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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EJRW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00356

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245550**
2.STATE VENDOR OR MEDICAID NO.
(L2) **304842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WARREN**
(L4) **410 SOUTH MCKINLEY STREET**
(L5) **WARREN, MN** (L6) **56762**

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 **06/09/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (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: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE NEII 06/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/12/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/20/2015
(L33)

Posted 06/17/2015 Co.

DETERMINATION APPROVAL

CCN: 24-5550

This facility has been designated at a Special Focus Facility (SFF)

On June 9, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 10, 2015, the Minnesota Department of Public Safety completed a PCR to verify that the facility has achieved and maintained compliance with Federal certification deficiencies issued pursuant to a standard survey completed on April 9, 2015. We presumed, based on your plan of correction, that the facility had corrected the deficiencies. We have determined, based on our visit, that the facility has corrected the deficiencies issued pursuant to our standard survey completed on April 9, 2015, as of May 28, 2015.

As a result of the revisit findings, this Department discontinued the Category 1 remedy of State monitoring.

In addition, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in their letter of April 28, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

Discretionary denial of payment for new Medicare and Medicaid admissions effective June 9, 2015 be rescinded as of May 28, 2015. (42 CFR 488.417 (b))

Furthermore, since Discretionary denial of payment for new Medicare and Medicaid Admissions did not go into effect. The NATCEP prohibition is also rescinded.

Refer to the CMS 2567b forms for both health and life safety code.

Effective May 28, 2015, the facility is certified for 52 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245550

June 12, 2015

Ms. Rebecca Sorenson, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, Minnesota 56762

Dear Ms. Sorenson:

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 May 28, 2015 the above facility is certified for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

June 12, 2015

Ms. Rebecca Sorenson, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, Minnesota 56762

RE: Project Number S5550025

Dear Ms. Sorenson:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On April 23, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective April 28, 2015. (42 CFR 488.422)

On April 28, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedy was being imposed:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 9, 2015. (42 CFR 488.417 (b))

However, as CMS Region V Office notified you in their letter of April 28, 2015, 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 June 9, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on April 9, 2015. The most serious deficiency was found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On June 9, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 10, 2015, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 9, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 28, 2015. We have determined, based on our

visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 9, 2015, as of May 28, 2015.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 28, 2015.

In addition, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in their letter of April 28, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 9, 2015 be rescinded as of May 28, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the discretionary denial of payment for new Medicare admissions, effective June 9, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the discretionary denial of payment for all Medicaid admissions, effective June 9, 2015, is to be rescinded.

Furthermore, CMS Region V Office advised you in their letter of April 28, 2015, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 9, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 28, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

Mark Meath

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

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245550	A. Building B. Wing	6/9/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **05/12/2015**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **05/12/2015**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **05/12/2015**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **05/12/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/12/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **05/12/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **05/12/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/12/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	06/12/2015	18618	06/09/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/9/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245550	A. Building B. Wing **01 - MAIN BUILDING 01**	6/10/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **05/28/2015**	ID Prefix	Correction Completed **04/10/2015**	ID Prefix	Correction Completed **05/15/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0011		LSC K0017		LSC K0025	
ID Prefix	Correction Completed **04/14/2015**	ID Prefix	Correction Completed **05/28/2015**	ID Prefix	Correction Completed **04/20/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0029		LSC K0038		LSC K0047	
ID Prefix	Correction Completed **05/08/2015**	ID Prefix	Correction Completed **05/05/2015**	ID Prefix	Correction Completed **04/15/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0073		LSC K0147		LSC K0154	
ID Prefix	Correction Completed **04/15/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0155		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	06/12/2015	27200	06/10/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/8/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245550	A. Building B. Wing **02 - KITCHEN ADDTION**	6/10/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0154	**04/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0155	**04/15/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/mm	**Date:** 06/12/2015	**Signature of Surveyor:** 27200	**Date:** 06/10/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 4/8/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

June 12, 2015

Ms. Rebecca Sorenson, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, Minnesota 56762

RE: Project Number S5550025

Dear Ms. Sorenson:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On April 23, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective April 28, 2015. (42 CFR 488.422)

On April 28, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedy was being imposed:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 9, 2015. (42 CFR 488.417 (b))

However, as CMS Region V Office notified you in their letter of April 28, 2015, 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 June 9, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on April 9, 2015. The most serious deficiency was found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On June 9, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 10, 2015, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 9, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 28, 2015. We have determined, based on our

visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 9, 2015, as of May 28, 2015.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 28, 2015.

In addition, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in their letter of April 28, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 9, 2015 be rescinded as of May 28, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the discretionary denial of payment for new Medicare admissions, effective June 9, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the discretionary denial of payment for all Medicaid admissions, effective June 9, 2015, is to be rescinded.

Furthermore, CMS Region V Office advised you in their letter of April 28, 2015, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 9, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 28, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

Mark Meath

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

Enclosure

cc: Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00356	A. Building B. Wing	6/9/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20430** Reg. # **MN Rule 4658.0210 Subp. 1** LSC	Correction Completed **05/12/2015**	ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp. 2** LSC	Correction Completed **05/12/2015**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **05/12/2015**
ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp. 4 A-I** LSC	Correction Completed **05/12/2015**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Subd. 3** LSC	Correction Completed **05/12/2015**	ID Prefix **21540** Reg. # **MN Rule 4658.1315 Subp. 2** LSC	Correction Completed **05/12/2015**
ID Prefix **21565** Reg. # **MN Rule 4658.1325 Subp. 4** LSC	Correction Completed **05/12/2015**	ID Prefix **21880** Reg. # **MN St. Statute 144.651 Subd. 2** LSC	Correction Completed **05/12/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	06/12/2015	18618	06/09/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/9/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EJRW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00356

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245550**
2.STATE VENDOR OR MEDICAID NO.
(L2) **304842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WARREN**
(L4) **410 SOUTH MCKINLEY STREET**
(L5) **WARREN, MN** (L6) **56762**

4. TYPE OF ACTION: **9** (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 **04/09/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Pat Sheehan, Supervisor SFM 05/15/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/02/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/20/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5550

This facility has been designated at a Special Focus Facility (SFF)

The facility has submitted an amended completion date for the following life safety code (LSC) deficiencies:

-LSC deficiency cited at K011 with an original completion date of April 18, 2015 has been amended, with a completion date of May 28, 2015

-LSC deficiency cited at K038 with an original completion date of May 15, 2015 has been amended, with a completion date of May 28, 2015.

Refer to the following CMS 2567 for details of the amendments.

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

F5550025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/08/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET WARREN, MN 56762**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Good Samaritan Society Warren 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	5-13-15 POC ok TR Amended 5-18-15 for new POC of 5-28-15 for K11 + K38 RECEIVED MAY - 8 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

No opportunity to correct DC: 5-27-14
EXIT: 4-9

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca Soenson — TITLE: Administrator — (X6) DATE: 5-5-15

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Facility was inspected as 2 buildings: Good Samaritan Society Warren (Marshal Manor) was built in 1968 as a 1-story building without a basement and was determined to be Type II (111) construction. In 1973 a 1-story addition was constructed to the east of the original building and was determined to be Type II (000) construction. In 2010 a kitchen addition was constructed to the north of the original building's dining room. It is 1-story, no basement and Type II(000) construction. In 2013 a connecting link was constructed to the east connecting the new hospital with the facility. This addition is i-1story , no basement and Type II(000) construction. The building is divided into 6 smoke zones with 1/2 hour fire rated barriers. An apartment building is attached to the southwest wing that is separated with a 2-hour fire barrier.	K 000		

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K 000	Continued From page 2 The facility is completely protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code (1999 edition) with automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 52 beds and had a census of 46 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 2 two hour fire separations that were found not in compliance with NFPA 101	K 011		

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K 011	Continued From page 3 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1 and 19.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect all of the residents, staff and visitors of the facility. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, observations revealed that the 2 hour fire separation located by room 114, had a gap between the double doors that is greater than 1/4 of an inch. This deficient condition was verified by the Maintenance Supervisor.	K 011		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017		

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K 017	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility had penetrations located throughout the facility that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for 6 of 52 residents, staff and visitors. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, observations revealed, that there were two holes found in the ceiling tile that is located by room 200C. This deficient condition was verified by the Maintenance Supervisor.	K 017		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems.	K 025		

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K 025	Continued From page 5 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of several smoke barrier walls construction that meet the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect residents, staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, observation revealed that there are penetrations in the smoke barrier wall caused by two HVAC flexible ducts passing through the smoke barrier wall above the ceiling tile located by room 300B. This deficient condition was verified by the Maintenance Supervisor.	K 025		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed	K 029		

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K 029	Continued From page 6 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, observation revealed that Room 112 a resident room converted into a storage room which is greater than 50 square feet has a door that is not equipped with a self-closing device. This deficient condition was verified by the Maintenance Supervisor.	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

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K 038	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a hard surfaced path to the public way for 1 of several means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2.1 and 7.2.1.5.4, 7.2.1.6.1(d), 7.7.2 (1) and the 2007 MN State Fire Code, Appendix I. The deficient practice could affect residents, staff, and visitors. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, observation revealed that the required exit located by room 114 did not have a hard surface path leading to the public way This deficient condition was verified by the Maintenance Supervisor.	K 038		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide 1 of several operational exit signs that marks the means of egress path in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.5.2. The	K 047		

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K 047	Continued From page 8 deficient practice could affect residents, staff and visitors, if the lack of properly illuminated exit sign prevented a means of egress from being utilized in a timely manner in an emergency situation. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, it was observed that the exit sign above the exit door located by room 114 was not located in a way that is observable from the corridor. This exit sign needs to be moved so that it can be seen clearly from the corridor and the directional indicator pointing to the required exit. This deficient condition was verified by the Maintenance Supervisor.	K 047		
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain combustible decoration in accordance with NFPA Life Safety Code 101 (00) section 19.7.5.4. The failure to treat and maintain the combustible decorations throughout the facility in accordance with NFPA Life Safety Code 101 (00) could allow smoke and fire to rapidly migrate through the corridors and negatively affect the egress capability in the event of an emergency for residents, visitors and staff of the facility.	K 073		

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K 073	Continued From page 9 Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, observations revealed that numerous decorations throughout the facility are being hung on the corridor side of the resident room doors that couldn't be verified as being treated with a fire retardant treatment. This deficient condition was verified by the Maintenance Supervisor.	K 073		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility was using unapproved electrical devices that are not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of residents, staff and visitors. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, observations revealed that there is an excessive amount of storage in front of, and around the main electrical panels that are located in the boiler room.	K 147		

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K 147	Continued From page 10 This deficient condition was verified by the Maintenance Supervisor.	K 147		
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1' This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire sprinkler system out of service policy to include the triggering criteria, and contact information in the event of the fire sprinkler being out of service and	K 154		

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K 154	Continued From page 11 the need for a fire watch to be initiated This deficient condition was verified by the Maintenance Supervisor.	K 154		
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, during record review and an interview with the Maintenance Supervisor, the facility failed to update and provide a complete list of contact information on the automatic fire alarm	K 155		

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K 155	Continued From page 12 system out of service policy. The policy was lacking any contact information for the Deputy State Fire Marshal. This deficient condition was verified by the Maintenance Supervisor.	K 155		

Bldg 1

K011

1. Smoke sweeps were applied to the identified gap of the 2 hour fire barrier identified in 2567.
2. Actual Correction Date: April 18th, 2015.
3. Responsible Party for completion: ICON Architects, Inc.

