/16, at 3:18 a.m., indicated staff used a sit to stand lift to transfer R17 into a recliner. The note indicated, "Approx [approximately] 20 min [minutes] later he wanted to get out of the recliner stating "it hurts my butt too much." There was no further documentation about R17's buttocks or the pain identified.

During the week of 8/28/16 - 9/3/16, the coccyx ulcer was not assessed.

During the week of 9/4/16 - 9/10/16, the coccyx ulcer was not assessed. On 9/4/16, at 10:15 p.m. staff noted "[R17] has let staff toilet him without behaviors. [R17] has been complaining of butt pain so we have been trying to get repositioned out of wheelchair as frequently as possible and put barrier cream on bottom."

During the week of 9/11/16 - 9/17/16, the coccyx ulcer was not assessed.

During the week of 9/18/16 - 9/24/16, the coccyx ulcer was measured but lacked any assessment information. On 9/22/16, at 1:45 a.m. over a month after the open area had been observed,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 41 R17's open coccyx wound was measured 2.5 cm (centimeters) x 1 cm. The nurse noted, "There are new sores in proximity to the open wound that were bleeding tonight. New Mepilex dressing applied." It further noted R17's behaviors prevented staff from toileting him. The record lacked a comprehensive assessment related to the development of new pressure ulcers. During the week of 9/25/16 - 10/1/16, the coccyx ulcer was measured, and new areas of concern were noted. There was no assessment of the wounds. On 9/28/16, at 12:10 a.m. R17's was observed to have two open areas, with a larger area measuring 2 cm x 1.5 cm and a smaller open wound measuring 1 cm x 2 cm. At 3:12 p.m. R17's coccyx was observed again. This time his open area was measured 2 cm x 0.5 cm and abrasions were noted on the left and right gluteus. During the week of 10/2/16 - 10/8/16, the coccyx ulcer was measured, but lacked any further assessment of the buttocks/coccyx. On 10/5/16, at 3:32 p.m. R17's coccyx was assessed and measured 0.5 cm x 1.5 cm. It identified staff was changing the Mepilex dressing daily due to feces "getting under the Mepilex." WOUND ASSESSMENTS: R17's Wound RN Assessments (a formalized assessment the facility used which included staging, evidence of healing, and interventions), Wound Data Collection (which contained measurements, daily monitoring, and wound bed characteristics), and WOC (Wound Ostomy Continence) Nurse Practioner (NP) Notes were reviewed for further ulcer information:	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 42	F 314		

During the week of 10/9/16 - 10/15/16, nearly three months after R17's coccyx had opened, the first formal wound assessment was completed. On 10/15/16, R17's first Wound Data Collection was completed, with the ulcer measuring 1.3 cm x 0.7 cm. The wound bed was observed 50% epithelial and 50% granulation (healthy tissues) with a Mepilex dressing changed every three days.

For the week of 10/16/16 - 10/22/16: On 10/19/16, the Wound RN Assessment identified a new re-occurring Stage 2 coccyx pressure ulcer with no drainage, slough, or eschar. The assessment noted the "size slightly increased over the past few days." On 10/19/16, Wound Data Collection measured the ulcer as 2.0 cm x 1.0 cm x 0.3 cm, and the wound bed was observed 50% epithelial and 50% granulation tissue. On 10/18/16, at 3:38 p.m. staff notified family of R17 refusals of cares/medications/treatments.

For the week of 10/23/16 - 10/29/16: On 10/24/16, the Wound Data Collection measured the coccyx ulcer to be 2 cm x 1 cm x 0.5 cm depth, noting the area was improving but was now open again with small areas that were beginning to open and "[R17] complained that it hurt when doing cares." The wound bed was observed 50% epithelial, 45% granulation, and 5% slough (yellow, devitalized/unhealthy tissue) with yellow drainage, indicating a higher stage. However, on 10/28/16, the Wound RN Assessment continued to assess the coccyx ulcer as a Stage 2, was observed with "no healing over the past week," and had "increased wound size, increased drainage, increased maceration surrounding the wound." At that time, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 43	F 314		

assessment noted the treatment would be changed to calcium alginate (soft, absorbing dressing) daily and would address pain by asking for an increase in Tylenol.

For the week of 10/30/16 - 11/5/16: On 11/3/16, the Wound Data Collection identified the coccyx measured 2 cm x 1 cm x 0.5 cm in depth, and the wound bed was observed to be 50% epithelial and 50% granulation tissue. On 11/3/16, Wound RN Assessment indicated the coccyx ulcer was a Stage 2 coccyx and had decreased redness of the peri wound and showed no deterioration. The assessment indicated R17 continued with a pressure reducing mattress and cushion in wheelchair, but was refusing to rest in bed on his sides.

For the week of 11/6/16 - 11/12/16: On 11/10/16, the Wound Data Collection identified the coccyx measured 2.1 cm x 1.0 cm x 0.5 cm with 50% epithelial tissue and 50% granulation. The ulcer was noted with serosanguineous (clear fluid with blood) drainage and the peri wound was blanchable and healing. On 11/10/16, the Wound RN Assessment indicated the coccyx ulcer was identified as a Stage 2 with decreased maceration of the peri wound, however, the size had no change in two weeks. The assessment indicated the physician would be notified for a new treatment.

For the week of 11/13/16 - 11/19/16: On 11/15/16, the Wound Data Collection identified the coccyx measured to be 2.5 cm x 1.0 cm x 0.5 cm with 50% epithelial and 50% granulation tissue with sanguineous (bloody) drainage and minimal odor. On 11/15/16, the Wound RN Assessment noted the coccyx ulcer remained a Stage 2 but the size

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 44	F 314		

had increased. The assessment indicated R17's treatment had changed on 11/11/16, to apply Aquacel Ag (soft, absorbing dressing containing silver which kills a variety of wound microbes) dressing every 3 days and as needed.

For the week of 11/20/16 - 11/26/16: On 11/25/16, the Wound Data Collection identified the coccyx measured 2.0 cm x 1.0 cm x 0.5 cm with 50% epithelial and 50% granulation tissue with sanguineous drainage and minimal odor. On 11/25/16, the Wound RN Assessment noted the coccyx ulcer as a Stage 2 and had decreased in size. R17's interventions remained the same and staff encouraged him to rest on sides in bed between meals as he tolerated. During the week

For the week of 11/27/16 - 12/3/16: On 12/2/16, the Wound Data Collection identified the coccyx measured 2.0 cm x 0.7 cm x 0.5 cm with 25% epithelial and 75% granulation tissue with sanguineous drainage and minimal odor. On 12/2/16, the Wound RN Assessment identified the coccyx ulcer continued to be a Stage 2 and was assessed "Width of wound slightly decreasing." The assessment directed R17 was now repositioned every two hours and an air mattress had been discussed, but "felt may be risk for Rt [resident]," and was not added. The assessment did not identify the risk the air mattress posed for R17.

For the week of 12/4/16 - 12/10/16: The 12/9/16, Wound Data Collection form identified the coccyx measured 1.5 cm x 1.0 cm x 0.5 cm noting there was sanguineous drainage and minimal odor. However, there was no description of the wound bed. On 12/9/16, the Wound RN Assessment identified the coccyx ulcer as a Stage 2 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 45	F 314		

increased maceration (softening, whitening of the skin usually associated with moisture) around the wound, noting R17 had increased behaviors during the past week.

For the week of 12/11/16 - 12/17/16: On 12/11/16, the Wound Data Collection identified the coccyx measured 2.0 cm x 1.0 cm x 0.5 cm with minimal serosanguineous drainage. The wound bed was 25% epithelial and 75% granulation tissue and the peri wound was reddened. R17 was identified to have pain at the site. On 12/14/16, the Wound RN Assessment indicated the coccyx ulcer was a Stage 2 with "no maceration around the ulcer." It identified staff continued to use Aquacel Ag for dressing changes and continued to offload and reposition every two hours as tolerated. A wound nurse appointment had been set up for 1/4/17.

For the week of 12/18/16 - 12/24/16: On 12/20/16, the Wound Data Collection the coccyx measured 2.0 cm x 1.0 cm x 0.5 cm with 75% epithelial and 25% granulation tissue with sanguineous drainage and minimal odor. On 12/20/16, the Wound RN Assessment indicated the coccyx was a Stage 2 and had "pink tissue showing healing." However, it identified the dressing at the time of assessment was saturated with urine and the "Dressing that was on the coccyx was not done correctly."

For the week of 12/25/16 - 12/31/16: On 12/26/16, the Wound Data Collection identified the coccyx measured 1.5 cm x 1.0 cm x 0.5 cm with the wound bed 75% epithelial and 25% granulation tissue. The ulcer had minimal serosanguineous drainage with the peri wound showing maceration and redness. On 12/29/16, the Wound RN Assessment identified the coccyx

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 46	F 314		

ulcer continued as a Stage 2 and had no change to size or depth but had deteriorated with blanchable redness and maceration of the peri wound. The assessment noted R17 refused to lay in bed for the assessment.

On 1/4/17, nearly four months after the coccyx ulcer had formed, the first wound nurse practitioner (NP) visit occurred for "a new occurrence of ulcerated area on the coccyx region." The NP described, "Coccygeal region shows a Stage 3 pressure ulcer in the crease measuring 2 cm x 1.3 cm and a small area on the right gluteal aspect measuring 0.7 cm x 0.2 cm there is also extensive excoriation on both gluteal aspects." The NP further noted, "wound bed appears to be 100% slough covered," and recommended Aquacel Ag applied to the coccyx with zinc oxide applied to areas of excoriation. In addition, she recommended pressure mapping for R17's wheelchair, a high grade Roho cushion be ordered, and to be encouraged to "offload frequently and make position changes throughout the day." Follow up would be in two weeks.

On 1/11/17, the wound NP visited and upon arrival, R17 had been sitting on the commode for an "extended period of time," and the dressing ordered was not in place leaving the ulcer area open and exposed. The NP measured the Stage 3 coccyx ulcer 1.1 cm x 0.5 cm x 0.1 cm and recommended dressing changes with Aquacel Ag every third day and as needed when saturated with urine/stool, not sitting on the commode over 10 minutes, and "minimize time sitting dependent on the coccyx."

On 1/18/17, the wound NP visited and noted R17 "continues to sit in his wheelchair for extended

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 47	F 314		

periods of time throughout the day" and "[R17's] prescribed Roho cushion has not been ordered yet pressure mapping has not been done although this is been my recommendation," which the NP had ordered on 1/4/17. The Stage 3 coccyx pressure ulcer was now 2 cm x 5 cm x 0.3 cm in depth and noted two new open areas on the right gluteal aspect measuring 2 cm x 0.5 cm and 1 cm x 0.5 cm with "extensive excoriated tissue." The NP further observed an area of deep redness measuring 8 cm x 7 cm. The NP recommended applying Aquacel Ag over the coccyx ulcer and a foam dressing over the new gluteal ulcers. Additionally, the NP directed "It's my recommendation of the Roho cushion be purchased and pressure mapped as soon as possible. [R17] should continue to be offered assistance with lying in bed and offloading the affected area frequently throughout the day."