K017

1. Ceiling tile identified in 2567 was replaced.
2. Actual Correction Date: April 10th, 2015.
3. Responsible party for completion: Director of Environmental Services

K025

1. Two smoke dampers will be installed into area identified in 2567.
2. Proposed Correction Date: May 15th, 2015.
3. Responsible party for completion: Director of Environmental Services

K029

1. Self-closing device was installed onto door of room 112.
2. Actual Correction Date: April 14th, 2015.
3. Responsible party for completion: Director of Environmental Services

K038

1. A hard surface path leading to the public way will be installed.
2. Proposed Correction Date: May 15th, 2015
3. Responsible party for completion: ICON Architects, Inc.

K047

1. The exit sign was moved so that it can be seen clearly from the corridor, with the directional indicator pointing to the exit.
2. Actual Completion Date: April 20th, 2015
3. Responsible party for completion: ICON Architects, Inc.

K073

1. Removed door decorations throughout facility that are on corridor side of resident room doors, unless they have been verified as being treated with a fire retardant treatment. Developed and implemented a new policy for residents and family members to be educated at admission regarding door décor.
2. Proposed Correction Date: May 8th, 2015.
3. Responsible party for completion: Activities & Environmental Services

K147

1. Removed storage items in front of and around the main electrical panels in the boiler room.
2. Actual Completion Date: May 5th, 2015.
3. Responsible party for completion: Director of Environmental Services

K154

1. Fire sprinkler system out of service policy updated to include the triggering criteria and contact info in the event the fire sprinkler is out of service and the need for a fire watch to be initiated.
2. Actual Correction Date: April 15th, 2015
3. Responsible party for completion: Administrator

K155

1. Contact information on the automatic fire Alarm system out of service policy has been Updated with correct information, including Contact information for the Deputy State Fire Marshal.
2. Actual Correction Date: April 15th, 2015
3. Responsible party for completion: Administrator

Sheehan, Pat (DPS)

From: Rebecca Sorenson <rsorens4@good-sam.com>
Sent: Friday, May 15, 2015 1:16 PM
To: Sheehan, Pat (DPS)
Cc: Anderson, James A (DPS); Whitney, Marian (DPS)
Subject: POC extension

Mr. Sheehan,

In our plan of correction for our survey dated April 8, 2015 we had listed today, May 15th, as the completion date for two of our D-level deficiencies, K038 and K011. Due to unforeseen circumstances, we are asking for an extension to this completion date.

1) The cement sidewalks have not been able to be poured, due to the continuous rainfall throughout this week and last week. We will have this project complete on or before May 28th, 2015.
2) The smoke dampers have taken longer than the vendor anticipated to come into stock. They are scheduled to arrive on May 21st-22nd and we anticipate having this project complete on or before May 28th, 2015.

I apologize for the need to modify our plan of correction. Please contact me if you need further information.

Becky Sorenson, Administrator
Good Samaritan Society-Warren
410 S McKinley St
Warren, MN 56762
218-745-5282 office
218-242-5901 cell

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EJRW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00356

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245550**

2.STATE VENDOR OR MEDICAID NO.
(L2) **304842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WARREN**
(L4) **410 SOUTH MCKINLEY STREET**
(L5) **WARREN, MN** (L6) **56762**

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 **04/09/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Viennea Andresen, HFE NEII — 05/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 05/20/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(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 05/20/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5550

This facility has been designated as a Special Focus Facility (SFF)

At the time of the April 9, 2015 survey the facility was not in substantial compliance with Federal participation requirements. The most serious deficiency area widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F). Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0259

April 23, 2015

Ms. Rebecca Sorenson, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, Minnesota 56762

RE: Project Number S5550025

Dear Ms. Sorenson:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On April 9, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

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

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

<u>Plan of Correction</u> - 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:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

Because your facility is designated as a Special Focus Facility (SFF). CMS's policy of progressive enforcement means that your facility would not be given an opportunity to correct before remedies are imposed. Since your facility meets the criterion remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective April 28, 2015. (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 F441, effective April 9, 2015. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, and appeal rights.

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 PoC 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 PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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 9, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 9, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

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
	245550	A. BUILDING _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 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	RECEIVED MAY - 8 2015 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 166 SS=D	This is a Special Focus Facility (SFF) 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to investigate and promptly resolve a grievance related to missing personal property and oral hygiene for 1 of 1 residents (R27) reviewed for personal property. Findings include: R27's annual Minimum Data Set dated 1/21/15, identified she had significant cognitive	F 166	POC on attachment Approved 5/8/15 SD	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca Sorenson | TITLE: Administrator | (X6) DATE: 5-5-15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 166	Continued From page 1 impairment, and diagnoses which included but were not limited to dementia, anxiety, and depression. On 4/07/2015, at 11:21 a.m. family member (FM)-B, who was the daughter of R27, was interviewed and stated that she had provided the facility a written grievance related to missing clothing, dirty clothes being found in R27's closet, and lack of oral care for R27 on 3/27/15, and the facility had not acknowledged and followed up on the grievance. A Suggestion or Concern form dated 3/27/15, was provided by the administrator and it identified that (FM)-B had made a written grievance on 3/27/15, which identified the following for R27: -missing clothing including two pairs of slacks, olive green and blue denim; -two missing shirts; -dirty clothes found in R27's closet, and another residents clothes were found in R27's closet; and -R27 lacked appropriate oral care. The response to the grievance was made by the facility administrator dated 3/30/15, and identified that instead of contacting the FM-B who made the written grievance, the administrator spoke with FM-C (a different daughter to R27 who was an employee of the facility). FM-C stated that there was lint on a velour jacket and FM-B was "obsessed" with R27's clothing, and the missing slacks were found and returned. There was no evidence that the facility administrator spoke to FM-B who had made the written grievance, and attempted to resolve all of the grievances FM-B had made.	F 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 166	Continued From page 2 During interview with the administrator on 4/08/2015, at 11:09 a.m. she established she was in charge of following up on all grievances due to the facility not currently having a social worker. The administrator confirmed she had not spoken to FM-B regarding her grievances, but rather spoke to FM-C who thought that the only concern was related to lint on R27's velour jacket. The administrator stated she should have followed the facility's policy for grievances and contacted FM-B and made an attempt to resolve FM-B's grievances. The policy and procedure for Grievances, Complaints or Concerns dated February 2013, was reviewed and identified the following: "An investigation must be completed on all grievances. The investigation may be informal, but must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint...The social services director then will report the findings to the individuals filing the concern and to the center administrator."	F 166		
F 176 SS=E	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by:	F 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 176	Continued From page 3 Based on observation, interview, and document review, the facility failed to determine if the practice of self-administration of medications was safe for 4 of 4 residents (R45, R1, R17, R46) in the sample who were observed self-administering medications. Findings include: R45's quarterly Minimum Data Set (MDS) dated 3/11/15, indicated R45 was alert and orientated and had diagnoses including anemia, diabetes mellitus and Bell's palsy. The care plan dated 4/8/15, did not address self-administration of medication. On 4/6/15, at 5:49 p.m. R45 was observed seated at a dining room table with three tablemates. Registered nurse (RN)-B approached R45 with a souffle cup of medications and eye drops. RN-B then placed the souffle cup of unknown medications on the table and walked away. At no time was RN-B observed to monitor R45 as he took the medications. R45's physician orders dated 3/26/15, lacked an order to self-administer mediations. R45's clinical record lacked a self-administration of medication assessment. R1's annual MDS dated 1/14/15, identified R1 with diagnoses of anemia, hypertension and depression. The MDS indicated R1 was alert and	F 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 176	Continued From page 4 oriented. The care plan dated 5/13/14, directed the staff to administer medications as ordered. The care plan did not indicate R1 had the ability to self-administer medications. On 4/6/15, at 6:15 p.m. R1 was observed seated in the dining room. RN-B was observed to approach R1 with a souffle cup of unknown medications. RN-B gave the medications to R1 and then walked away. R1 took the medications on her own. At no time did RN-B observe R1 to ensure she had taken the medications safely. R1's physician orders dated 4/8/15, did not include an order for self-administration of medications. R1's clinical record lacked a self-administration as medication assessment. R17's quarterly MDS dated 2/18/15, indicated R17 was alert and oriented and had diagnoses including congestive heart failure and depression. The care plan dated 4/8/15, did not address self-administration of medications. On 4/6/15, at 5:50 p.m. R17 was observed seated in the dining room. RN-B approached R17 with a souffle cup of medications. She placed the medications on the table and walked away. RN-B was not observed to stay with R17 until she had	F 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	04/09/2015

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GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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F 176	Continued From page 5 taken the medications. R17 was observed to take the medications independently. The physician order dated 4/7/15, did not address self-administration of the medications. R17's clinical record lacked a self-administration assessment. On 4/8/15, at 11:30 a.m. RN-A stated none of the residents in the facility were safe to administer their own medications. She stated the staff administering the medications were to stay with the residents to ensure they had taken all of the medications. On 4/8/15, at 2:00 p.m. the director of nursing (DON) stated none of the residents in the facility were able to self-administer their medications. She verified the staff were to stay with the residents while they received medications. R46's quarterly MDS dated 3/15/15, indicated R46 had short-term and long-term memory problems, and the following diagnoses: dementia, hypertension, diabetes mellitus and atrial fibrillation (irregular heartbeat). R46 was observed on 04/06/15, at 5:51 p.m. seated in a wheelchair next to a table in the dining room. At that time, trained medication aide (TMA)-A delivered R46's medications in a medication cup, set the medications down on the table in front of R46, then walked away. TMA-A immediately went to assist another resident prepare for the evening meal. At 5:55 p.m. TMA-A answered the telephone, then started	F 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	04/09/2015

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F 176	Continued From page 6 feeding another resident the evening meal. TMA-A did not stay to observe R46 take the medications. At 6:04 p.m. R46 sat alone at the table, then started putting the medications into his mouth with right hand, one by one until the medication cup was empty. R46's Medication Administration Record (MAR) dated 4/6/15, indicated (TMA)-A had administered Coumadin 3 mg, Lipitor 10 mg, Glipizide 5 mg and Metoprolol 50 mg for p.m. medications. R46's physician orders dated 3/18/15, did not include an order for self-administration of medications. On 04/09/15, at 1:39 p.m. the DON confirmed R46 had not been assessed to self-administer medications and did not have a physician order to self-administer medications. The DON stated R46 would not be safe or appropriate to administer own medications, and stated the staff member should have stayed with the resident until the medications taken. The Resident Self-Administration of Medication procedure dated 7/2014, directed the staff to ensure any resident who wished to self-administer their medications to be assessed by the interdisciplinary team and have a current physician's order prior to self-administering the medications.	F 176		

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F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a bed of adequate size for 1 of 1 resident (R46) who had requested a larger bed. Findings include: R46's quarterly Minimum Data Set (MDS) dated 3/15/15, identified R46 as an individual with severe cognitive impairments and diagnoses including dementia, status post stroke and diabetes mellitus. The MDS indicated R46 required extensive assistance of one staff with bed mobility and transfers, and was 72 inches tall (six feet). On 4/6/15, at 7:00 p.m. R46 approached the state agency staff and informed her that his bed was too short. He reported he had expressed the concern to the director of nurses (DON). On 4/9/15, at 9:00 a.m. R46 approached a second state agency staff member and reported his bed was too short. He explained his back was sore because his feet routinely were off of the bed at night.	F 246		

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F 246	Continued From page 8 On 4/9/15, at 10:30 a.m. R46 approached a third state agency staff member and reported his bed was too short. He stated he had received a new bed but that one was too short. On 4/9/15, at 10:35 a.m. registered nurse (RN)-B assisted R46 to bed. R46's bed was not equipped with a foot board. When positioned flat in the bed R46 appeared to have 2-3 inches at the head and the foot of the bed. However, R46 stated he slept with the head of the bed elevated. R46 was observed to raise the head of the bed. When he did this, his body slid down in the bed causing his feet to extend over the end of the bed. R46 stated his feet hung over the end of the bed nightly because the bed was too short. The care plan dated 4/8/15, did not address any concerns related to a short bed. The progress notes from 2/1/15 - 4/8/15, did not address any concern related to R46's comfort while in bed. On 4/9/15 at 11:30 a.m. the maintenance director stated he was aware R46 had expressed concerns about the length of his bed. He stated in the past month, R46 had a "bed extender" placed on his bed which he had removed and "thrown out his door." He had also had a different bed placed in his room which he refused. The maintenance director measured the bed and stated it was 79 inches long. He confirmed no other adjustments for the bed had been completed. On 4/9/15, at 11:40 a.m. RN-A stated R46 had	F 246		

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F 246	Continued From page 9 expressed concerns with the bed length about two weeks ago and had been offered a bed extender which he refused. She reviewed R46's record and confirmed the record lacked documentation related to the concern and no further attempts to satisfy R46's request had been made. On 4/9/15, at 2:10 p.m. the DON stated she was aware R46 had expressed concerns about his bed. She indicated R46 had been offered a bed extender and a different bed which were both rejected by R46. She confirmed she was aware R46 had expressed dissatisfaction with his bed, yet no further attempts to improve his bed had been attempted. She stated R46 may benefit from an occupational therapy evaluation, but confirmed an assessment of his bed needs had not been completed. The DON reviewed R46's record and confirmed the record lacked documentation related to the two attempts the facility had made to satisfy R46's concerns with his bed, nor had they attempted to comprehensively assess R46's needs. The Accommodation of Resident Need policy dated 2/2013, directed the staff to ensure the resident had the right to reside and receive services in the center with reasonable be accommodations of individual needs and preferences.	F 246		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		

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F 279	Continued From page 10 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop a plan of care with interventions and measurable goals for the care and treatment of a pressure ulcer for 1 of 3 (R48) residents who had developed a pressure ulcer. Findings Include: R48's Minimum Data Set (MDS) dated 3/4/15, indicated R48 was cognitively intact, required extensive assist of one staff with transfers and bed mobility. R48 was at risk for development of pressure ulcers and had pressure reducing devices for chair and bed. R48's Diagnosis List dated 2/25/15, identified	F 279		

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F 279	Continued From page 11 R48's diagnoses as diabetes type II, coronary atherosclerosis, chronic airway obstruction, pressure ulcer buttock, lower limb amputation, below knee, and lower limb amputation, above the knee. R48's Braden Scale (tool used to predict pressure ulcer risk) dated 3/11/15, indicated R48 was at risk for pressure ulcers. R48's physician order dated 3/19/15, indicated: cleanse wound with wound cleanser and apply hydrocolloid dressing to pressure ulcer on right buttock crease. Change dressing daily and as needed in the afternoon related to pressure ulcer right buttock. R48's Daily Skilled Note dated 3/19/15, indicated R48 was being observed for skin and/or extremity issues, potential complications/risks, and interventions for wounds/ulcers (pressure ulcer). R48's Wound Data Collection form dated 4/1/15, indicated: pressure ulcer to right buttock, length 0.5 centimeters (cm) width 0.5 cm, with no undermining. On 04/08/2015, at 11:48 a.m. registered nurse (RN)-A verified R48 had developed a pressure ulcer and R48's care plan did not address his pressure ulcer or interventions. RN- A further stated, "The pressure ulcer should have been added to the care plan when it was discovered. It should identify the problem, goals and what interventions would be implemented." On 04/08/2015, at 12:23 p.m. the director of nursing confirmed her expectations were for staff to develop, follow and revise each residents' care plan to meet the individual needs of each resident.	F 279		

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F 279	Continued From page 12 The facility Care Plan Policy issued 9/12, indicated, "Each resident will have an individualized comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional spiritual, emotional, psychosocial and educational needs."	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services according to the care plan to minimize falls for 1 of 3 residents (R22) reviewed for accidents. Findings include: R22's diagnoses included Alzheimer's disease and a healing traumatic fracture of the right hip. R22's Fall Care Area Assessment (CAA) dated 3/25/15, revealed the following: R22 had fallen related to slipping while wearing socks with no shoes, had intermittent confusion which resulted in a risk for falls, and had been using the call light appropriately.	F 282		

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F 282	Continued From page 13 R22's care plan dated 4/7/15, identified R22 was at risk for falls. Interventions for minimization of falls for R22 directed staff to have frequently used items within R22's reach, to ensure pathways were free from clutter and spills, and to have a call light within reach at all times. On 4/8/15, at 2:26 p.m. R22 was observed lying in bed, eyes closed. R22's push-button call light was observed clipped to the room's privacy curtain which hung near the foot of R22's bed, and out of R22's reach. On 4/8/15, at 2:28 p.m. the director of nursing (DON) confirmed with the surveyor that R22's call light was not within reach. DON then removed the call button from the privacy curtain and clipped it to R22's blanket at the top edge, within R22's reach. The facility Care Plan Policy dated 9/12, directed that each resident would have an individualized care plan for facility staff to follow to meet the residents' needs. The policy further directs the care plan is to be utilized to direct the necessary care and services for the residents to maintain their highest well-being.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		

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F 323	Continued From page 14 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to minimize falls related to improper call light placement for 1 of 3 residents (R22) reviewed for accidents. Findings include: R22's diagnoses included Alzheimer's disease and a healing traumatic fracture of the right hip. R22 had also been admitted to hospice related to end-stage heart disease. R22's Fall Care Area Assessment (CAA) dated 3/25/15, revealed the following: R22 had fallen related to slipping while wearing socks with no shoes, had intermittent confusion which resulted in a risk for falls, and R22 had been using the call light appropriately. R22's Cognition CAA dated 3/25/15, identified R22 was moderately cognitively intact. R22's Activities of Daily Living (ADL) CAA identified a recent hospitalization due to a fall which resulted in a right hip fracture, and dependence on staff for toileting, transferring and mobility. The CAA further revealed R22 had poor balance and received physical and occupational therapy to regain function and safety. R22's care plan dated 4/7/15, identified R22 was	F 323		

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F 323	Continued From page 15 at risk for falls. Interventions for minimization of falls for R22 directed staff to have frequently used items within R22's reach, to ensure pathways were free from clutter and spills, and to have a call light within reach at all times A facility Incident Report dated 3/8/15, at 8:20 p.m. revealed R22 had fallen while in stocking feet. The Fall Scene Investigation revealed R22 had been up to the toilet independently and fell while looking through a dresser. The corrective action at the time was to encourage R22 to use the call light before rising. A facility fall risk assessment and analysis, dated 3/8/15, the day of R22's fall, revealed R22 was at risk for falls related to a recent fall, the use of diuretics, frequent incontinence of bowel and bladder and loss of balance with standing. Interventions documented for R22 were: instructed to wear shoes or gripper socks and use the call light to call for assistance before standing. On 4/8/15, at 2:26 p.m. R22 was observed lying in bed, eyes closed. R22's push-button call light was observed clipped to the room's privacy curtain which hung near the foot of R22's bed, and out of R22's reach. On 4/8/15, at 2:28 p.m. the director of nursing (DON) confirmed with the surveyor that R22's call light was not within reach. DON then removed the call button from the privacy curtain and clipped it to R22's blanket at the top edge, within R22's reach. On 4/9/15, at 9:07 a.m. registered nurse (RN)-A stated it would be a "standard of practice" for R22	F 323		

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F 323	Continued From page 16 to have ability to call for assistance. On 4/9/15, at 11:41 a.m. the DON confirmed R22's care plan, and verified it would be expected to have a call light within reach at all times. The facility policy titled, Prevention Management of Falls, dated 9/2012, directed implementation of interventions, including adequate supervision consistent with resident needs, goals, plan of care and current standards of practice were required in order to reduce the risk of an accident.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure adequate indications for the use of psychoactive medications and/or appropriate monitoring of resident mood/behavior to determine efficacy for 3 of 5 residents (R32, R29, R33) reviewed for unnecessary medications. Findings include: R32's behaviors were not monitored following medication changes and target behaviors nor the indication for the use of multiple antidepressants and antipsychotic medication was identified. R32's quarterly MDS dated 3/23/15, identified R32 as having mild cognitive impairment and diagnosis including multiple sclerosis, depression, psychosis and delusional disorder. The MDS indicated R32 expressed mood concerns about feeling down, having little energy, trouble concentrating and trouble falling asleep. The MDS also indicated R32 had not displayed behavior concerns during the assessment period but had received antipsychotic and antidepressant medications daily, and required extensive to total assistance of one to two staff members with all activities of daily living. The Psychotropic Medication Care Area	F 329		

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F 329	Continued From page 18 Assessment (CAA) following the last annual MDS dated 7/24/14, indicated R32 received antidepressant and antipsychotic medications and was followed by the psychiatric center. The care plan dated 8/13/14, indicated R32 had major depressive disorder, psychotropic disorder with delusion evidenced by cognitive impairments and confusion which varied from day to day and hour to hour. The care plan directed the staff to encourage non pharmacological interventions such as activities and to contact the family if concerns were identified. The care plan did not identify or describe R32's behaviors which required multiple antidepressant or antipsychotic medications. On 3/6/15, from 3:00 p.m. to 8:00 p.m., on 3/7/15, from 8:00 a.m. to 4:30 p.m., on 3/8/15, from 7:00 a.m. to 3:30 p.m. and on 3/9/15, from 8:00 a.m. to 4:00 p.m. R32 was observed to be totally dependent upon staff for all activities of daily living. She was observed to sleep in her wheelchair when out of her room. She responded to staff questions and was able to follow a conversation, however, she would frequently fall asleep during the conversations. R32 was observed to have a very flat affect. The physician orders dated 4/9/15, included the following medications: - Buspar (antidepressant medication) 15 mg three times a day - started on 7/18/14. - Cymbalta (antidepressant medication) 60 milligrams one a day order dated 5/1/14.	F 329		