On 1/20/17, the Wound Data Collection noted newly formed blisters on bilateral heels. The left heel measured 5 cm x 1.5 cm while the left heel measured 7 cm x 1.2 cm. At that time, R17 stated "it hurts," and the assessment noted foam boots were being used. However, R17's medical record lacked evidence to support the foam boots were being used.

For the week of 1/22/17 - 1/28/17, the wound nurse did not visit. Although R17's ulcers were measured, the documentation lacked a description of the wound bed for the coccyx and left heel. On 1/27/17, the Wound Data Collections were performed on the coccyx measuring 2.0 cm x 2.0 cm and left heel blister had opened measuring 6 cm x 2 cm with a red peri wound measuring 2 cm x 4 cm with intact wound margins. On 1/27/17, a week after blisters had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 48	F 314		

formed, the Wound RN Assessment of the right heel ulcer identified the ulcer was unstageable with "Dark area, possible Eschar [dead tissue], 3 cm diameter, with approximately 3-5 cm of erythema [superficial reddening] around dark area. No blister at present. Drainage is serous with faint odor." It further noted the "Wound care nurse assesses would [sic] weekly at present." No Wound RN Assessment was provided for the left heel.

On 2/1/17, R17 was seen by the wound NP for his coccyx and new concerns on bilateral heels. The NP noted the coccyx Stage 3 ulcer measured 1.6 cm x 0.7 cm x 0.2 cm "has stalled and healing." The right heel measured 9 cm x 12 cm with deep tissue injury in the center measuring 5.5 cm x 6 cm, which was classified as unstageable. In addition, it was noted to contain necrotic tissue. The left heel had opened measuring 7 cm x 7.5 cm and was classified as a Stage 2 pressure ulcer, which was draining bright red sanguinous fluid along with serous fluid. Both heels were debrided during the visit. The NP recommended Aquacel Ag to all open areas with Mepilex foam dressings. In addition, she recommended heel protectors worn at all times along with frequent position changes and encouraged to lie in bed. During the week R17's had the following behaviors: On 1/29/17, at 1:34 p.m. R17 didn't eat breakfast or take medications, but did allow staff to reposition every two hours and allowed toileting. On 1/31/17, at 2:10 a.m. R17 was pleasant until staff placed the transfer belt on his when he attempted to strike staff, was transferred into bed then settled down and fell asleep. No other behaviors noted. On 2/2/17, at 9:50 p.m. R17 was swearing at breakfast, threw his breakfast plate at the table, refused toileting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 49	F 314		

and refused medications. R17 was laid down in bed as he allowed, was eventually calm in bed sleeping. On 2/4/17, at 12:19 a.m. R17 refused to go to bed for the evening shift and refused the first attempt on night shift.

During the week of 2/5/17 - 2/11/17, the wound nurse did not visit. On 2/6/17, the Wound Data Collection was completed on the coccyx, however, it lacked measurements or any description of the wound bed. It directed to see the wound nurse charting. On 2/9/17, the Wound Data Collection noted the right heel measured 5 cm x 2 cm with minimal odor, serous drainage, and redness around the ulcer. The left heel measured 6 cm x 6 cm and did not have an odor or drainage. The data collection lacked descriptions of the wound bed for either heels. No RN Wound Assessment or staging was completed.

During the week of 2/12/17 - 2/18/17, the wound nurse did not visit. On 2/12/17, the Wound Data Collection noted the right heel measured 5 cm x 2 cm with a moderate amount of drainage, but did not describe the type of drainage, and had a strong foul odor. The left heel measured 7 cm x 6 cm with minimal drainage and a strong foul odor. The data collections lacked descriptions of the wound bed for either heel, or address the change in odor. On 2/18/17, the Wound Data Collection indicated the coccyx was 2.0 cm x 1.0 cm, however, it lacked any description of the wound bed. No RN Wound Assessment or staging was completed for the week.

On 2/22/17, the wound NP noted R17 had not been allowing staff to change incontinence briefs or reposition him. The NP observed the coccyx to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 50	F 314		

be more denuded measuring 6 cm x 4 cm and "extensively erythematous with skin cracking and drainage that is serous." The Stage 3 coccyx ulcer measured 1.5 cm x 0.5 cm with no decrease in size and "did not have the appropriate dressings in place," and "there is extensive peri wound erythema that's related to pressure." The NP noted the left heel ulcer had healed and the right heel continued to contain black eschar in the central aspect measured 1.5 cm in diameter. The NP debrided the necrotic slough at the time of the visit, and recommended the right heel dressing be changed daily or when saturated, the coccyx ulcer continued to be changed with Aquacel Ag and a foam dressing, while denuded areas were treated with zinc oxide. Follow up was noted within the next two weeks.

The week of 2/26/17 - 3/4/17, the wound nurse did not visit. On 3/1/17, Wound Data Collection noted the right heel measuring 2 cm x 3 cm with black eschar and the coccyx measured 2 cm x 0.6 cm. It did not give any further description of the wound bed for that week. On 3/3/17, the Wound RN Assessment identified the right heel ulcer as unstageable, noting eschar was present with no increase in odor or drainage.

On 3/8/17, the wound NP noted R17 was more belligerent and swearing during visit. The Stage 3 coccyx ulcer was observed with increased wound margins and drainage, measuring 1.5 cm x 0.5 cm x 0.2 cm. The NP noted an area in the center had a deep tissue injury. A new Stage 1 area of pressure was noted on the right gluteal aspect measuring 2.5 cm x 3 cm, while the left gluteal had new Stage 1 pressure ulcerations measuring 6 cm x 2 cm. The right heel was measured 1 cm x 2.5 cm with thick black and yellow tissue, with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 51	F 314		

an odor and felt boggy. The coccyx treatment continued with daily dressing change using Aquacel Ag, however, staff were instructed to use a thick layer of zinc oxide over new Stage 1 areas. R17's treatment was changed to include Iodosorb (antimicrobial and desloughing) topically to the eschar on the right heel before covering with Aquacel Ag daily. The NP recommended monitoring the right heel for signs of infection. Wound follow up in one week.

On 3/15/17, the wound NP noted R17 had heel protectors on during the visit, however, staff "admit to increased drainage in the right foot and continued ulceration in the coccyx area related to [R17] not offloading as much as possible many days refuses to lie in bed and he sits in his wheelchair for extended periods of time." During visit the right heel measured 4 cm x 2.7 cm x 1.0 cm with the eschar evolving into slough. The heel was debrided during the visit until it was 90% slough and 10% granulation tissue. The coccyx continued to measure 1.7 cm x 0.7 cm x 0.3 cm, observed to be larger that day. The left gluteal aspect had a 2 cm x 2 cm area of excoriation. The NP recommended the coccyx dressing be changed every two to three days or when saturated, with zinc oxide applied thickly to gluteal aspects, and the right heel changed daily with Iodosorb to the necrotic slough.

On 3/22/17, the wound NP noted R17 was agitated and yelling during visit. The right heel unstageable ulcer was noted to evolve to a Stage 3 ulcer, which was not measured or debrided due to agitation. The coccyx ulcer was measured 1.4 cm x 0.8 cm x 0.2 cm and two Stage 2 ulcers were noted in the left gluteal aspect, which were not measured as R17 was incontinent during the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	**200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 52	F 314		

dressing change. The treatment was not changed during this visit.

For the week of 3/26/17 - 4/1/17, the wound nurse did not visit. On 3/27/17, Wound Data Collection on the coccyx was documented as 1.0 cm x 2.0 cm and the right heel to be 2 cm x 3 cm. No Wound RN Assessment or staging was completed for the right heel ulcer. On 3/28/17, the Wound RN Assessment identified the coccyx ulcer was not staged and lacked a description of the wound bed.

During the week of 4/2/17 - 4/8/17, the wound nurse did not visit. On 4/5/17, the Wound Data Collection identified staff attempted to assess the coccyx ulcer, however, due to R17's behaviors staff was unable to observe or measure the coccyx for the week. Although notes identified an inability to complete wound assessments due to resident behaviors, R17's progress notes dated 4/8/17, at 12:30 p.m. indicated no behaviors noted this shift., 4/7/17, at 1:56 p.m. very sleepy no behaviors, 4/3/17, at 2:37 p.m. no behaviors, and 4/2/17, at 9:30 p.m. was pleasant no behaviors and at 12:16 p.m. ate breakfast and slept through dinner with no behaviors. On 4/6/17, the Wound Data Collection noted the right heel ulcer was still open and draining a serous fluid, and staff applied Iodoform covered with Telfa. However, no assessments were completed for the week. In addition, no Wound RN Assessments was completed for the week.

On 4/12/17, the wound NP noted improvement during visit as the right heel Stage 3 ulcer showed decreased wound margins with healthy granulation tissue measuring 2.5 cm x 1.6 cm with serous drainage. The Stage 2 coccyx ulcer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 53	F 314		

had decreased in size measuring 1.5 cm x 0.7 cm x 0.1 cm. It noted the areas of peri wound maceration and denuded tissue were healed. The NP recommended continuing dressing changes daily. Would follow up sometime in the next couple of weeks.

R17's Occupational Therapy (OT) Evaluation, dated 2/17/17, (over a month after pressure mapping had been ordered) R17 was referred for pressure mapping "to determine if seating system needs to be changed to promote healing and prevent future skin breakdown." OT recommendations included changing to a different type of cushion, such as a Roho air cushion, as pressure was noted in the ischial tuberosities and R17 was unable to offload independently. It was noted the cushion at the time, while not causing pressure to the coccyx, was "general purpose and does not fully redistribute pressure." A gel overlay was added. R17's progress notes from 2/17/17 to 3/13/17, failed to provide any information on the status of the Roho cushion ordered by the NP. A Care Conference Note dated 3/1/17, at 1:01 p.m. indicated family "questioned about the pressure mapping" and RN-A wrote she would "check on it and let [family] know." There was no further information available in the progress notes regarding the status of the Roho cushion and communication with the family.

An OT therapy progress note, dated 3/31/17, identified R17's wheelchair was "Fit with pressure reducing wheelchair cushion with no concerns at this time." This occurred nearly three months after the wound NP had recommended a high grade seat cushion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 54 R17's Treatment Administration Record (TAR) indicated the following: - 7/16, R17 had orders for "Pressure relieving Foam boots to both feet when resident is in bed. two times a day for Pressure relief," with a start date of 12/15/15. Staff documented 14 refusals and and had worn them 48 times. On 4/20/17, at 9:59 a.m. RN-A stated she was not aware of who had ordered the blue foam boots, stating R17 had always had them, and did not know if the boots were pressure relieving. On 4/20/17, at 2:31 p.m. the physical therapist (PT)-A stated the blue foam boots were offloading and pressure reducing, however, PT was not aware of who had ordered the boots. - 8/16, R17 refused to wear the boots 11 times and had worn them 45 times. A physician's order, dated 8/29/16, identified R17 had "refused pressure relieving foam boots when in bed." The physician ordered for R17 to wear the foam boots to both feet when in bed as needed. - 9/16, R17 refused to wear the foam boots once on 9/20/16. The rest of the dates were left with no indication if the foam boots had been worn, offered, refused or if alternatives had been tried. - 10/16, all of the dates were left with no indication if the foam boots had been worn, offered, refused or if alternatives had been tried. - 11/16, all of the dates were left with no indication if the foam boots had been worn, offered, refused or if alternatives had been tried. - 12/16, all of the dates were left with no indication if the foam boots had been worn,	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 55	F 314		

offered, refused or if alternatives had been tried.