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F 329	Continued From page 19 - Remeron (antidepressant medication) 30 mg at bedtime. The order had been decreased on 12/19/14, from 45 mg per day. - Risperdal (antipsychotic medication) 1 mg at bedtime. The medication had been decreased on 2/12/15, from 0.5 mg in the morning and 1 mg in the evening. - Wellbutrin XL (antidepressant medication) 150 mg every morning. The medication had been decreased on 2/12/15, from 300 mg to 150 mg daily. The psychiatric clinic referrals indicated the following information: - 10/21/14, indicated R32 slept about 60% of the 30 minute evaluation. Risperdal decreased to 0.5 mg in a.m. and 1 mg at bedtime. The note identified R32's diagnoses but did not justify the use of multiple antidepressant medications. -12/2/14, indicated the Risperdal had been decreased on 12/2/14. However, the clinic referral lacked indication as to why R32 required four different antidepressant medications and an antipsychotic medication. - 2/12/15, indicated the Risperdal had been decreased further to 1 mg at bedtime and the Wellbutrin had been reduced to 150 mg a day. The note indicated R32 was cooperative "when awake." The progress notes from 1/1/15 - 4/8/15, indicated the nursing staff would document what medications R32 was receiving but at no time would they indicate what type of mood/behaviors R32 displayed. In addition, the clinical record did not address R32's medication reduction nor did it	F 329		

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	245550	A. BUILDING _____ B. WING _____	04/09/2015

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F 329	Continued From page 20 indicate any type of potential behavioral changes in relationship to the medication changes. The behavior documentation from 12/1/14 - 4/8/15, revealed R32 had not displayed any type of behaviors. On 4/8/15, at 11:10 a.m. registered nurse (RN)-A stated R32 slept much of the time and did not initiate conversations. She stated R32 had a very flat affect. On 4/8/15, at 11:50 p.m. licensed practical nurse (LPN)-B stated R32 did not display any type of behaviors and could not recall R32 displaying any type of adverse behaviors. On 4/8/15, at 12:50 p.m. nursing assistant (NA)-E stated R32 did not display behaviors. She stated R32 frequently slept in her chair. On 4/8/15, at 2:00 p.m. the DON stated R32 did not display behaviors. She stated anytime a resident had an antidepressant or antipsychotic medication change, the staff were to document on the resident's behaviors weekly for 8 weeks to determine how the resident was responding to the medication change. She reviewed R32's record and confirmed the record lacked documentation related to the medication changes and how R32 had responded to the medication changes. She verified the staff had not followed the system to ensure qualitative behavior monitoring. She stated all of the residents in the	F 329		

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F 329	Continued From page 21 facility who received psychotropic medications were to be reviewed monthly by the nursing staff. The DON added the facility did not currently have a medication reduction committee. R29's mood and behaviors were not monitored following medication changes. In addition, target behaviors and indication for the use of psychoactive medications were not identified. The annual MDS dated 1/12/15, identified R29 as an alert and oriented individual with diagnoses including depression, insomnia and hypertension. The MDS also indicated R29 required extensive assistance with activities of daily living and occasionally expressed feeling down, depressed hopeless and having trouble falling asleep. The Psychotropic CAA dated 1/15/14, indicated R29 received medications daily for the treatment of depression and R29's mood and behavior was monitored daily. The care plan dated 5/17/14, indicated the resident had a history of feeling down or depressed and directed the staff to contact the family as personal needs arose and attempt to change the subject if R29 appeared depressed. The plan directed the staff to encourage the resident to talk about past life interests such as gardening, dewing, baking and her family. The physician orders dated 1/28/15, included an order for Risperdal (antipsychotic medication). On 1/29/15, the Risperdal was decreased from	F 329		

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F 329	Continued From page 22 0.5 mg in the morning and 1 mg at bedtime to 0.5 mg twice a day. The physician had directed the staff to monitor R29's behavior once a week to monitor for adverse side effects. On 4/6/15, from 4:00 p.m. to 8:00 p.m., on 4/7/15, from 8:00 a.m. to 4:30 p.m., on 4/8/15, from 7:00 a.m. to 3:00 p.m. and on 4/9/15, from 8:00 a.m. to 2:00 p.m. R29 was observed to eat her meals in the dining room, participated in activities and had quiet time alone in her room. At no time was R29 observed to display any type of disruptive behaviors. The physician visit notes dated 11/25/14, and 1/28/15, did not address R29's mood or behaviors. The behavior documentation from 12/1/14 - 4/8/15, indicated R29 had not expressed any type of maladaptive behaviors. The progress notes from 12/1/14 - 4/8/15, indicated on 1/14/15, R29 talked to the staff about an accident from the past in which a girl and family had passed away. A note on 4/1/15, the nurse staff repeated R29's current Risperdal order and indicated they would monitor for behaviors. However, the clinical record lacked identification of what type of behaviors R29 displayed, why Risperdal was being used and identification of the goals as to what the Risperdal was to improve.	F 329		

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F 329	Continued From page 23 On 4/8/15, at 12:50 p.m. NA-E stated R29 had displayed behaviors in the past in which she would see people looking into her windows. She stated R29 did not currently display any behaviors. On 4/8/15, at 1:50 p.m. RN-A stated R29 displayed behaviors of telling false stories in the past. She confirmed R29's record did not identify this as a behavior, nor did the record include justification as to why Risperdal was appropriate for R29. On 4/8/15, at 2:05 p.m. the DON stated R29's target behaviors were to be easily identified in the record and on the care plan. She confirmed the care plan did not identify the behaviors, and the behavior documentation did not address R29's behaviors of past life fears. She confirmed R29 had received a medication reduction and the staff were to be documenting how the medication change was effecting R29 but confirmed the record lacked documentation. She stated the facility had a behavior committee but it had disbanded. R33 lacked clinical indications for the use of an antipsychotic and antidepressant medication and behavior/mood monitoring to determine efficacy of the medications. The quarterly MDS dated 2/16/15, identified R33 had severely impaired cognition, had no behaviors during the assessment period and required extensive assistance for all activities of daily living. The MDS indicated R33's diagnoses	F 329		

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F 329	Continued From page 24 included: dementia with delusional features, anxiety and depression. R33's current medication orders dated 4/2015, identified R33 received Zoloft (an antidepressant medication) 50 mg daily, with a start date of 10/31/14, and Seroquel (an antipsychotic medication) 25 mg daily, with a start date of 11/14/14. On 4/8/15, at 7:09 a.m. R33 was observed dressed for the day and seated in a wheelchair next to the nurses station, with her head lowered, eyes closed and legs crossed. R33 appeared to be sleeping. At 7:33 a.m. R33 was at the dining room table with her head lowered, eyes closed, arms crossed in front of her chest and eyes closed. R33 appeared to be sleeping. At 7:44 a.m. R33 was still sleeping at the dining room table. R33's care plan dated 9/3/14, lacked identification of the use of an antipsychotic and antidepressant medications, the target behaviors displayed by the resident, any non pharmacological interventions, or possible side effects of the medications. The progress notes from 1/1/15 - 4/9/15, indicated the nursing staff would document the targeted behaviors and as needed medication use for R33's Ativan (anti anxiety medication), but lacked documentation of the Zoloft and Seroquel targeted behaviors and side effect monitoring.	F 329		

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F 329	Continued From page 25 Review of the Behavior documentation from 12/1/14 - 4/9/15, revealed R33 had not displayed any type of behaviors or mood indicated for the anti-depressant or anti-psychotic medication use. Review of the physician visit note dated 1/6/15, indicated R33's Ativan was ordered every 4 hours as needed for agitation, but did not address the targeted behaviors for the Zoloft or Seroquel use. Review of physician visit note dated 3/3/15, indicated R33 had been less agitated, but did not include any other documentation regarding the antidepressant or antipsychotic use. On 4/9/15, at 11:28 a.m. RN-B stated R33 was a very nice lady and was often sleepy. RN-B reported R33 had not displayed any behaviors or mood problems and was doing very well. On 4/9/15, at 11:32 a.m. NA-F reported R33 sometimes looked for her husband but that's it, and denied having any other behaviors or hallucinations. On 4/9/15, at 2:38 p.m. NA-G reported R33 was pretty easy to take care of, then stated the only behavior the staff had identified was R33 looked for her husband, and when she does they remind her he went home. NA-G denied R33 having any other behaviors, mood, hallucinations or delusions.	F 329		

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F 329	Continued From page 26 On 4/9/15, at 2:15 p.m. the consulting pharmacist confirmed R33 was prescribed Zoloft for increased anxiety, and Seroquel for delusions and hallucinations. When asked if he would expect the physician or the facility to identify targeted behaviors for the prescribed medications, he responded he could not speak to that. On 4/9/15, at 1:41 p.m. the DON reported R33 had hallucinations of dead children and was inconsolable, however, the DON was unable to produce that information in R33's medical record. After review of the record, the DON was unable to confirm R33's targeted behaviors for the Zoloft and Seroquel use. The DON confirmed R33's care plan lacked information identifying the use of an anti-psychotic and anti-depressant medication, the targeted behaviors, non pharmacological interventions and possible side effects of those medications. The DON stated if there was not a care plan in place for those medications the staff were not documenting behaviors related to those medications, and confirmed the staff were only documenting behaviors related to the Ativan use. The DON confirmed targeted behaviors are expected to be in place for all psychotropic medications. The Psychopharmacological Medications and Sedative/Hypnotics policy dated 3/2015, directed the staff to monitor resident behaviors with medication changes and review the medications every three months by a medication reduction committee. In the review, the staff were to	F 329		

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F 329	Continued From page 27 document the rationale for continuing the medication, evaluate the resident's target symptoms and the effect of the medication on the severity, frequency and other characteristics of the resident.	F 329		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		

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F 441	Continued From page 28 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility staff failed to establish an infection control system to ensure timely monitoring of infections to ensure appropriate surveillance of infections. This had the potential to affect all 44 residents in the facility. In addition, the facility failed to demonstrate appropriate hand washing techniques to maintain sanitary conditions during the dining meal for 2 of 2 residents (R13, R32) who were observed in the east dining room. Findings include: Infection surveillance was not completed timely to determine any trends and potential infection outbreaks. The facility had not developed policies that identified how they were going to complete infection surveillance, log and track infections. In addition, the facility did not track/trend any resident infections which did not require treatment with antibiotics. On 4/9/15, at 9:10 a.m. the director of nurses (DON) stated she monitored the infections in the facility by running a report at the end of the month which identified the residents who received an	F 441		