- 1/17, R17 was documented to have worn the foam boots on 1/27/17. All other dates were left with no indication if the foam boots had been worn, offered, refused or if alternatives had been tried, even after R17 developed bilateral heel blisters on 1/20/17.

- 2/2/17, after the wound NP visit, new orders were placed on the TAR which read "heel protectors on at all times except standing one time a day."

R17's progress notes, from 8/2/16 to 1/27/17, were reviewed. The notes indicated R17 spent time in his wheelchair and recliner overnight and had the identified behaviors of refusing to lie down in bed, be toileted, and resistive to cares. R17's progress notes lacked documentation of attempted alternatives for refused interventions. In addition, there was no evidence of discussions with family regarding resident refusals, available options for pressure ulcer interventions, or risk/benefit involved with pressure ulcer worsening/development.

R17's Braden Scale for Predicting Pressure Sore Risk, completed 9/1/16, identified he was at moderate risk of development related to his skin being constantly moist, very limited mobility, and requiring moderate to maximum assistance with moving. When re-assessed on 2/23/17, he was again identified at moderate risk.

R17's Positioning Assessment and Evaluation, completed 9/1/16, identified R17 was "able to be quite impendent if he wants to, other times his behaviors hinder him to the point where he has to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 56	F 314		

rely on staff. He becomes confused often and doesn't always understand what you want him to do." The assessment noted a pressure relieving mattress was on the bed and cushion was in the wheelchair. The assessment lacked identification of the type of cushion/mattress R17 was using for pressure relief, and under the check boxes to "specify type," staff only indicated the cushion was "pressure reducing" and the mattress was "pressure relieving." It lacked identification of R17's coccyx pressure ulcer, a repositioning schedule, and pressure relieving boots.

R17's Positioning Assessment and Evaluation, was re-assessed on 11/30/16, indicated he needed extensive assistance with all cares and used a wheelchair for mobility around the facility, and "becomes confused often and doesn't always understand what you want him to do." The assessment noted a pressure relieving cushion in his wheelchair, but did not identify a pressure reducing mattress. This assessment also lacked identification of the type of pressure reduction cushion used. Again, it lacked identification of R17's coccyx pressure ulcer, a repositioning schedule, and pressure relieving boots.

R17's current care plan, dated 11/6/16, identified an ADL (activities of daily living) deficit related to confusion and weakness. The care plan indicated R17 had been a check and change every three hours until 2/28/17, when it had been revised and now directed staff to check and change R17 every two hours and as needed. Although R17's quarterly MDS had identified his urinary incontinence had improved from always to frequently incontinent, toileting schedule had been changed to every two hours as RN-A stated he was constantly incontinent of urine. However,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 57	F 314		

there was no bladder assessment completed to support this change. In addition, R17 had "alteration in coccyx with gluteal abrasions R/T [related to] Resistance to cares, Incontinence," and the following interventions had been added to the care plan: "Refer to RN wound assessment/Wound Data assessment for tx [treatment] plan. Observe response and consult with MD [doctor] as needed," "Reposition/offload/turning every 2 hours in bed and chair. Attempt to re approach if resistive," "Provide pressure relieving cushion in chair," "Notify nurse immediately of any new areas of skin breakdown," and "House supplement and Arginaid for increased protein." R17 care plan further identified he had a "behavior symptom R/T (related to) Alzheimer's disease, dementia, PTSD (post traumatic stress disorder) and pain E/B (evidenced by) hitting out at staff, yelling, hollering out, hallucinations and refusal of care," with the following interventions: staff waited to give R17 medications if sleeping, as he would strike out and re-approach often, minimize disruptive behaviors with tasks to divert attention, offer to remove R17 to different location for activities, and discuss behavior and why behaviors is inappropriate.

R17's care plan lacked interventions for the bilateral heel ulcers, including current treatments and nursing interventions for pressure relief. In addition, the care plan failed to provide documentation on the type of pressure reduction cushion to utilize in R17's wheelchair and failed to identify if a pressure reduction mattress was currently in use on the bed. R17's care plan lacked interventions for behaviors which impeded wound healing and minimized pressure ulcer development. When R17's care plan was revised

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 58	F 314		

on 2/28/17, the mattress was removed from the identified interventions.

On 4/20/17, at 7:53 a.m. NA-D stated R17 was repositioned and toileted every two hours and if he refused they would re-approach. NA-D further stated R17 had days he was unwilling to cooperate and days he was very cooperative, staff tried the best they could. NA-D reported R17 wore blue foam boots because of the sores on his heels and stated they had been there for quite a while, further reporting R17 did just find with them on and didn't refuse them. R17 had them on while he was in the wheelchair, and maybe the bed too, unless he was resistive.

On 4/20/17, at 9:59 a.m. and again at 2:44 p.m. RN-A stated R17 was at risk for pressure ulcers due to his behaviors, during which he would fight, kick, and yell, and staff would attempt to re-approach him later. However, he could go a whole shift without being changed or laid down, which is the reason the coccyx ulcer had not healed. RN-A stated the floor nurses were supposed to complete the Wound Data Collection sheets with dressing changes every day of the week, while the RN came in once a week to measure and assess the wound, see if it is getting better and update the physician. RN-A reported the floor nurses were expected to describe the wound bed on the Wound Data Collection sheets, however, reported "none of us are that knowledgeable about the wound terms or staging." She stated she had never seen a stage 3 pressure ulcer and did not feel comfortable staging ulcers nor was she comfortable with choosing appropriate dressings for the ulcer. RN-A further reported she and the floor nurses had not received any education on the monitoring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 59	F 314		

and treatment of pressure ulcers. RN-A stated they finally called the wound nurse for the coccyx because it had stalled out but was now healing again. RN-A stated R17 was supposed to be repositioned every two hours and nursing assistants were expected to reposition residents from side to side as part of their standard protocol whenever they entered a room. RN-A reported no formal assessment tool had been used to come up with R17's repositioning schedule, and there was no standard she knew of, it was just something that had been "in my mind for different places I've worked at." RN-A stated R17's toileting schedule had been revised from every three hours to every two hours and had been communicated to staff on the care plan. She further stated his toileting schedule had been revised because he was constantly incontinent, however, R17's urinary needs had not been re-assessed. RN-A reported she went off what staff told her. RN-A reported R17's heel blisters had just come up overnight, stating he did not have any foam boots on while in bed and did not know if he had been rubbing his feet causing them. She further attempted to protect the blisters/heels the best they could, and when they did break open had the wound nurse assess them. RN-A stated prior to the blisters staff would put the blue foam boots on in bed or use pillows to prop up his heels, stating the foam boots were there prior to the wounds, R17 just did not use them in bed. RN-A was unaware the order for the blue foam boots had been changed from twice a day to as needed stating "well that's dumb." RN-A stated, "I wonder if the blisters didn't pop up because the blue boots weren't on overnight." Now he was supposed to wear them at all times and staff never reported he refused to wear them. RN-A further stated some staff change out the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 314	Continued From page 60	F 314		

blue boots to his regular gray boots when using the sit to stand lift. That was okay as long as staff remembered to change R17 back into his blue foam boots afterward "which is a necessity." RN-A stated R17 had worn the gray regular boots prior to the blisters when up in the wheelchair, and thought if staff forgot to replace them with the blue foam boots after using the lift, that could have contributed to the pressure ulcers as well. RN-A reported she was not aware if the blue foam boots were in fact pressure reducing, as they were an intervention before RN-A started. RN-A thought a pressure reducing air mattress had been discussed at one time. However, it was determined to place R17 at a fall risk. RN-A stated R17's repositioning and mattress had not been re-assessed after the heel ulcers had formed, stating the only thing she had been concerned with was making sure the blisters were covered and protected. "I just never even considered" it. RN-A acknowledged she had not put any interventions pertaining to R17's heels on the care plan or Kardex, stating she had communicated to staff the blue foam boots needed to be on him in his wheelchair and at all times. RN-A stated the risks and benefits of refusing the foam boots would have been discussed along with his behaviors with family during a care conference; however, no documentation was found to support this.

On 4/20/17, at 2:31 p.m. physical therapist (PT)-A stated R17's blue foam boots were pressure reducing in order to offload the heels. PT-A stated one of the biggest things while in sitting in the wheelchair is the strap on the back of the foot pedals which rubs and the foam boots protect them, especially if they don't move around like we do. PT-A reported the boots were important to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 61	F 314		

wear in bed as the heel was a "huge pressure point." PT-A stated R17 had not been seen by PT for anything pressure related.

On 4/21/17, at 8:13 a.m. LPN-A stated if R17 didn't wear the blue foam boots, staff attempted to elevate his heels on pillows and could get his boots on most of the time. However, she further stated R17 would not be in bed the whole night and would get up in the wheelchair. LPN-A reported the night shift typically checked off the box in the TAR indicating if R17 was wearing the foam boots while in bed, and if there was no check, then R17 probably refused them. LPN-A doubted there was any documentation of staff attempting to elevate the heels with pillows. LPN-A stated family had brought in the gray hard sole boots for R17 to wear, and staff told family R17 could not wear them. Once in a while at night family would put them on him. LPN-A stated R17's refusals to wear the blue foam boots and family placing the gray boots on R17 had not been communicated to RN-A. LPN-A stated RN-A could always look in the medical record to see if he was refusing. LPN-A stated the wound nurse came in to measure R17's ulcers, sometimes coming once or twice a week then maybe not for two weeks if the wounds were looking better.

On 4/21/17, at 8:40 a.m. LPN-C stated R17 was wearing the blue foam boots while in bed before developing blisters, and he wore black slippers brought in by family while up in the wheelchair. LPN-C observed R17's gray boots with the hard sole and stated the black ones were pretty much identical. LPN-C stated R17 was fine with wearing the blue foam boots while in bed, and if he refused would redirect, try to keep a pillow in between the feet to relieve pressure, and would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 62	F 314		

place the boots on him once asleep. LPN-C stated alternative interventions like pillows should be documented in the progress notes, and reasons should have been documented on the TAR if there was not a check mark that R17 was wearing the blue foam boots.

During interview on 4/21/17, at 9:19 a.m. wound nurse practitioner (NP) stated her visits varied in frequency depending on how acute the ulcers were at the time. When more acute R17 had been seen maybe twice a week at the most. NP stated R17 had an unstageable deep tissue injury on the right heel which was now a stage 3 pressure ulcer, slowly healing, and "doing much better than I thought it would." NP reported R17 also had a pressure ulcer on his coccyx which previously had an area of moisture associated skin damage. NP stated she would expect the staff to monitor R17's wounds like any other nursing home, doing skin assessments, and following through with treatment orders. NP reported R17's noncompliance was a factor in the ulcer formation, and further stated the right heel deep tissue injury could have been from staying in his wheelchair, bed or sit to stand lift. Although NP stated it was somewhat hard to say what caused it, R17 had to be in a dependent position somewhere for the blisters to form in the inner aspect of the heels. WNP stated a higher grade chair cushion had been discussed with family, who refused to buy one, and thought R17 had a higher grade offloading mattress on his bed. WNP reported the blisters came up over a weekend, all of a sudden they were there. She stated R17 had been wearing regular socks and tennis shoes prior to the blisters without issue, however, they could have contributed to the blisters forming.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 63	F 314		

During interview on 4/21/17, at 1:09 p.m. the director of nursing services (DNS) stated she would expect staff to follow the care plan on R17's toileting and repositioning schedules. If the resident needed to go more often, the resident would be taken. DNS further stated she would expect staff to re-approach if repositioning was refused, with maybe a new staff member or nurse offering. In there was no repositioning scheduled, then residents were to be repositioned every two hours and as needed as a standard. The DNS stated R17 was "cantankerous," and if he was refusing the blue foam boots would expect staff to tell him the risks and keep trying to talk him into them. She was not aware if the risks and benefits had been discussed with family, stated she would look into, and reported RN-A would have documented a discussion regarding the risk/benefits, however, no further information was provided. The DNS further stated all residents had a Panacea clinical foam mattress for pressure reduction. The DNS stated the Wound RN Assessment had to be completed in order for the Wound Data Collection sheets to kick in, so if the RN did not complete the assessment the data collection would not show up for the floor nurses to complete. The DNS verified floor nurses were supposed to complete the Wound Data Collection which included the description of the wound bed. However, the wound nurse came in every week, and if the wound nurse did not come then the RN was responsible for assessing the wound. The DNS stated staff had not requested more education on pressure ulcers, and she was not aware of any issues with pressure ulcer care. The DNS stated she had not "heard a word about it." The DNS reported she was in the process of doing chart audits and had not gotten to pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 64 ulcers yet. The DNS stated R17 had a coccyx ulcer and then his heels opened up, but reported, with his skin breakdown, he had all of it before she came to the facility. The DNS reported she had not seen his ulcers, but had been trying to see a dressing change and kept missing it. She further reported staff had not brought any concerns regarding R17 to her attention. The DNS was not aware whether R17's skin had been comprehensively re-assessed after the heel ulcers developed, but would have expected staff to re-assess him for different equipment, mattresses, the treatment being done, and "all of that." She further stated they "really need to find out why he is breaking down." During interview on 4/21/17, at 1:51 p.m. the administrator stated he was not aware of issues with pressure ulcer management or not following the care plans. He reported anytime he would ask about wounds he would be told everything was okay. The facility had their national consultant team come to the facility to do a pre-survey review during which they went through every resident in the building and made sure care plans were complete. The administrator further stated the interdisciplinary team discussed residents with skin issues, looking at incontinence status, and every quarter went through every resident in the building. Again, he stated every time he would bring up skin or pain, he was told everything was okay. The administrator reported there were issues with skin checks and skin monitoring not being completed last survey so staff were provided with education. The RN case manager should measure wounds weekly so that it is consistent with one person doing the measurements.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 65 During interview on 4/24/17, at 9:23 a.m. the medical director (MD) stated the facility kept him informed with pressure ulcers through faxes and updates on forms. The MD stated he was not exactly sure how the facility monitored pressure ulcers, but thought ulcers were measured weekly, and depending on the resident, would be seen by a wound specialist nurse. The MD reported he also saw residents on rounds, however, R17 was not his patient so he had never observed R17's ulcers nor had he been made aware of any issues regarding R17. The MD reported residents' nutritional risk and pressure ulcers were discussed broadly in the quality meetings, but not in great depth. The MD stated obviously with pressure ulcers the facility should look at positioning, getting him into bed, making sure he is on a cushion or mattress that assists in healing. The MD stated he would expect the facility to monitor the ulcers weekly, apply appropriate treatments, and consult the wound specialist for greater stages. In addition, he expected the facility to assess how R17 was sitting in the chair for areas of pressure. Further more, the MD acknowledged R17 had behavioral issues, that if R17 could kick off the pressure relieving boots, alternatives would be tired to help heal the ulcers. The MD could not say for certain if alternative interventions would have prevented the ulcer formation, as he was not aware of previous assessments and interventions. The MD further stated he was not aware of how the facility assessed pressure ulcer risk, would assume it was done on admission, and did not know what process was in place to continue to assess pressure ulcer risk. A facility policy entitled Pressure Ulcers, revised 1/17, directed the facility would comprehensively	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 66	F 314		

assess residents and, using assessed interventions, ensure residents did not develop pressure ulcers unless unavoidable. In addition, the policy directed residents with current pressure ulcers would receive treatment to prevent further pressure ulcers, and receive "appropriate assessments and services to promote and maintain skin integrity."
R1's annual MDS dated 1/27/17, indicated diagnoses that included heart failure, hypertension, and diabetes. The MDS identified R1 was moderately cognitively impaired, required extensive assistance with activities of daily living (ADL) and was totally dependent on staff assistance for bed mobility and transfers. The MDS further identified a risk for pressure ulcers and indicated a pressure reducing device was utilized in the bed and wheelchair.

R1's CAA dated 1/27/17, indicated R1 was totally dependent on staff for bed mobility and was at risk of developing pressure ulcers related to immobility, incontinence, cognitive loss and poor nutrition. The CAA did not identify a frequency for turning or repositioning. R1's care plan dated 3/17/17, identified a potential for impairment to skin integrity related to peripheral neuropathy and diabetes. The care plan directed staff to keep R1's skin clean and dry, elevate heels off of the bed, use of a pressure reducing cushion in the wheelchair and a foot cradle on the bed. The care plan failed to identify a frequency for offering turning or repositioning.

A Braden Scale for Predicting Pressure Sore Risk, dated 2/1/17, indicated R1 was at risk for pressure ulcer development. R1's Positioning Assessment & Evaluation form, dated 1/23/17, identified skin was clean, dry, and intact and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 67 identified the use of a mechanical lift in and out of bed and a mechanical stand for toileting. R1's Wound RN Assessments (a formalized assessment with staging, evidence of healing, and interventions), Wound Data Collection (which contained measurements daily monitoring, and wound bed characteristics) and Skin Observation sheets were reviewed and identified the following: - 1/23/17: Coccyx - Resident has two small areas on coccyx area. Areas are dry and scabbed over. - 2/9/17: Skin Observation - Other - 2 x 2 cm superficial open area. Pink in color. Continue to apply protective cream with 10% zinc. - 2/20/17: Skin Observation - Other - Pink 2 x 2 cm open area on coccyx. Applied 10% zinc. - 2/25/17: Skin Observation - Other - Dressing on coccyx. Intact. Unable to observe. - 3/9/17: Wound RN Assessment - Coccyx. Not staged. No odor or drainage. Dressing was off, applied zinc cream and non stick pad after peri care. Resident tolerated without difficulty. Continue with current plan of treatment. Identified as a pressure ulcer. - 3/11/17: Wound RN Assessment - Coccyx. No odor or drainage. Continue with current plan of treatment. Identified as a non-pressure wound. - 3/12/17: Wound RN Assessment - Right buttock - continue with current plan of treatment. No depth noted, no odor or drainage noted. - 3/19/17: Wound RN Assessment - Left and	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	**200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 68 right buttock - left and right have open area, no measurable depth. Identified as a non-pressure wound. Physician was notified regarding wound status. Requested new wound care orders. - 3/25/17: Wound Data Collection - Coccyx - redness. No measurements or wound characteristics indicated . - 3/26/17: Wound Data Collection - Coccyx - redness. No measurements or wound characteristics indicated. - 3/26/17: Wound RN Assessment - Gluteals - Identified as a pressure ulcer. Continue with current plan of care. No odor or drainage. - 4/10/17: Wound Data Collection - Buttocks. No measurements or wound characteristics indicated . - 4/13/17: Wound Data Collection - Coccyx. No measurements or wound characteristics indicated. - 4/14/17: Wound Data Collection - Coccyx. No measurements or wound characteristics indicated. - 4/19/17: Wound RN Assessment - Right gluteus. Unstageable pressure ulcer. Wound has openings and skin will need to be debrided. Continue with current plan of treatment. - 4/19/17: Wound Data Collection - Coccyx. Dry, shearing on coccyx. 1.5 (length) x 1.0 (width) x 0.1 (depth) cm Right gluteus. Another small spot on right side gluteus measures 0.5 x 1.0 cm. (Comments noted RN-A opened this assessment to add measurements). Zinc cream and	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 69	F 314		

hydrocolloid dressing applied. No wound characteristics are indicated.

During and interview on 4/17/17, at 5:08 p.m. RN-A stated R1 had an unstageable pressure ulcer which was discovered on 3/9/17. She stated the wound healed and then reopened. RN-A stated the wound nurse would be seeing R1 on 5/21/17.

When interviewed on 4/20/17, at 8:34 a.m. RN-A stated the nurse working the medication and treatment cart was responsible for assessing the wound. She stated licensed practical nurses (LPN's) complete the wound data collection form and were expected to do measurements when collecting the data. RN-A stated it was not acceptable to have only two measurements of the wound from January 2017 to present RN-A stated she is not a "pro" so she does not stage the wounds, indicating she did not want to get it wrong and stated the facility does have a wound nurse who comes in to see residents, but had not seen R1. RN-A stated she worked the overnight shift on 4/19/19, and stated measurements were added to the wound data collection form dated 4/19/17, at 1:39 p.m. RN-A stated there are currently two open areas She stated one needed to be debrided. RN-A stated she had not received training on pressure ulcers, and had not asked for training, therefore, she was not comfortable in describing the wound. RN-A indicated all nurses had been informed they are to measure the wounds but stated it was not being done. RN-A stated she talked with the administrator about this, who informed her the nurses need to be held accountable for completing this or be written up. RN-A stated the current DNS was aware this was not being completed. RN-A indicated the prior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 70	F 314		

DNS tried some things, but the administrator would not allow some of the things she wanted to try.

When interviewed on 4/20/17, at 9:33 a.m.NA-D stated was unaware of what the turning and repositioning schedule was for R1 and stated she would have to refer to the Kardex. NA-D then verified the Kardex did not identify a turning and repositioning schedule and stated that indicated an every two hour schedule.

During observation on 4/20/17, at 10:35 a.m. RN-A completed a dressing change on R1's coccyx. RN-A stated there was a light serosanguinous drainage on the old dressing. The wound on the coccyx measured 1.5 cm x 1.3 cm. The wound bed was pink with intact edges. There was no slough or eschar was present. RN-A applied an ointment and a new dressing. RN-A identified the wound as a Stage II. When interviewed at this time, R1 stated it helped to sit R1 in her recliner or lay her in bed to relieve pressure from her buttocks.