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F 441	Continued From page 29 antibiotic during the month. The DON stated she transferred information from the computer report onto a log and monitored what infections were in the building at the end of the month. The infection control logs included antibiotic reports for 1/15- 3/15. No other reports were available for review. On 4/9/15, at 9:15 a.m. the DON stated the infection control had been monitored by an RN who was no longer employed at the facility. The DON stated she was unable to locate any other information related to infection control. The DON reported the facility had a "flu" outbreak in December 2014- January 2015, however she was unable to locate the documentation indicating when and where the "outbreak" had started or ended. She confirmed if a resident displayed symptoms of infections like fever, cough or viral infection which would not treated with an antibiotic, it would not be added to the report unless the resident had a been to the doctor and received a diagnosis of a viral infection. She stated she received information regarding infections daily at report but did not track or trend them until the end of the month. The Infection Control Surveillance procedure dated 11/2014, guided the staff on the type of information to gather from the clinical records and how to document them on a graph or log, however, the procedure did not direct the staff on the frequency of the monitoring to ensure the data collected was completed in a timely fashion.	F 441		

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F 441	Continued From page 30 Staff did not demonstrate proper hand washing techniques when residents were assisted to eat. During a dining observation on 4/6/15, from 6:07 p.m. to 6:20 p.m. licensed practical nurse (LPN)-B was observed to help two residents with their meal. R32 was seated to her left side and R13 was to her right. At 6:07 p.m. LPN-B used her right ungloved hand to feed R32's sandwich, then wiped R13's face with a paper napkin with the same right ungloved hand. LPN-B was observed to go back to feeding R32 her sandwich with the same ungloved hand that was used to wipe R13's face. At 6:12 p.m., LPN-B used her right hand to wipe R32's face then continued to feed R13 with the same hand. LPN-B did not wash her hands or use hand sanitizer during the entire dining observation. On 4/6/15, at 6:23 p.m. LPN-B confirmed she handled R32's chicken salad sandwich with her bare hands. LPN-B confirmed she fed two residents at a time without washing her hands in between, and stated she should have been wearing gloves. On 4/9/15, at 1:37 p.m. the DON stated staff should try and not use the same hand to feed more than one resident at a time. The DON confirmed all staff are expected to use hand sanitizer between residents when assisting multiple residents with meals. The facility's Hand Hygiene and Handwashing	F 441		

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F 441	Continued From page 31 policy dated 11/14, indicated hand hygiene should be completed before having direct contact with residents.	F 441		

Please Note: this addendum is in reserve order - tag F166 is at the bottom of the page and works back.

F-441

SS: F

1. R45 and R18 eye drops administered per policy/procedure including the use of gloves and hand hygiene. R13 and R32 are experiencing sanitary dining. Infection control system has been implemented to ensure monitoring of infections and appropriate surveillance of infections.
2. A control log will be designed to track all components including location, symptoms cultures and organisms identified, antibiotics used and resolution. Analysis of infections will be part of the surveillance.
3. All licensed nurses in the facility have been educated on all components of the infection control program 4/23/15; all staff will be educated 5/6/15 regarding infection control.
4. Audits for the infection control program will be developed to monitor logs weekly x 3 and monthly x 3. All findings taken to QAPI for further recommendation.
5. Completion date: May 12, 2015

F-329

SS: D

1. Current psychopharmacological medications will be reviewed by pharmacy consultant with all recommendations sent to physician for approval for R27, R32, R29, R33. For residents continuing to receive psychopharmacological medications for behavior/mood care plan interventions will be reviewed and plan of care updated to reflect current needs of resident.
2. All residents identified with a behavior/mood focus care plans have been reviewed to ensure all address non-pharmacological approaches appropriate to the resident. Current and future residents will have nursing assessment completed upon admission, quarterly, annually and with significant change and PRN to address the need for this type of medication and applying non-pharmacological interventions.
3. MDS/Case Manager will be educated on how to appropriately monitor reduction of psychopharmacological medications and implementation of non-pharmacological mood/behavior interventions. Training provided by DON for Licensed staff on gradual dose reduction 4/23/15.
4. Mood/behavior documentation review audits will be completed on R27, R32, R29 and R33 plus random residents. Audits conducted weekly x 3 then monthly x 3. All findings brought to QAPI for further recommendations.
5. Completion date: May 12, 2015

F-323

SS: D

1. Care plan for resident R22 has been reviewed and revised based off of most current nursing assessments to reflect appropriate needs for resident for falls prevention.
2. All residents current and future will have nursing assessments completed upon admission, quarterly, annually and with significant change as well as post falls, and all plans of care will be updated to reflect most current assessments and prevention interventions.
3. All staff will be educated on 5/6/15 on falls prevention and standards of care; CNA's will receive additional education 4/29/15, on our standards of practice regarding call light usage. Licensed nursing staff educated 4/42/15 on falls prevention.
4. Random auditing on falls prevention in care plans to ensure interventions are resident specific according to the most recent assessment will be completed weekly x 4 and then monthly x 3. All findings will be presented to QAPI for further recommendation.
5. Completion date: May 12, 2015

F-282

SS: D

1. Fall data collection and falls evaluation completed and care plan for resident R22 has been reviewed and revised based off of most current nursing assessments to reflect appropriate needs for resident.
2. All residents current and future will have nursing assessments completed upon admission, quarterly, annually and with significant change as well as with falls and all plans of care will be updated to reflect most current assessments and falls prevention interventions.
3. All staff will be educated on 5/6/15 on standards of care; CNA's will receive additional education 4/49/15, on our standards of practice regarding call light usage. Licensed Nursing staff educated on 4/43/15 on completing a care plan and introducing new interventions.
4. Random chart and observation auditing will be completed weekly x 4 and then monthly x 3. All findings will be presented to QAPI for further recommendation.
5. Completion date: May 12, 2015

F-279

SS: D

1. New plan of care was developed with interventions and measurable goals for R48 based on comprehensive assessments for pressure ulcers.
2. All residents care plans have been reviewed for care and treatment of pressure ulcers and updated as needed to ensure proper goals and interventions are current and appropriate.
3. All licensed staff was educated on 4/23/15 on policy/procedure for care planning including development and implementation. On 4/29/15 certified nursing assistance were educated on delivery of care per care plan interventions.
4. Audits will be completed to ensure appropriate care plan interventions for pressure ulcers are in place and observation audits for intervention implementation weekly x 3 and then monthly x 3.
5. Completion date: May 12, 2015

F-246

SS: D

1. R46 evaluated by OT 4/22/2015. Care plan to reflect residents needs for bed request.
2. All residents requesting a longer bed will receive a physician's order for OT evaluation. Action plan for resident developed based on OT evaluation and care plan updates.
3. On 5/6/15 all staff will be educated on Good Samaritan Society policy/procedure for accommodations of resident needs.
4. All requests for accommodations will be audited for resolution per Good Samaritan Society policy/procedure.
   Administrator/designee will audit x 3 months. All findings will be brought to QAPI for further recommendations.
5. Completion date: May 12, 2015

F-176

SS: E

1. Assessment for self-administration was completed on R45, R1, R17 and R46; care plans updated per findings of assessment.
2. Residents who have expressed desire to self admin medications after set up will have a self-administration assessment completed and if deemed appropriate a physician's order will be obtained and care plan updated.
3. On 4/23/1515 all licensed nurses and TMA's were educated on proper medication administration and resident self-administration policy/procedure.
4. Spot audits on proper medication administration and audits on appropriate self-administration will be completed weekly x4 and monthly x 3. All findings will be presented to QAPI for further recommendations.
5. Completion date: May 12, 2015

F-166

SS: D

1. On 4/8/15 administrator called and discussed grievance with family member who had reported the grievance. Administrator met face to face with resident family member on 4/16/15. Facility is still investigating 1 missing piece of clothing; administrator will continue to work with family until resolved.
2. All grievances reported, back to last standard survey, dated 11/7/14 have been reviewed by administrator to ensure that all are resolved.
3. Administrator educated on 4/8/15 to Good Samaritan Society policy/procedure on grievances/complaints/concerns. All staff educated on 5/6/15 regarding Good Samaritan Society grievance/complaints/concerns/procedure.
4. All grievances will be audited for resolution completed per Good Samaritan Society policy/procedure x 3 months. All audits will be presented to QAPI for review and further recommendations.
5. Completion date: May 12, 2015

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

F5550025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/08/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET WARREN, MN 56762**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Good Samaritan Society Warren 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	5-13-15 POC ok TR RECEIVED MAY - 8 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

No opportunity to correct
DC: 5-27-14
EXIT: 4-9

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebecca Soenson	Administrator	5-5-15

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Facility was inspected as 2 buildings: Good Samaritan Society Warren (Marshal Manor) was built in 1968 as a 1-story building without a basement and was determined to be Type II (111) construction. In 1973 a 1-story addition was constructed to the east of the original building and was determined to be Type II (000) construction. In 2010 a kitchen addition was constructed to the north of the original building's dining room. It is 1-story, no basement and Type II(000) construction. In 2013 a connecting link was constructed to the east connecting the new hospital with the facility. This addition is i-1story , no basement and Type II(000) construction. The building is divided into 6 smoke zones with 1/2 hour fire rated barriers. An apartment building is attached to the southwest wing that is separated with a 2-hour fire barrier.	K 000		

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K 000	Continued From page 2 The facility is completely protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code (1999 edition) with automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 52 beds and had a census of 46 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 2 two hour fire separations that were found not in compliance with NFPA 101	K 011		

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K 011	Continued From page 3 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1 and 19.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect all of the residents, staff and visitors of the facility. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, observations revealed that the 2 hour fire separation located by room 114, had a gap between the double doors that is greater than 1/4 of an inch. This deficient condition was verified by the Maintenance Supervisor.	K 011		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017		

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K 017	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility had penetrations located throughout the facility that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for 6 of 52 residents, staff and visitors. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, observations revealed, that there were two holes found in the ceiling tile that is located by room 200C. This deficient condition was verified by the Maintenance Supervisor.	K 017		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems.	K 025		

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K 025	Continued From page 5 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of several smoke barrier walls construction that meet the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect residents, staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, observation revealed that there are penetrations in the smoke barrier wall caused by two HVAC flexible ducts passing through the smoke barrier wall above the ceiling tile located by room 300B. This deficient condition was verified by the Maintenance Supervisor.	K 025		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed	K 029		

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K 029	Continued From page 6 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, observation revealed that Room 112 a resident room converted into a storage room which is greater than 50 square feet has a door that is not equipped with a self-closing device. This deficient condition was verified by the Maintenance Supervisor.	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

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K 038	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a hard surfaced path to the public way for 1 of several means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2.1 and 7.2.1.5.4, 7.2.1.6.1(d), 7.7.2 (1) and the 2007 MN State Fire Code, Appendix I. The deficient practice could affect residents, staff, and visitors. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, observation revealed that the required exit located by room 114 did not have a hard surface path leading to the public way This deficient condition was verified by the Maintenance Supervisor.	K 038		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide 1 of several operational exit signs that marks the means of egress path in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.5.2. The	K 047		