When interviewed on 4/20/17, at 11:13 a.m. OT-A observed the cushion in R1's wheelchair. OT-A stated the cushion contained a foam gel combination. The top cushion was all gel, approximately one inch thick. The cushion consisted of approximately one inch squares across the entire cushion. The front right corner had three squares missing. The bottom cushion was a gel/foam combination and was approximately three inches thick. The back of the cushion where the seat and back of the wheelchair met, was torn and worn away. Both back corners were worn and missing completely. OT -A stated a combination of these two cushions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 71	F 314		

with a cover, would be appropriate for R1, but in this condition they needed to be replaced. After pushing on the back of the cushion, OT -A stated it would not affect R1's coccyx.

When interviewed on 4/21/17, at 9:32 a.m., LPN-A stated R1 had a decline in her ADLs, and had a pressure ulcer that healed and returned to the coccyx. LPN-A stated RN-A was responsible for completing the assessment and weekly measurements.

When interviewed on 4/21/17, at 1:09 p.m., the DNS stated the nurses are expected to do the wound and data collection tools. She stated the floor nurses do the collection, including the measurements and the registered nurses do the assessments. She stated the facility has a wound nurse who comes in weekly and completes the assessments and treatments and stated if the wound nurse was not in, the floor nurses were expected to get them done. The DNS stated RN-A was responsible for completing the weekly assessment and was expected to stage the pressure ulcers. The DNS denied any concerns being brought to her attention about the data collection and assessments not being completed.
R10's quarterly MDS dated 3/5/17, indicated R10 had diagnoses which included hemiplegia, diabetes mellitus, heart failure, hyperlipidemia, and hypertension. The MDS identified R10 was severely cognitively impaired, required extensive assistance with ADL, and was totally dependent on staff assistance for bed mobility and transfers. The MDS indicated R10 had no stage 1 or greater or unhealed pressure ulcer. Also, the MDS identified R10 was at risk for pressure ulcers, and a pressure reducing device was utilized in the wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 72	F 314		

R10's CAA dated 9/20/16, indicated R10 required extensive assistance of two for bed mobility, was unable to ambulate, and required extensive assistance of two with full body lift for out of bed transfers. The CAA also indicated R10 was frequently incontinent of bladder and wore incontinence briefs, and was at risk of developing pressure ulcers.

R10's care plan, last reviewed 3/6/17, identified R10 was at risk for skin impairment related to diabetes and identified the goal was to remain free of breakdown. Interventions listed included repositioning resident from side to side every three hours and as needed, and to offload out of wheelchair every three hours and as needed. Also identified, R10 had a pressure reducing cushion on wheelchair. R10's care plan identified he had a previous intervention for a standard pressure reducing mattress on the bed, but this was noted as resolved on 12/9/16, and there were no current interventions for a pressure reducing mattress.

R10's Kardex Report, dated 4/20/17, identified to reposition resident from side to side every three hours and as needed and to offload out of the wheelchair every three hours and as needed. The Kardex Report also indicated R10 had a pressure reducing cushion in the wheelchair, but failed to identify a pressure reducing mattress for the bed.

R10's Braden Scale for Predicting Pressure Sore Risk, dated 3/2/17, indicated R10 was at risk for developing pressure ulcers.

On 12/2/16, Wound RN Assessments indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 73	F 314		

R10 had a coccyx pressure ulcer which had completely healed, with no open areas or redness. The assessment directed to continue current treatment of Sensicare (protective barrier) three times a day and as needed preventatively, and wound care appointments were only required as needed.

R10's Skin Observation Record, dated 2/17/17, indicated skin check was completed, no skin conditions observed.

R10's Skin Observation Record, dated 2/24/17, indicated redness on left and right buttocks, 10% zinc was applied.

R10's Skin Observation Record, dated 3/3/17, indicated red bottom.

R10's Skin Observation Record, dated 3/10/17, indicated no skin conditions observed.

R10's Skin Observation Record, dated 4/7/17, indicated one very small open area on coccyx, zinc cream applied.

R10's Skin Observation Record, dated 4/14/17, indicated two small open areas coccyx, house cream with zinc applied.

Review of R10's progress note, dated 4/14/17, indicated physician saw R10 and ordered an air mattress for the bed.

R10's Wound Data Collection, dated 4/20/17, completed by RN-A, indicated wound on coccyx measured 0.5 cm x 0.3 cm x 0.1 cm, and was described as shearing on bed, no slough, needed debrided around edges to remove dried skin, skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 314	Continued From page 74	F 314		

has had first protective layer removed, and to apply zinc cream every time there was a voiding.

During an interview on 4/20/17, at 9:25 a.m. RN-A stated R10 had a history pressure ulcers. RN-A stated R10 had no mobility, was either lying in bed or up in the wheelchair, but liked to be up in wheelchair. RN-A indicated when R10 was in his bed, he was always laying on his bottom. RN-A stated he was positioned with pillows, and they had tried wedges for repositioning, but R10 ended up moving them out of position. RN-A stated she had last observed the wound on 4/14/17, with the physician, and the wound was pinhole size. RN-A stated R10 should have an air mattress on his bed, because the physician ordered one, however, RN-A stated she had forgotten to let the maintenance department know to put one on R10's bed. RN-A stated she had not updated R10's care plan to address the open area on his coccyx, and RN-A stated R10 had not yet been seen by the wound care nurse.

During an observation on 4/20/17, at 10:25 a.m. of RN-A assessing the coccyx wound, RN-A stated no zinc ointment had been applied today. RN-A described the wound as 0.3 x 0.5 x 0.1 open area on left buttock near gluteal folds. RN-A described another area on R10's coccyx as quarter sized, area pink, no open area. RN-A applied zinc oxide cream to the wound area, and stated she expected cream to be applied with every incontinence. There was no pressure reducing mattress observed on R10 bed.

Review of the facility's policy, Pressure Ulcers, dated 1/17, indicated the purpose was to provide appropriate assessment and prevention of pressure ulcers, as well as treatment when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 314	Continued From page 75 necessary.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal	F 315		5/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 315	Continued From page 76 bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure toileting programs for urinary incontinence were offered, and a decline in bowel continence was re-assessed, for 1 of 1 residents (R17) reviewed for incontinence. Findings include: R17's annual Minimum Data Set (MDS), dated 11/30/16, indicated he was always incontinent of urine, but continent of bowel. R17's Care Area Assessment (CAA), dated 12/1/16, identified urinary incontinence related to immobility and urinary urgency and indicated "Refusal for help at times. Have to re-approach several times per shift." R17's urinary incontinence CAA was not completed, and lacked care plan considerations including an overall goal, complications, or risk factors for incontinence. R17's quarterly MDS, dated 2/23/17, indicated he was severely cognitively impaired and was frequently incontinent of urine and, was now frequently incontinent of bowel, when he had been continent on the previous assessment. R17's Bladder Assessment, completed 9/1/16, identified functional incontinence (secondary to other factors). The assessment indicated R17 was on a check and change program, in which staff checked and changed his brief every three hours and as needed. The Bladder Assessment further noted "[R17] has refused in the past related to hallucinations and delusions," and indicated R17 needed extensive assistance of	F 315	1. Bowel and bladder assessment and evaluation completed on R17. Care plan updated to reflect appropriate toileting program and interventions. 2. All current residents have been reviewed for current bowel and bladder assessment and reassessed as needed for current incontinence. Care plans reviewed and updated to reflect current incontinence retraining or management programs as appropriate. 3. All Licensed staff will be retrained on GSS policies and procedures for bowel and bladder assessment regarding data collection, assessment, and care planning for incontinence on May 17th 2017 by DNS. 4. Routine audits will be completed on R17 and other residents for a decline in bowel and bladder, to prevent reoccurrence of deficiency weekly x 4, monthly x2. DNS, or designee, will be responsible for compliance. Audit results will be reviewed by Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 315	Continued From page 77	F 315		

two staff with the sit to stand lift for toileting.

R17's current care plan, dated 11/6/16, identified an ADL (activities of daily living) deficit related to confusion and weakness. The care plan indicated R17 had been on a check and change program every three hours until 2/28/17, when it was changed and directed staff to check and change him every two hours.

R17's medical record lacked any further bladder assessments. In addition, no bowel assessments were provided.

During continuous observation on 4/19/17, at 7:06 a.m., R17 was observed sitting in his wheelchair in his room. At 7:34 a.m., an unidentified staff member came to take R17 to breakfast. The staff member asked R17 if he wanted to use the bathroom before breakfast and R17 refused. R17 was observed eating breakfast until 8:55 a.m., at which time licensed practical nurse (LPN)-B brought R17 back into his room. LPN-B left the room and returned a few minutes later and moved his bedside table and water pitcher within reach. R17 was overheard yelling "get the hell out," and LPN-B left the room. There were no offers of repositioning at this time. R17 remained in his wheel chair until 9:28 a.m., when LPN-B escorted him to an activity. R17 remained in the activity activity until 10:01 a.m. when it was brought to nursing assistant (NA)-A's attention that R17 had not been offered toileting for over two hours.

During interview on 4/19/17, at 10:07 a.m., NA-A reported she was not sure when R17 was last toileted and stated another nursing assistant could have offered and they usually

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 315	Continued From page 78	F 315		

communicated verbally one another. NA-A went over to the wall computer stating they were suppose to chart in Point of Care when they re-approached/offered toileting and repositioning, further stating R17 was scheduled to be toileted at 9:00 a.m., and she usually checked at 2:00 p.m. before she left. NA-A reported R17 had been repositioned last when he got up at 5:00 a.m. and was last toileted at 5:34 a.m., stating R17 had been up when NA- had gotten to work at 6:00 am., so he "should be checked here shortly." NA-A reported R17 was toileted and repositioned every three hours or "when he is deciding to move on us," because he had a reoccurring wound on the coccyx and wound on the heels.

During observation on 4/19/17, at 10:19 a.m. NA-A asked R17 if he needed to use the bathroom and brought R17 into his room. While in his room, NA-A and NA-E used a sit to stand lift to assist R17 into a upright position, then quickly changed his brief. R17 swore and hollered at them during the change. NA-A stated R17's brief was dry; however, she changed it because he had been in it for a while. NA-A further stated R17 was usually incontinent of bladder but was usually continent of bowel and could sit on the commode to have a bowel movement.

During observation on 4/19/17, at 1:55 p.m., R17 was observed lying in bed as his dressings to the coccyx and right heel were changed. At that time, R17 was observed be incontinent of urine and R17 verbalized needing go the the bathroom. NA-A assisted R17 with the sit to stand lift to the commode to have a bowel movement. At that time, NA-A stated R17 had a medium amount of urine in his brief and had been incontinent. NA-A left R17 to sit on the commode to have a bowel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 315	Continued From page 79	F 315		

movement. During interview at 2:34 p.m., NA-A stated, to her knowledge, R17 had last been offered toileting around 9:00 a.m., when she had last checked on him. Nearly four hours had elapsed before R17 was offered toileting or had been checked for urinary incontinence.

During interview on 4/20/17, at 7:53 a.m., NA-D stated R17 was toileted every two hours and if he refused they would re-approach. NA-D further stated R17 had days he was unwilling to cooperate and days he was very cooperative and stated, staff tried the best they could. NA-D reported R17 was only incontinent of bladder, and if staff could get him on the commode, R17 would have a bowel movement. NA-D reported R17 would only have a bowel movement while on the commode. NA-D stated he wound not go in his brief.

During interviews on 4/20/17, at 9:59 a.m., and 2:44 p.m., RN-A stated R17 had functional incontinence related to mobility and his toileting schedule had been revised from every three hours to every two hours and had been communicated to staff on the care plan. She further stated his toileting schedule had been revised because he was constantly incontinent of urine. RN-A reviewed the nursing assistant documentation for the quarterly MDS assessment, stating she only had documentation from 2/17/17 to 2/23/17, which indicated R17 was continent of bowel 50% (percent) of the time and incontinent of bowel 50% of the time. RN-A reported she was unaware R17 had gone from continent of bowel to frequently incontinent of bowel because "I don't look back at the old MDS." Instead, RN-A stated she relied on what staff told her. She stated if staff alerted her of two different

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 80	F 315		

changes, she would do a significant change MDS. RN-A stated bowel and bladder assessments were suppose to be done quarterly with the MDS; however, did not have a quarterly bowel and bladder assessment on R17. RN-A stated the NA's may have charted incorrectly on bowel incontinence, marking him as incontinent when he was actually continent; however, no incorrect documentation was provided. RN-A stated R17's change in bowel incontinence on the quarterly MDS was not re-assessed, so she could not say if the charting was inaccurate or if R17 had a decline in bowel continence. RN-A stated R17 could have been placed on a bowel program if there had been a decline, but again had not re-assessed for one. RN-A stated she was not sure "what the CAA was all about," how to complete them, or what to put in them. RN-A stated she had received training on the MDS but had not been told what was suppose to go into a CAA.

During interview on 4/21/17, at 1:09 p.m., the Director of Nursing Services (DNS) stated she would expect staff to follow the care plan on R17's toileting schedule and stated if a resident needed to go more often, she would expect staff to take him. The DNS further stated she would expect staff to re-approach if a resident refused.

A facility policy entitled Assessment (MDS), revised 11/15, directed a "Review of assessments will be done every three months and as appropriate. The comprehensive assessment will be revised to ensure current accuracy."

A facility policy entitled Care Plan, revised 11/16, directed "Residents will receive and be provided the necessary care and services to attain or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 81 maintain the highest practicable well-being in accordance with the comprehensive assessment."	F 315		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure bed rails were assessed for use and maintained in a safe and functional manner for 3 of 5 residents (R39, R58, R12) reviewed for accidents and 15 of 17	F 323	1.Physical device and restraint assessment and evaluation completed for residents R12, R39, and R58 for the use of positioning bars and the evaluation was determined these are not in use for	5/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 82 additional occupied beds observed during an environmental tour. Findings include: R39's Admission Record, dated 10/28/15, identified diagnoses of weakness and repeated falls. R39's quarterly Minimum Data Set (MDS), dated 4/5/17, indicated she was cognitively intact, required extensive assistance for bed mobility, dressing, toilet use, and personal hygiene, and was totally dependent on staff for transfers. The MDS further indicated bed rails were "not used" for R39. R39's care plan, revised on 3/2/17, identified an activities of daily living (ADL) self care performance deficit with bed mobility and indicated R39 was able to turn from side to side independently in bed and was able to hold self to the side using grab bars. Review of a Physical Device and Restraint Assessment, dated 5/31/16, indicated a formed/lip mattress was recommended for R39. The question regarding bed rail/side rail/assist bar was marked, "Not applicable." During an observation on 4/17/17, at 5:06 p.m., R39's bed was observed with bilateral side rails. The bed rails were observed to be loose. The rails moved approximately three inches and were not secure to the bed. During an interview on 4/17/17, at 5:08 p.m., R39 stated she used the bed rails to help her turn while in bed and stated she hadn't noticed the bed rails were loose. She stated, "They've always been that way." During interview on 4/17/17, at 5:20 p.m.,	F 323	restraining and the resident are able to get in and out of bed freely. The risk and benefits have been gone over and informed consent has been obtained for the residents R12, R39 and R58. If there is a Maintenance reviewed to ensure assistive devices were properly in place and functional. 2. All current residents using positioning bars have been assessed using the physical device and restraint assessment and reassessed as needed for current use of assistive devices. The risk and benefits have been gone over and informed consent has been obtained for the residents that have been determined to require positioning bars. Maintenance reviewed to ensure all current residents assistive devices were properly in place and functional. All residents are assessed upon admission for use of assistive devices. If the need is present then it is reviewed quarterly to ensure the device is still appropriate for the resident 3.All Licensed staff will be retrained on GSS policies and procedures regarding data collection, assessment, and care planning for assistive device including positioning bars use on May 17th 2017 by DNS and Administrator. All maintenance staff was educated on the proper placement and use for assistive devices on May 17th 2017 by Administrator. All staff were re-educated for notifying maintenance in writing for any repair needs. 4.Audits for placement of positioning bars, risk and benefit of use documentation and obtaining consent prior to placement of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 83 registered nurse (RN)-A stated R39 did not use side rails. During an interview on 4/19/17, at 12:47 p.m., nursing assistant (NA)-A stated R39 used the bed rails to turn from side to side. NA-A verified the bed rails were loose and stated she hadn't noticed but would notify maintenance right away. R39's record lacked completion of any device assessment for the use of bed rails, including assessment for the risk or entrapment, reviewing the risk and benefits of use with the resident or resident representative and obtaining informed consent prior to installation, and ensuring the bed's dimensions were appropriate for R39's size and weight. R58's Admission Record, dated 2/14/17, identified diagnoses of Alzheimer's disease, dementia, and weakness. R58's admission MDS, dated 2/26/17, indicated R58 had severe cognitive impairment, required extensive assistance for bed mobility and was totally dependent on staff for transfers. The MDS further indicated bed rails were "not used" for R58. R58's care plan, revised 2/20/17, indicated R58 had an ADL self care performance deficit with bed mobility and indicated assistance of two staff to turn her from side to side. During an interview on 4/17/17, at 5:22 p.m., RN-A stated R58 did not use side rails. During an observation on 4/17/17, at 6:46 p.m., bed rails were attached to both upper ends of R58's bed and were observed to be loose. The bed rails moved approximately two to three inches and were not secured to the bed.	F 323	will be conducted randomly weekly x 4, monthly for a quarter X2 quarters. Audit results will be reviewed by Quality Committee for further recommendations.	

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	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 84	F 323		

During an interview on 4/19/17 at 12:43 p.m., NA-A stated R58 didn't really use the bed rails for turning or repositioning because she depended on staff to help with that. NA-A stated she was aware R58's bed rails were loose and stated she reported this to maintenance "a couple weeks ago." NA-A stated the process to report issues to maintenance included filling out a form located outside of the maintenance office, but stated she had reported R58's loose bed rails verbally and had not filled out the form

R58's record lacked completion of any device assessment for the use of bed rails, such as assessment for the risk or entrapment, reviewing the risk and benefits of use with the resident or resident representative and obtaining informed consent prior to installation, and ensuring the bed's dimensions were appropriate for R58's size and weight.

R12's Admission Record, dated 8/24/16, identified diagnoses of weakness, neuropathy, and history of pressure ulcers. R12's quarterly MDS, dated 2/26/17, indicated she was cognitively intact and required extensive assistance for bed mobility and transfers. The MDS further indicated bed rails were "not used" for R12. A Care Area Assessment (CAA), dated 9/8/16, indicated R12 was at risk for a functional decline in ADLs due to changing cognitive status and physical limitations. R12's care plan, revised 2/15/17, indicated R12 had an ADL self care performance deficit with bed mobility, and indicated assistance of one staff for "guiding and assist bars."

During an interview on 4/17/17, at 5:24 p.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 323	Continued From page 85 RN-A stated R12 did not use side rails. During an observation on 4/18/17, at 9:59 a.m., the bed rails attached to both upper ends of R12's bed were observed to be loose. The bed rails moved approximately three inches and were not secure to the bed. During an interview on 4/18/17, at 10:05 a.m., R12 stated she used the bed rail to assist with turning and to sit up. R12 stated the bed rails were "loose, but still work okay." R12's record lacked completion of any device assessment for the use of bed rails, including assessment for the risk or entrapment, reviewing the risk and benefits of use with the resident or resident representative and obtaining informed consent prior to installation, and ensuring the bed's dimensions were appropriate for R12's size and weight. During an interview on 4/19/17, at 1:04 p.m., the administrator stated an assessment for the use of bed rails should be completed for each resident upon admission and were located in their medical record. During an interview on 4/19/17, at 1:10 p.m. maintenance (M)-A stated he was not aware that R39, R58, and R12's bed rails were loose. He stated the maintenance staff observed resident rooms and beds quarterly, but depended on staff to use the maintenance forms to notify them when problems were identified. M-A stated, "No one let me know." M-A stated he had "just started" documenting room and bed inspections in January 2017, and provided documentation of 13 beds that he had inspected.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 323	Continued From page 86 A facility tour of all 34 resident beds was conducted with M-A on 4/19/17 at 3:17 p.m. During the tour, 33 of 34 current resident beds had bed rails attached to the bed. Four different types of bed rails were observed. One type of bed, identified as "CS 7" by M-A, were utilized in 17 resident rooms. Of the 17 CS 7 beds, 15 had bed rails that were observed to be slightly to very loose. M-A stated the rails on the beds loosen as residents use them, "because of the way the tightening knob works. It doesn't have a locking device on it." M-A stated he would be calling the manufacturer of the CS 7 beds to discuss the issue. When interviewed on 4/20/17, at 8:02 a.m., RN-A stated, "No assessment is done for side rails. They are just on every bed." RN-A stated when a new resident was admitted, "They get whatever bed is in the room unless a special bed or mattress is needed," and then maintenance would be notified. RN-A stated, "We don't really look at the rails." During an interview on 4/21/17, at 7:30 a.m., the director of nursing services (DNS) stated she could not find a Physical Device and Restraint Assessment for R39, R58, or R12. The DNS stated staff should be completing the assessment for residents upon admission, to determine if the bed rail was necessary and to ensure the resident's safety. At 12:51 p.m., The DNS stated, "The Physical Device and Restraint Assessment form has good components on it, but is not being used. They [staff] just need some education on how to complete that and to know if it's [bed rails] used correctly, it's not a restraint."	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 323	Continued From page 87 Review of the facility's policy, Bed Safety-Including Bed Rails/Side Rails/Assist Bars, revised 11/16, included, "Physical or chemical restraints, including bed rails/side rails, will only be used to treat medical symptoms identified by a medical provider." Also included, "1. A medical provider order that includes the medical symptom and necessity for use is required for a bed rail/side rail. 2. Bed rail/side rail usage will occur only when medical necessity for bed rails/side rails is documented and when the total bed environment (i.e., bed frame, mattress, bed rails/side rails and overlays) have been inspected and verified to be free of entrapment risk. 3. Residents will be assessed for the appropriateness of side rails...Assessments include, but are not limited to, the use of the Physical Device and Restraint Assessment...5. No bed should have a bed rail/side rail without an identified medical necessity determined by the medical provider."	F 323		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 356		5/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 356	Continued From page 88 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to post daily, the required nurse staffing information. This practice had the potential to affect all 34 residents residing at the facility, family, staff, and visitors.	F 356	1.The current posting for nursing staff hours was posted on 04/17/2017. 2.All current and future residents are at risk for this deficient practice. 3.All licensed nurses were re-educated on	