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K 047	Continued From page 8 deficient practice could affect residents, staff and visitors, if the lack of properly illuminated exit sign prevented a means of egress from being utilized in a timely manner in an emergency situation. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, it was observed that the exit sign above the exit door located by room 114 was not located in a way that is observable from the corridor. This exit sign needs to be moved so that it can be seen clearly from the corridor and the directional indicator pointing to the required exit. This deficient condition was verified by the Maintenance Supervisor.	K 047		
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain combustible decoration in accordance with NFPA Life Safety Code 101 (00) section 19.7.5.4. The failure to treat and maintain the combustible decorations throughout the facility in accordance with NFPA Life Safety Code 101 (00) could allow smoke and fire to rapidly migrate through the corridors and negatively affect the egress capability in the event of an emergency for residents, visitors and staff of the facility.	K 073		

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K 073	Continued From page 9 Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, observations revealed that numerous decorations throughout the facility are being hung on the corridor side of the resident room doors that couldn't be verified as being treated with a fire retardant treatment. This deficient condition was verified by the Maintenance Supervisor.	K 073		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility was using unapproved electrical devices that are not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of residents, staff and visitors. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, observations revealed that there is an excessive amount of storage in front of, and around the main electrical panels that are located in the boiler room.	K 147		

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K 147	Continued From page 10 This deficient condition was verified by the Maintenance Supervisor.	K 147		
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire sprinkler system out of service policy to include the triggering criteria, and contact information in the event of the fire sprinkler being out of service and	K 154		

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K 154	Continued From page 11 the need for a fire watch to be initiated This deficient condition was verified by the Maintenance Supervisor.	K 154		
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, during record review and an interview with the Maintenance Supervisor, the facility failed to update and provide a complete list of contact information on the automatic fire alarm	K 155		

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K 155	Continued From page 12 system out of service policy. The policy was lacking any contact information for the Deputy State Fire Marshal. This deficient condition was verified by the Maintenance Supervisor.	K 155		

Bldg 1

K011

1. Smoke sweeps were applied to the identified gap of the 2 hour fire barrier identified in 2567.
2. Actual Correction Date: April 18th, 2015.
3. Responsible Party for completion: ICON Architects, Inc.

K017

1. Ceiling tile identified in 2567 was replaced.
2. Actual Correction Date: April 10th, 2015.
3. Responsible party for completion: Director of Environmental Services

K025

1. Two smoke dampers will be installed into area identified in 2567.
2. Proposed Correction Date: May 15th, 2015.
3. Responsible party for completion: Director of Environmental Services

K029

1. Self-closing device was installed onto door of room 112.
2. Actual Correction Date: April 14th, 2015.
3. Responsible party for completion: Director of Environmental Services

K038

1. A hard surface path leading to the public way will be installed.
2. Proposed Correction Date: May 15th, 2015
3. Responsible party for completion: ICON Architects, Inc.

K047

1. The exit sign was moved so that it can be seen clearly from the corridor, with the directional indicator pointing to the exit.
2. Actual Completion Date: April 20th, 2015
3. Responsible party for completion: ICON Architects, Inc.

K073

1. Removed door decorations throughout facility that are on corridor side of resident room doors, unless they have been verified as being treated with a fire retardant treatment. Developed and implemented a new policy for residents and family members to be educated at admission regarding door décor.
2. Proposed Correction Date: May 8th, 2015.
3. Responsible party for completion: Activities & Environmental Services

K147

1. Removed storage items in front of and around the main electrical panels in the boiler room.
2. Actual Completion Date: May 5th, 2015.
3. Responsible party for completion: Director of Environmental Services

K154

1. Fire sprinkler system out of service policy updated to include the triggering criteria and contact info in the event the fire sprinkler is out of service and the need for a fire watch to be initiated.
2. Actual Correction Date: April 15th, 2015
3. Responsible party for completion: Administrator

K155

1. Contact information on the automatic fire Alarm system out of service policy has been Updated with correct information, including Contact information for the Deputy State Fire Marshal.
2. Actual Correction Date: April 15th, 2015
3. Responsible party for completion: Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING 02 - KITCHEN ADDTION B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 02 Kitchen Addition and Connecting Link THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Good Samaritan Society Warren 02 Kitchen Addition was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	5-13-15 poc ok TL RECEIVED MAY - 8 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebecca Spencer	Administrator	5-5-15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **02 - KITCHEN ADDTION** B. WING _____	**04/08/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET WARREN, MN 56762**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was inspected as 2 buildings: Good Samaritan Society Warren (Marshal Manor) was built in 1968 as a 1-story building without a basement and was determined to be Type II (111) construction. In 1973 a 1-story addition was constructed to the east of the original building and was determined to be Type II (000) construction. In 2010 a kitchen addition was constructed to the north of the original building's dining room. It is 1-story, no basement and Type II(000) construction. It is 1-story, no basement and Type II(000) construction. In 2013 a connecting link was constructed to the east connecting the new hospital with the facility. This addition is i-1story , no basement and Type II(000) construction. The building is divided into 6 smoke zones with 1/2 hour fire rated barriers. An apartment building is attached to the southwest wing that is separated with a 2-hour fire barrier.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **02 - KITCHEN ADDTION** B. WING _____	**04/08/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET WARREN, MN 56762**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility is completely protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code (1999 edition) with automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 52 beds and had a census of 46 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to	K 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **02 - KITCHEN ADDTION** B. WING _____	**04/08/2015**

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GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET WARREN, MN 56762**

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K 154	Continued From page 3 be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire sprinkler system out of service policy to include the triggering criteria, and contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated This deficient condition was verified by the Maintenance Supervisor.	K 154		
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to	K 155		

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 - WARREN	**410 SOUTH MCKINLEY STREET WARREN, MN 56762**

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K 155	Continued From page 4 be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 10:00 AM to 3:00 PM on 04/08/2015, during record review and an interview with the Maintenance Supervisor, the facility failed to update and provide a complete list of contact information on the automatic fire alarm system out of service policy. The policy was lacking any contact information for the Deputy State Fire Marshal. This deficient condition was verified by the Maintenance Supervisor.	K 155		

Bldg 1

K011

1. Smoke sweeps were applied to the identified gap of the 2 hour fire barrier identified in 2567.
2. Actual Correction Date: April 18th, 2015.
3. Responsible Party for completion: ICON Architects, Inc.

K017

1. Ceiling tile identified in 2567 was replaced.
2. Actual Correction Date: April 10th, 2015.
3. Responsible party for completion: Director of Environmental Services

K025

1. Two smoke dampers will be installed into area identified in 2567.
2. Proposed Correction Date: May 15th, 2015.
3. Responsible party for completion: Director of Environmental Services

K029

1. Self-closing device was installed onto door of room 112.
2. Actual Correction Date: April 14th, 2015.
3. Responsible party for completion: Director of Environmental Services

K038

1. A hard surface path leading to the public way will be installed.
2. Proposed Correction Date: May 15th, 2015
3. Responsible party for completion: ICON Architects, Inc.

K047

1. The exit sign was moved so that it can be seen clearly from the corridor, with the directional indicator pointing to the exit.
2. Actual Completion Date: April 20th, 2015
3. Responsible party for completion: ICON Architects, Inc.

K073

1. Removed door decorations throughout facility that are on corridor side of resident room doors, unless they have been verified as being treated with a fire retardant treatment. Developed and implemented a new policy for residents and family members to be educated at admission regarding door décor.
2. Proposed Correction Date: May 8th, 2015.
3. Responsible party for completion: Activities & Environmental Services

K147

1. Removed storage items in front of and around the main electrical panels in the boiler room.
2. Actual Completion Date: May 5th, 2015.
3. Responsible party for completion: Director of Environmental Services

K154

1. Fire sprinkler system out of service policy updated to include the triggering criteria and contact info in the event the fire sprinkler is out of service and the need for a fire watch to be initiated.
2. Actual Correction Date: April 15th, 2015
3. Responsible party for completion: Administrator

Bldg2

K155

1. Contact information on the automatic fire Alarm system out of service policy has been Updated with correct information, including Contact information for the Deputy State Fire Marshal.
2. Actual Correction Date: April 15th, 2015
3. Responsible party for completion: Administrator

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0259

April 23, 2015

Ms.. Rebecca Sorenson, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, Minnsota 56762

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5550025

Dear Ms.. Sorenson:

The above facility was surveyed on April 6, 2015 through April 9, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s) 5550s15lic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On Apiril 6, 7, 8, and 9 2015, surveyors of this Department's staff visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	RECEIVED MAY - 8 2015 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Certification Programs; 705 5th St. N.W. Suite A, Bemidji, MN 56601-2933	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 430	MN Rule 4658.0210 Subp. 1 Room Assignments Subpart 1. Room assignments and furnishings. A nursing home must attempt to accommodate a resident's preferences on room assignments, roommates, and furnishings whenever possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 430	Continued From page 2 review, the facility failed to provide a bed of adequate size for 1 of 1 resident (R46) who had requested a larger bed. Findings include: R46's quarterly Minimum Data Set (MDS) dated 3/15/15, identified R46 as an individual with severe cognitive impairments and diagnoses including dementia, status post stroke and diabetes mellitus. The MDS indicated R46 required extensive assistance of one staff with bed mobility and transfers, and was 72 inches tall (six feet). On 4/6/15, at 7:00 p.m. R46 approached the state agency staff and informed her that his bed was too short. He reported he had expressed the concern to the director of nurses (DON). On 4/9/15, at 9:00 a.m. R46 approached a second state agency staff member and reported his bed was too short. He explained his back was sore because his feet routinely were off of the bed at night. On 4/9/15, at 10:30 a.m. R46 approached a third state agency staff member and reported his bed was too short. He stated he had received a new bed but that one was too short. On 4/9/15, at 10:35 a.m. registered nurse (RN)-B assisted R46 to bed. R46's bed was not equipped with a foot board. When positioned flat	2 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 430	Continued From page 3 in the bed R46 appeared to have 2-3 inches at the head and the foot of the bed. However, R46 stated he slept with the head of the bed elevated. R46 was observed to raise the head of the bed. When he did this, his body slid down in the bed causing his feet to extend over the end of the bed. R46 stated his feet hung over the end of the bed nightly because the bed was too short. The care plan dated 4/8/15, did not address any concerns related to a short bed. The progress notes from 2/1/15 - 4/8/15, did not address any concern related to R46's comfort while in bed. On 4/9/15 at 11:30 a.m. the maintenance director stated he was aware R46 had expressed concerns about the length of his bed. He stated in the past month, R46 had a "bed extender" placed on his bed which he had removed and "thrown out his door." He had also had a different bed placed in his room which he refused. The maintenance director measured the bed and stated it was 79 inches long. He confirmed no other adjustments for the bed had been completed. On 4/9/15, at 11:40 a.m. RN-A stated R46 had expressed concerns with the bed length about two weeks ago and had been offered a bed extender which he refused. She reviewed R46's record and confirmed the record lacked documentation related to the concern and no further attempts to satisfy R46's request had been made.	2 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 430	Continued From page 4 On 4/9/15, at 2:10 p.m. the DON stated she was aware R46 had expressed concerns about his bed. She indicated R46 had been offered a bed extender and a different bed which were both rejected by R46. She confirmed she was aware R46 had expressed dissatisfaction with his bed, yet no further attempts to improve his bed had been attempted. She stated R46 may benefit from an occupational therapy evaluation, but confirmed an assessment of his bed needs had not been completed. The DON reviewed R46's record and confirmed the record lacked documentation related to the two attempts the facility had made to satisfy R46's concerns with his bed, nor had they attempted to comprehensively assess R46's needs. The Accommodation of Resident Need policy dated 2/2013, directed the staff to ensure the resident had the right to reside and receive services in the center with reasonable be accommodations of individual needs and preferences. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review all resident room furnishings to ensure room furnishings accomodate resident needs and preferences. Facility staff could be educated accomodation of residents needs. The administrator or designee could develop a monitoring system to ensure ongoing compliance.	2 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 430	Continued From page 5 Time Period for Correction: Twenty-one (21) days.	2 430		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to develop a plan of care with interventions and measurable goals for the care and treatment of a pressure ulcer for 1 of 3 (R48) residents who had developed a pressure ulcer. Findings Include: R48's Minimum Data Set (MDS) dated 3/4/15, indicated R48 was cognitively intact, required extensive assist of one staff with transfers and bed mobility. R48 was at risk for development of pressure ulcers and had pressure reducing devices for chair and bed. R48's Diagnosis List dated 2/25/15, identified R48's diagnoses as diabetes type II, coronary atherosclerosis, chronic airway obstruction,	2 560		