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	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

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F 356	Continued From page 89 Findings include: During the initial facility tour on 4/17/17, at 2:14 p.m. the facility staff posting form was dated 4/10/17. The form was in a clear plastic sleeve mounted on the wall near the front door. Also observed in the plastic sleeve behind the posting dated 4/10/17, was the facility staff posting, dated 4/3/17. During an interview on 4/17/17, at 2:14 p.m., the administrator stated he did not know why the facility staff posting was not current. He stated there was a miscommunication as to who was printing and posting the staffing information. The administrator stated in the absence of the director of nursing services (DNS), he typically had been posting the staffing information, however, he had been off over the weekend. A facility policy titled, Nursing Daily Staffing Posting, dated 12/15, directed staff to post the facility's daily staffing according to federal CMS staff posting requirements.	F 356	the GSS policy and procedure for posting of the nursing staff hours by DNS and Administrator on May 17th 2017. 4.Observation audits will be conducted to ensure the nurses are posting the nursing staff hours daily for 4 weeks and then weekly for 2 months by DNS, or designee.	
F 431 SS=F	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures	F 431		5/27/17

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 431	Continued From page 90	F 431		

that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the

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	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 91 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a system to ensure the disposition of controlled medications (medications that have a high likelihood of abuse) to prevent diversion. This had the potential to affect 34 of 34 residents currently residing in the facility. Findings include: An observation of the facility's medication storage room on 4/21/17, at 1:15 p.m., revealed a cupboard which contained medications intended for destruction. During the observation, LPN-A stated the narcotic medications needing to be destroyed were kept in a locked cupboard in the medication storage room, near the front of the building. LPN-A stated all nurses had access to the locked cupboard with medication keys. LPN-A stated if a resident discharged or a narcotic medication was discontinued, "We just take the medication from the medication cart, pull the form from the three ring binder, wrap it around the medication, secure with a rubber band, and put it in the cupboard in the medication room." LPN-A stated those narcotic medications were not counted or reconciled once they were placed in that cupboard. LPN-A stated once they were pulled from the carts they were kept in the locked cupboard in the medication room until they were destroyed. LPN-A stated,"we would not know if narcotics were missing." During interview on 4/21/17, at 1:40 p.m., the director of nursing services (DNS) stated the	F 431	1.All discontinued controlled medications were properly destroyed on May 3rd 2017 by DNS. 2.All current and future residents are at risk for this deficient practice. 3.All Licensed Nurses and TMAs were re-educated on GSS policy and procedures destruction of controlled medications on May 3rd 2017 by DNS. 4.Audits will be completed to monitor destruction of controlled medications and prevent reoccurrence of deficiency weekly x 4, monthly x2. DNS, or designee, will be responsible for compliance. Audit results will be reviewed by Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 92	F 431		

narcotics to be destroyed were kept in the locked cupboard in the medication room. DNS stated she thought either two registered nurses or the pharmacist destroyed narcotics. DNS stated she didn't know where they kept the paperwork.

During interview on 4/21/17, at 1:42 p.m., LPN-C stated all nurses that carry medication keys would have access to the medication storage cupboard. LPN-C stated narcotics were not counted once they are pulled from the medication cart.

During interview on 4/21/17, at 1:15 p.m. the consulting pharmacist (CP) stated he understood the narcotics needing to be destroyed, were kept in a locked drawer in the DNS office. The CP stated he had concerns about controlled substances being stored in the locked medication room cupboard, with all nurses having access, due to the potential for diversion.

During interview on 4/21/17, at 3:02 p.m. the administrator stated he was not aware of narcotic reconciliation requirements, however, stated they had an issue with medication diversion last year, where the police were involved and it was reported to the Office of Health Facility Complaints (OHFC).

The facility policy Controlled Substances, dated 5/16, identified the purpose was to provide safe storage for all controlled substances. The policy indicated scheduled drugs that had been discontinued should be placed in a locked box in the medication room, as soon they had been discontinued, or as indicated by state law. The policy directed the scheduled drugs should continue to be counted until disposal was completed.

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	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 441		5/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 94 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement and maintain an infection control program to help prevent the development and transmission of infections. In addition, the facility failed to follow the recommendations for hand hygiene and glove use for 1 of 4 residents (R19) observed for personal cares and 1 of 4 residents (R19) observed during a blood glucose check. Findings include:	F 441	1.NA-B was re-educated on proper hand hygiene on 4/24/2017. RN-B was re-educated on proper use of gloves during glucose checks on 04/18/2017. Facility has implemented an infection control program to monitor and track infections throughout the facility. 2.We reviewed the last 3 months of infections for all current residents and tracked and trend. 3.All staff were re-educated on the GSS policy and procedure for infection control.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 441	Continued From page 95 A three ring binder containing infection control data collection forms, Monthly Infection Control Report, Monthly Report of Resident Infections in Center, and Order Listing Report, was provided by registered nurse (RN)-A. The Monthly Infection Control Report Form contained the following columns: resident name, room number, date admitted, date of infection, site of infection, culture taken yes/no, causative agent, antibiotic treatment, cautionary measures, isolation yes/no, center acquired yes/no. The Monthly Report of Resident Infections in Center form contained the following columns: incidence rate formula, site, nosocomial infections, community acquired infections. The Order Listing Report listed the resident names, the name of the antibiotic ordered, and the date of the order. The data was reviewed for December 2016 through April 2017, and the following was noted: Monthly Infection Control Report, dated December 2016, listed one resident with pneumonia. The column for date of infection was blank. The Monthly Report of Resident Infections, dated December 2016, was blank. The Order Listing Report for order date range of 12/1/16 through 12/31/16, identified seven residents names and orders for Azithromycin, Clindamycin, Nystatin powder, Ciprofloxacin, and Amoxicillin. Monthly Infection Control Report, dated January 2017, was blank. The Monthly Report of Resident Infections, dated January 2016, was blank. The Order Listing Report, dated 3/28/17, for orders ranging from 1/1/7 through 1/31/17, identified 26 resident names and listed antibiotics ordered: Tamiflu, Oseltamivir, Nystatin powder, Levofloxacin, Zithromax, Cefprozil, Ciprofloxacin,	F 441	All nursing staff will be retrained on proper hand hygiene, glove usage on May 17th 2017 by DNS and Administrator. 4.Observations audits will be completed on 5 employees to prevent reoccurrence of deficiency of hand hygiene and glove usage weekly x 4, monthly x 2. DNS, or designee, will be responsible for compliance. Monthly audits will be completed of the infection control program x 3 months and then once a quarter for two quarters for compliance to prevent reoccurrence by DNS, or designee. Audit results will be reviewed by Quality Committee for further recommendations.	

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	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 441	Continued From page 96	F 441		

Bactrim DS, Macrobid, Augmentin, and Amoxicillin.

Monthly Infection Control Report, dated February 2017, was blank. The Monthly Report of Resident Infections dated February 2017, was blank. An Order Listing Report, dated 3/28/17 for orders dates ranging from 2/1/17 through 2/28/17, identified seven resident names and listed antibiotics ordered: Nystatin powder, Ciprofloxacin, Tamiflu, Bactrim DS, Augmentin, Doxycycline.

Monthly Infection Control Report, dated March 2017, was blank. The Monthly Report of Resident Infections, dated March 2017, was blank. There was no Order Listing Report for March 2017.

Monthly Infection Control Report, dated April 2017, was blank. The Monthly Report of Resident Infections, dated April 2017, was blank. The Order Listing Report, dated 4/20/17, identified seven resident names and listed antibiotics/antiviral's: Nystatin powder, Levofloxacin, Augmentin, and Amoxicillin. The date range for the report dated 4/20/17, was 2/17/17 through 3/17/17.

The collected data lacked any trending or analysis of the infections in the facility to determine the cause of infection, and to determine if they had potential to, or were, spreading in the facility.

During an interview on 4/18/17, at 2:39 p.m., RN-A stated she was responsible for infection control surveillance. She stated, for the last several months she had only pulled the antibiotic/antiviral report from the computer,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 441	Continued From page 97	F 441		

placed them in a three ring binder and set up the infection control forms for each month. RN-A stated, for tracking and trending, she pulled the antibiotic reports at the end of each month. RN-A stated infection control tracking and trending was supposed to be a part of the monthly quality assurance meeting each month.

The facility policy titled Infection Control dated 12/15, indicated an infection control program would be maintained in the facility for residents, visitors, and employees, to help prevent the development and transmission of diseases and infection.
R19's Annual Minimum Data Set (MDS), dated 1/27/17, indicated R19 was severely cognitively impaired, required extensive assistance for all ADLs and was frequently incontinent of bowel and bladder.

During observation on 4/19/17, at 8:49 a.m., nursing assistant (NA)-B entered R19's room, turned on the room lights, closed the door, and announced to R19 that it was time to get ready for the day. NA-B donned gloves and used a washcloth to wipe R19's face, and then used the same washcloth to clean her peri area. The white washcloth was observed covered with stool, and stool was observed on both of NA-B's gloves. NA-B stated she needed to "get some wipes," and with her soiled gloved hands, NA-B opened a clear, plastic bag sitting on the floor and threw the soiled washcloth into the bag. Without removing the soiled gloves, NA-B opened the top drawer of the night stand, and removed a package of disposable wipes and a tube of protective cream. NA-B used several disposable wipes to clean R19's peri area and disposed of each soiled wipe by opening a second clear plastic bag on the floor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 98	F 441		

with her soiled gloves and throwing the wipes inside. NA-B picked up the tube of protective cream, squeezed a portion of the contents onto her gloves, and applied the cream to R19's bottom, still wearing the same pair of gloves. NA-B then picked up the package of disposable wipes and the tube of protective cream from the bed and placed them onto the bedside table. NA-B removed the gloves, used her bare hands to open the plastic bag on the floor, and threw the gloves into the bag. NA-B walked into R19's bathroom and without washing her hands, donned a new pair of gloves. NA-B returned to R19's bedside, placed a clean brief on R19, and pulled up her pants. She assisted R19 to sit on the edge of the bed and removed her gloves. Without washing her hands, NA-B removed R19's foot pedals from the wheelchair, pulled the wheelchair to the side of the bed, and put R19's shoes on. She then used her bare hands to pick up and move the two plastic bags on the floor and retrieved the gait belt hanging on a hook on the back of R19's door. NA-B placed the gait belt on R19, locked the wheelchair, touched the handles on the walker to bring it closer to R19, and assisted R19 to transfer into the wheelchair, using her walker. R19's bed linens were observed with stool and were wet with urine. Without donning gloves, NA-B pulled R19's linens from her bed, and rolled them into a ball on the bed. NA-B went into R19's bathroom and without washing her hands, donned a new pair of gloves. NA-B returned to R19's bed, picked up the soiled linens from the bed, and attempted to place them into the plastic bag on the floor, however, the plastic bag ripped and the contents fell on to the floor. NA-B removed her gloves, and without washing her hands, removed R19's gait belt and hung it on the hook on the back of the door,

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	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 99	F 441		

picked up R19's glasses on the bedside stand, and placed them on her face. NA-B went into the bathroom, retrieved a new plastic garbage bag, and with her bare hands, picked up the ripped garbage bag, gathered the soiled linens from the floor, and placed them inside the new bag. The white washcloth, covered with stool, remained on the floor. NA-B went into R19's bathroom and without washing her hands, donned a pair of gloves and picked up the soiled washcloth from the floor and put it into the bag. She removed her gloves and threw them into the bag. With her bare hands, NA-B tied the two plastic bags, put R19's foot pedals on the wheelchair, picked up the two plastic bags from the floor, touched the door handle, opened R19's door and walked in the hallway to the wooden receptacle to dispose of the two bags, touching the lids of the laundry and garbage bins. NA-B returned to R19's room, and without washing her hands, pushed R19 to the dining room for breakfast.