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	00356	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 560	Continued From page 6 pressure ulcer buttock, lower limb amputation, below knee, and lower limb amputation, above the knee. R48's Braden Scale (tool used to predict pressure ulcer risk) dated 3/11/15, indicated R48 was at risk for pressure ulcers. R48's physician order dated 3/19/15, indicated: cleanse wound with wound cleanser and apply hydrocolloid dressing to pressure ulcer on right buttock crease. Change dressing daily and as needed in the afternoon related to pressure ulcer right buttock. R48's Daily Skilled Note dated 3/19/15, indicated R48 was being observed for skin and/or extremity issues, potential complications/risks, and interventions for wounds/ulcers (pressure ulcer). R48's Wound Data Collection form dated 4/1/15, indicated: pressure ulcer to right buttock, length 0.5 centimeters (cm) width 0.5 cm, with no undermining. On 04/08/2015, at 11:48 a.m. registered nurse (RN)-A verified R48 had developed a pressure ulcer and R48's care plan did not address his pressure ulcer or interventions. RN- A further stated, "The pressure ulcer should have been added to the care plan when it was discovered. It should identify the problem, goals and what interventions would be implemented." On 04/08/2015, at 12:23 p.m. the director of nursing confirmed her expectations were for staff to develop, follow and revise each residents' care plan to meet the individual needs of each resident. The facility Care Plan Policy issued 9/12, indicated, "Each resident will have an individualized comprehensive plan of care that	2 560		

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2 560	Continued From page 7 will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional spiritual, emotional, psychosocial and educational needs." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies and provide staff education related to the development of comprehensive care plans. The administrator or designee could develop and auditing system in order to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services according to the care plan to minimize falls for 1 of 3 residents (R22) reviewed for accidents. Findings include:	2 565		

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	00356	A. BUILDING: _____ B. WING _____	04/09/2015

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2 565	Continued From page 8 R22's diagnoses included Alzheimer's disease and a healing traumatic fracture of the right hip. R22's Fall Care Area Assessment (CAA) dated 3/25/15, revealed the following: R22 had fallen related to slipping while wearing socks with no shoes, had intermittent confusion which resulted in a risk for falls, and had been using the call light appropriately. R22's care plan dated 4/7/15, identified R22 was at risk for falls. Interventions for minimization of falls for R22 directed staff to have frequently used items within R22's reach, to ensure pathways were free from clutter and spills, and to have a call light within reach at all times. On 4/8/15, at 2:26 p.m. R22 was observed lying in bed, eyes closed. R22's push-button call light was observed clipped to the room's privacy curtain which hung near the foot of R22's bed, and out of R22's reach. On 4/8/15, at 2:28 p.m. the director of nursing (DON) confirmed with the surveyor that R22's call light was not within reach. DON then removed the call button from the privacy curtain and clipped it to R22's blanket at the top edge, within R22's reach. The facility Care Plan Policy dated 9/12, directed that each resident would have an individualized care plan for facility staff to follow to meet the residents' needs. The policy further directs the care plan is to be utilized to direct the necessary	2 565		

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2 565	Continued From page 9 care and services for the residents to maintain their highest well-being. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee (s)could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee (s) could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 565		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections;	21390		

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21390	Continued From page 10 F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility staff failed to establish an infection control system to ensure timely monitoring of infections to ensure appropriate surveillance of infections. This had the potential to affect all 44 residents in the facility. In addition, the facility failed to demonstrate appropriate hand washing techniques to maintain sanitary conditions during the dining meal for 2 of 2 residents (R13, R32) who were observed in the east dining room. Findings include: Infection surveillance was not completed timely to determine any trends and potential infection outbreaks. The facility had not developed policies that identified how they were going to complete infection surveillance, log and track infections. In addition, the facility did not track/trend any resident infections which did not require treatment with antibiotics.	21390		

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21390	Continued From page 11 On 4/9/15, at 9:10 a.m. the director of nurses (DON) stated she monitored the infections in the facility by running a report at the end of the month which identified the residents who received an antibiotic during the month. The DON stated she transferred information from the computer report onto a log and monitored what infections were in the building at the end of the month. The infection control logs included antibiotic reports for 1/15- 3/15. No other reports were available for review. On 4/9/15, at 9:15 a.m. the DON stated the infection control had been monitored by an RN who was no longer employed at the facility. The DON stated she was unable to locate any other information related to infection control. The DON reported the facility had a "flu" outbreak in December 2014- January 2015, however she was unable to locate the documentation indicating when and where the "outbreak" had started or ended. She confirmed if a resident displayed symptoms of infections like fever, cough or viral infection which would not treated with an antibiotic, it would not be added to the report unless the resident had a been to the doctor and received a diagnosis of a viral infection. She stated she received information regarding infections daily at report but did not track or trend them until the end of the month. The Infection Control Surveillance procedure dated 11/2014, guided the staff on the type of information to gather from the clinical records and how to document them on a graph or log,	21390		

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21390	Continued From page 12 however, the procedure did not direct the staff on the frequency of the monitoring to ensure the data collected was completed in a timely fashion. Staff did not demonstrate proper hand washing techniques when residents were assisted to eat. During a dining observation on 4/6/15, from 6:07 p.m. to 6:20 p.m. licensed practical nurse (LPN)-B was observed to help two residents with their meal. R32 was seated to her left side and R13 was to her right. At 6:07 p.m. LPN-B used her right ungloved hand to feed R32's sandwich, then wiped R13's face with a paper napkin with the same right ungloved hand. LPN-B was observed to go back to feeding R32 her sandwich with the same ungloved hand that was used to wipe R13's face. At 6:12 p.m., LPN-B used her right hand to wipe R32's face then continued to feed R13 with the same hand. LPN-B did not wash her hands or use hand sanitizer during the entire dining observation. On 4/6/15, at 6:23 p.m. LPN-B confirmed she handled R32's chicken salad sandwich with her bare hands. LPN-B confirmed she fed two residents at a time without washing her hands in between, and stated she should have been wearing gloves. On 4/9/15, at 1:37 p.m. the DON stated staff should try and not use the same hand to feed more than one resident at a time. The DON confirmed all staff are expected to use hand sanitizer between residents when assisting multiple residents with meals.	21390		

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21390	Continued From page 13 The facility's Hand Hygiene and Handwashing policy dated 11/14, indicated hand hygiene should be completed before having direct contact with residents. SUGGESTED METHOD OF CORRECTION: The administrator or director of nursing, or designee could review the facility policy and procedure related to ongoing infection control surveillance and analysis of infections at the time they occur, and could in-service all employees on the basics of infection control practices to reduce and prevent the spread of infection. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.	21426		

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21426	Continued From page 14 (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a tuberculosis risk assessment for the facility and failed ensure a two-step tuberculin skin test (TST) was completed for 5 of 5 newly hired employees: nursing assistant (NA-A), dietary aide (DA-A , DA-B, DA-C), laundry assistant (LA)-A) reviewed for the tuberculosis (TB) program. Findings include: On 4/9/15, at 9:00 a.m. the director of nurses (DON) was asked provide the Tuberculosis Risk Assessment for the facility. The DON stated she would locate the document. On 4/9/15, at 1:30 p.m. the DON provided a copy of a TB risk assessment dated 4/9/15. She stated she was unable to locate the risk assessment and completed a new assessment while the survey staff was out of the building. She reported the facility was at low risk for tuberculosis and the assessment would be completed again in 2017. She confirmed the facility did not have a current risk assessment at the time of the survey.	21426		

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21426	Continued From page 15 Review of personal records revealed the following: NA-A was hired on 2/23/15, and received a one step TST on 2/23/15. The record lacked a second TST. DA-A was hired on 2/5/15, and received a one step TST on 2/5/15. The record lacked a second TST. DA-B was hired on 3/15/15, received a one step TST on 3/15/15. The record lacked a second TST. DA-C was hired on 2/10/15, and received a one step TST on 2/10/15. The record lacked a second TST. LA-A was hired on 2/22/15, and received a one step TST on 2/22/15. The record lacked a second TST. The Center for Disease Control (CDC) at : http://www.cdc.gov/tb/education/provider_edmaterials.htm recommended a two step TST for all healthcare workers. On 4/9/15, at 1:30 p.m. the director of nursing stated all staff members were to receive a two step TST. She stated she was unaware why the staff consistently did not receive the second step TST. Review of the Annual Tuberculosis Risk Assessment policy dated 6/2012, directed the staff to conduct an annual tuberculosis risk assessment for the facility.	21426		

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21426	Continued From page 16 A policy regarding healthcare worker TST testing was requested and none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director,	21540		

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21540	Continued From page 17 the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure adequate indications for the use of psychoactive medications and/or appropriate monitoring of resident mood/behavior to determine efficacy for 3 of 5 residents (R32, R29, R33) reviewed for unnecessary medications. Findings include: R32's behaviors were not monitored following medication changes and target behaviors nor the indication for the use of multiple antidepressants and antipsychotic medication was identified. R32's quarterly MDS dated 3/23/15, identified R32 as having mild cognitive impairment and diagnosis including multiple sclerosis, depression, psychosis and delusional disorder. The MDS indicated R32 expressed mood concerns about feeling down, having little energy, trouble concentrating and trouble falling asleep. The MDS also indicated R32 had not displayed behavior concerns during the assessment period but had received antipsychotic and antidepressant medications daily, and required extensive to total assistance of one to two staff members with all activities of daily living. The Psychotropic Medication Care Area Assessment (CAA) following the last annual MDS	21540		