During an interview on 4/19/17, at 9:10 a.m., NA-B verified R19 was incontinent of stool and urine and stated, "That's why I stripped her bed." NA-B indicated she didn't notice any stool on her gloves and stated, "But I need to wash my hands more, be more conscious." NA-B stated she should have washed her hands or used hand sanitizer when she removed her gloves and before leaving R19's room. NA-B stated, "I've worked here a long time. Sometimes you just need reminders."

During an interview on 4/20/17, at 7:26 a.m., registered nurse (RN)-A stated, "I would bet that person [NA-B] didn't even think about it because they are just trying to get things done." RN-A indicated infection control, glove use, and hand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 441	Continued From page 100	F 441		

hygiene were discussed at staff meetings each month, but staff were not being observed for correct procedures. RN-A stated it would be beneficial to have someone audit and monitor glove use and hand hygiene, and to follow staff and educate, but stated, "It's a time thing."

When interviewed on 4/21/17, at 9:34 a.m., the director of nursing service (DNS) stated, "They do have to foam in and foam out, and they should wash hands when done with the residents." When asked if staff were directed to wash hands when changing gloves, DNS stated, "I think so, but I'm probably old school."

Review of the facility's policy, Handwashing, Gowns, Gloves, Masks and Goggles (For Home Health), revised 12/05, directed staff to use non-sterile gloves for procedures involving resident care where gloves are needed but where sterile technique is not required. The policy further directs, "Gloves will never be re-used or washed and will be discarded in the proper container in the resident's room." The policy did not include directions for appropriate glove use and hand hygiene.

During an observation on 4/18/17, at 3:44 p.m., registered nurse (RN)-B entered R16's room to check the blood glucose level. RN-B performed hand hygiene and donned gloves. RN-B wiped R16's finger with an alcohol wipe, poked the finger with a lancet, placed the lancet on R16's bed and obtained blood from the finger for the reading. RN-B then removed the gloves, placed the glucometer in a plastic container and placed it on a shelf in R16's room. RN-B grabbed the lancet with bare hands and brought it to the bathroom in R16's room, placing it on the edge of the sink. RN-B washed and dried her hands,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 441	Continued From page 101 picked up the used lancet with her right hand, wiped off the edge of the sink with the paper towel still in her left hand, exited R16's room, and placed the lancet in the sharps container. RN-B opened the laptop on top of the medication cart, touching it with both hands, grabbed a plastic cup and stated she was going to set up medications for the next resident. RN-B did not perform hand hygiene after disposing the lancet. When interviewed at this time, RN-B stated, this is typically how she handles the used lancets, placing it on the sink while washing her hands, and carries it with bare hands to the cart, placing it in the sharps container. RN-B stated she was unsure what the policy indicated related to hand hygiene and sharps. A policy for the disposal of contaminated sharps was requested, but not received.	F 441		
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and	F 520		5/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 520	Continued From page 102 (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assessment and Assurance (QAA) committee established an appropriate plan of action to address the identified lack of a comprehensive infection control program to include consistent tracking, trending, and analysis of illnesses and infections to prevent potential spread to others. In addition, the facility failed to establish an action plan to address the identified issues in the pressure ulcer program. This had the potential to affect all 34 residents who currently resided in the facility, staff, and visitors to the facility.	F 520	1.The Quality Committee has developed action plans that have been implemented for tracking, trending and providing analysis of illness and infections and pressure ulcer management. 2.All residents are at risk of this deficient practice. 3.Education was provided for the administrator and DNS on the QAPI policy and Quality Committee functions by the GSS Quality Improvement Consultant on 5-17-17. Facility QAA Committee is providing oversight of the Quality rounds	

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	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 520	Continued From page 103 Findings include: The facility's Quality Assessment and Assurance (QAA) committee met monthly and discussed potential concerns, however, the program lacked action plans that corrected identified problems and failed to monitor/sustain identified areas which lacked current standards. Although the lack of a comprehensive infection control program was previously identified as deficient during a past survey, and was identified by the facility administrator in December 2016 as not being completed, the QAA committee did not conduct a root cause analysis to determine why and what system failed in meeting the standards and failed to develop and implement an action plan to prevent a repeat event. See F441- Based on observation, interview, and document review, the facility failed to implement and maintain an infection control program to help prevent the development and transmission of infections. In addition, the facility failed to failure to follow the recommendations for hand hygiene and glove use for 1 of 4 residents (R19) observed for personal cares and 1 of 4 residents (R19) observed during a blood glucose check.. During an interview on 4/21/17, at 1:51 p.m. the administrator indicated the facility's infection control process included gathering and analyzing the information monthly and the information was brought to the QAA committee and to the safety committee meetings each month. The administrator stated, "I know that there has been a concern with getting things done on time," and indicated the infection control program had "changed hands a couple different times." The	F 520	and focus audit process on an on-going basis. Participating in the development of survey plan of correcting and follow up monitoring, reviewing suggestions or concerns on an on-going basis, and reviewing Safety/Incident reports and infection control reports and actions, on at least a quarterly basis. Facility QAA committee will determine if a performance improvement project is needed which will include a root cause analysis. 4.Monthly Audits X 2 quarters on QAA committee function which will include review of tracking, trending, and analysis of illness and infections and pressure ulcer management by the GSS Quality Performance Improvement Consultant. Results of these audits will be presented to the QAA Committee monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 520	Continued From page 104	F 520		

administrator indicated the infection control information had been "missing" since December, 2016. The administrator stated the facility had conducted infection control audits in the past, looking at proper handwashing, glove use, ensuring staff were free of communicable diseases, proper disposal of soiled laundry, and isolation procedures. The administrator stated the audits were given to a licensed practical nurse and she watched cares to ensure staff were consistently practicing current policies. The administrator indicated the infection control audits were "ongoing," however, no audits had been completed "in the last year or so."

During a telephone interview on 4/24/17, at 9:23 a.m. the facility's medical director (MD) stated the infection control program had not been identified as a concern at the QAA committee meetings. The MD indicated he was also the MD at another facility, and at that facility, he was provided a monthly report with the infections, but had not seen a monthly report from this facility. The MD stated this facility had an influenza outbreak recently and that information would be important, to know where the residents were in the facility and to manage their care, to prevent the spread of the infection and to prevent residents from needing hospitalization.

See F314 - Based on observation, interview, and document review, the facility failed to comprehensively assess, monitor, and treat pressure ulcers in order to heal current pressure ulcers and prevent further development of others for 3 or 3 residents (R17, R1, R10) who developed pressure ulcers while residing in the facility. This resulted in actual harm to R17 who developed new pressure ulcers to the heels and

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	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 520	Continued From page 105	F 520		

had worsening of a chronic coccyx pressure ulcer.

When interviewed on 4/20/17, at 8:34 a.m. RN-A stated the nurse working the medication and treatment cart was responsible for assessing the wound. She stated licensed practical nurses (LPN's) complete the wound data collection form and were expected to do measurements when collecting the data. RN-A stated it was not acceptable to have only two measurements of the wound from January 2017 to present RN-A stated she is not a "pro" so she does not stage the wounds, indicating she did not want to get it wrong and stated the facility does have a wound nurse who comes in to see residents. RN-A stated she had not received training on pressure ulcers, and had not asked for training, therefore, she was not comfortable in describing the wound. RN-A indicated all nurses had been informed they are to measure the wounds but stated it was not being done. RN-A stated she talked with the administrator about this, who informed her the nurses need to be held accountable for completing this or be written up. RN-A stated the current DNS was aware this was not being completed. RN-A indicated the prior DNS tried some things, but the administrator would not allow some of the things she wanted to try.

When interviewed on 4/21/17, at 1:09 p.m., the DNS stated the nurses are expected to do the wound and data collection tools. She stated the floor nurses do the collection, including the measurements and the registered nurses do the assessments. She stated the facility has a wound nurse who comes in weekly and completes the assessments and treatments and stated if the wound nurse was not in, the floor nurses were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 106 expected to get them done. The DNS stated RN-A was responsible for completing the weekly assessment and was expected to stage the pressure ulcers. The DNS denied any concerns being brought to her attention about the data collection and assessments not being completed Review of the facility's policy, QAPI [Quality Assurance Performance Improvement] Committee Functions, revised 3/16, indicated the activities of the committee included providing oversight of the quality rounds and focus audit process on an ongoing basis, participating in the development of survey plan of corrections and follow-up monitoring, reviewing suggestions or concerns on an ongoing basis, and reviewing safety/incident reports and infection control reports and actions, on at least a quarterly basis.	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/20/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society Redwood Falls was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/21/2017

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 St. Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Redwood Falls is a one-story building with no basement. The facility is fully fire sprinkler protected, and was determined to be of Type II(000) construction. The original building was constructed in 1962, with building additions in 1966 and 1975. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 43 beds and had a census of 34 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 353	Continued From page 2	K 353		
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to test and maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.3.2 & 14.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 43 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 04/20/2017 record review, observations and staff interview revealed the sprinkler gauges	K 353	1.The sprinkler gauge was replaced on 10/23/2012 and is not due until October 2017. Per Fire Marshall no action required at this time. 2.This will be completed September 30th 2017. 3.Environmental service director will be responsible for correction and monitoring to prevent reoccurrence.	5/27/17

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K 353	Continued From page 3 exceed their 5 year limit for calibration or replacement. This deficient conditions was confirmed by the Maintenance Supervisor.	K 353		
K 361 SS=E	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to maintain spaces open to the corridor as addressed in the Life Safety Code, NFPA 101 2012 edition section 19.3.6.1. This deficient practice could allow for smoke or fire to enter the corridor making it untenable for 20 of the 43 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 04/20/2017 observations and staff interview revealed the chapel in the west wing was open to the corridor and not protected with a smoke detector. This deficient conditions was confirmed by the Maintenance Supervisor.	K 361	1.A smoke detector was added to the chapel on the west side of the building. 2.This was completed on May 4th 2017. 3.Environmental service director will be responsible for correction and monitoring to prevent reoccurrence.	5/27/17