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21540	Continued From page 18 dated 7/24/14, indicated R32 received antidepressant and antipsychotic medications and was followed by the psychiatric center. The care plan dated 8/13/14, indicated R32 had major depressive disorder, psychotropic disorder with delusion evidenced by cognitive impairments and confusion which varied from day to day and hour to hour. The care plan directed the staff to encourage non pharmacological interventions such as activities and to contact the family if concerns were identified. The care plan did not identify or describe R32's behaviors which required multiple antidepressant or antipsychotic medications. On 3/6/15, from 3:00 p.m. to 8:00 p.m., on 3/7/15, from 8:00 a.m. to 4:30 p.m., on 3/8/15, from 7:00 a.m. to 3:30 p.m. and on 3/9/15, from 8:00 a.m. to 4:00 p.m. R32 was observed to be totally dependent upon staff for all activities of daily living. She was observed to sleep in her wheelchair when out of her room. She responded to staff questions and was able to follow a conversation, however, she would frequently fall asleep during the conversations. R32 was observed to have a very flat affect. The physician orders dated 4/9/15, included the following medications: - Buspar (antidepressant medication) 15 mg three times a day - started on 7/18/14. - Cymbalta (antidepressant medication) 60 milligrams one a day order dated 5/1/14. - Remeron (antidepressant medication) 30 mg at bedtime. The order had been decreased on	21540		

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GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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21540	Continued From page 19 12/19/14, from 45 mg per day. - Risperdal (antipsychotic medication) 1 mg at bedtime. The medication had been decreased on 2/12/15, from 0.5 mg in the morning and 1 mg in the evening. - Wellbutrin XL (antidepressant medication) 150 mg every morning. The medication had been decreased on 2/12/15, from 300 mg to 150 mg daily. The psychiatric clinic referrals indicated the following information: - 10/21/14, indicated R32 slept about 60% of the 30 minute evaluation. Risperdal decreased to 0.5 mg in a.m. and 1 mg at bedtime. The note identified R32's diagnoses but did not justify the use of multiple antidepressant medications. -12/2/14, indicated the Risperdal had been decreased on 12/2/14. However, the clinic referral lacked indication as to why R32 required four different antidepressant medications and an antipsychotic medication. - 2/12/15, indicated the Risperdal had been decreased further to 1 mg at bedtime and the Wellbutrin had been reduced to 150 mg a day. The note indicated R32 was cooperative "when awake." The progress notes from 1/1/15 - 4/8/15, indicated the nursing staff would document what medications R32 was receiving but at no time would they indicate what type of mood/behaviors R32 displayed. In addition, the clinical record did not address R32's medication reduction nor did it indicate any type of potential behavioral changes in relationship to the medication changes.	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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21540	Continued From page 20 The behavior documentation from 12/1/14 - 4/8/15, revealed R32 had not displayed any type of behaviors. On 4/8/15, at 11:10 a.m. registered nurse (RN)-A stated R32 slept much of the time and did not initiate conversations. She stated R32 had a very flat affect. On 4/8/15, at 11:50 p.m. licensed practical nurse (LPN)-B stated R32 did not display any type of behaviors and could not recall R32 displaying any type of adverse behaviors. On 4/8/15, at 12:50 p.m. nursing assistant (NA)-E stated R32 did not display behaviors. She stated R32 frequently slept in her chair. On 4/8/15, at 2:00 p.m. the DON stated R32 did not display behaviors. She stated anytime a resident had an antidepressant or antipsychotic medication change, the staff were to document on the resident's behaviors weekly for 8 weeks to determine how the resident was responding to the medication change. She reviewed R32's record and confirmed the record lacked documentation related to the medication changes and how R32 had responded to the medication changes. She verified the staff had not followed the system to ensure qualitative behavior monitoring. She stated all of the residents in the facility who received psychotropic medications were to be reviewed monthly by the nursing staff. The DON added the facility did not currently have a medication reduction committee.	21540		

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	00356	A. BUILDING: _____ B. WING _____	04/09/2015

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21540	Continued From page 21 R29's mood and behaviors were not monitored following medication changes. In addition, target behaviors and indication for the use of psychoactive medications were not identified. The annual MDS dated 1/12/15, identified R29 as an alert and oriented individual with diagnoses including depression, insomnia and hypertension. The MDS also indicated R29 required extensive assistance with activities of daily living and occasionally expressed feeling down, depressed hopeless and having trouble falling asleep. The Psychotropic CAA dated 1/15/14, indicated R29 received medications daily for the treatment of depression and R29's mood and behavior was monitored daily. The care plan dated 5/17/14, indicated the resident had a history of feeling down or depressed and directed the staff to contact the family as personal needs arose and attempt to change the subject if R29 appeared depressed. The plan directed the staff to encourage the resident to talk about past life interests such as gardening, dewing, baking and her family. The physician orders dated 1/28/15, included an order for Risperdal (antipsychotic medication). On 1/29/15, the Risperdal was decreased from 0.5 mg in the morning and 1 mg at bedtime to 0.5 mg twice a day. The physician had directed the staff to monitor R29's behavior once a week to monitor for adverse side effects.	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	04/09/2015

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21540	Continued From page 22 On 4/6/15, from 4:00 p.m. to 8:00 p.m., on 4/7/15, from 8:00 a.m. to 4:30 p.m., on 4/8/15, from 7:00 a.m. to 3:00 p.m. and on 4/9/15, from 8:00 a.m. to 2:00 p.m. R29 was observed to eat her meals in the dining room, participated in activities and had quiet time alone in her room. At no time was R29 observed to display any type of disruptive behaviors. The physician visit notes dated 11/25/14, and 1/28/15, did not address R29's mood or behaviors. The behavior documentation from 12/1/14 - 4/8/15, indicated R29 had not expressed any type of maladaptive behaviors. The progress notes from 12/1/14 - 4/8/15, indicated on 1/14/15, R29 talked to the staff about an accident from the past in which a girl and family had passed away. A note on 4/1/15, the nurse staff repeated R29's current Risperdal order and indicated they would monitor for behaviors. However, the clinical record lacked identification of what type of behaviors R29 displayed, why Risperdal was being used and identification of the goals as to what the Risperdal was to improve. On 4/8/15, at 12:50 p.m. NA-E stated R29 had displayed behaviors in the past in which she would see people looking into her windows. She stated R29 did not currently display any behaviors.	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21540	Continued From page 23 On 4/8/15, at 1:50 p.m. RN-A stated R29 displayed behaviors of telling false stories in the past. She confirmed R29's record did not identify this as a behavior, nor did the record include justification as to why Risperdal was appropriate for R29. On 4/8/15, at 2:05 p.m. the DON stated R29's target behaviors were to be easily identified in the record and on the care plan. She confirmed the care plan did not identify the behaviors, and the behavior documentation did not address R29's behaviors of past life fears. She confirmed R29 had received a medication reduction and the staff were to be documenting how the medication change was effecting R29 but confirmed the record lacked documentation. She stated the facility had a behavior committee but it had disbanded. R33 lacked clinical indications for the use of an antipsychotic and antidepressant medication and behavior/mood monitoring to determine efficacy of the medications. The quarterly MDS dated 2/16/15, identified R33 had severely impaired cognition, had no behaviors during the assessment period and required extensive assistance for all activities of daily living. The MDS indicated R33's diagnoses included: dementia with delusional features, anxiety and depression. R33's current medication orders dated 4/2015,	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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21540	Continued From page 24 identified R33 received Zoloft (an antidepressant medication) 50 mg daily, with a start date of 10/31/14, and Seroquel (an antipsychotic medication) 25 mg daily, with a start date of 11/14/14. On 4/8/15, at 7:09 a.m. R33 was observed dressed for the day and seated in a wheelchair next to the nurses station, with her head lowered, eyes closed and legs crossed. R33 appeared to be sleeping. At 7:33 a.m. R33 was at the dining room table with her head lowered, eyes closed, arms crossed in front of her chest and eyes closed. R33 appeared to be sleeping. At 7:44 a.m. R33 was still sleeping at the dining room table. R33's care plan dated 9/3/14, lacked identification of the use of an antipsychotic and antidepressant medications, the target behaviors displayed by the resident, any non pharmacological interventions, or possible side effects of the medications. The progress notes from 1/1/15 - 4/9/15, indicated the nursing staff would document the targeted behaviors and as needed medication use for R33's Ativan (anti anxiety medication), but lacked documentation of the Zoloft and Seroquel targeted behaviors and side effect monitoring. Review of the Behavior documentation from 12/1/14 - 4/9/15, revealed R33 had not displayed any type of behaviors or mood indicated for the anti-depressant or anti-psychotic medication use.	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21540	Continued From page 25 Review of the physician visit note dated 1/6/15, indicated R33's Ativan was ordered every 4 hours as needed for agitation, but did not address the targeted behaviors for the Zoloft or Seroquel use. Review of physician visit note dated 3/3/15, indicated R33 had been less agitated, but did not include any other documentation regarding the antidepressant or antipsychotic use. On 4/9/15, at 11:28 a.m. RN-B stated R33 was a very nice lady and was often sleepy. RN-B reported R33 had not displayed any behaviors or mood problems and was doing very well. On 4/9/15, at 11:32 a.m. NA-F reported R33 sometimes looked for her husband but that's it, and denied having any other behaviors or hallucinations. On 4/9/15, at 2:38 p.m. NA-G reported R33 was pretty easy to take care of, then stated the only behavior the staff had identified was R33 looked for her husband, and when she does they remind her he went home. NA-G denied R33 having any other behaviors, mood, hallucinations or delusions. On 4/9/15, at 2:15 p.m. the consulting pharmacist confirmed R33 was prescribed Zoloft for increased anxiety, and Seroquel for delusions and hallucinations. When asked if he would expect the physician or the facility to identify targeted behaviors for the prescribed	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	04/09/2015

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21540	Continued From page 26 medications, he responded he could not speak to that. On 4/9/15, at 1:41 p.m. the DON reported R33 had hallucinations of dead children and was inconsolable, however, the DON was unable to produce that information in R33's medical record. After review of the record, the DON was unable to confirm R33's targeted behaviors for the Zoloft and Seroquel use. The DON confirmed R33's care plan lacked information identifying the use of an anti-psychotic and anti-depressant medication, the targeted behaviors, non pharmacological interventions and possible side effects of those medications. The DON stated if there was not a care plan in place for those medications the staff were not documenting behaviors related to those medications, and confirmed the staff were only documenting behaviors related to the Ativan use. The DON confirmed targeted behaviors are expected to be in place for all psychotropic medications. The Psychopharmacological Medications and Sedative/Hypnotics policy dated 3/2015, directed the staff to monitor resident behaviors with medication changes and review the medications every three months by a medication reduction committee. In the review, the staff were to document the rationale for continuing the medication, evaluate the resident's target symptoms and the effect of the medication on the severity, frequency and other characteristics of the resident. SUGGESTED METHOD OF CORRECTION:	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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21540	Continued From page 27 The director of nursing and or designee could assure that policies and procedures are updated and that staff training has been completed to assure each resident's drug regimen is appropriately monitored following an adjustment in psychotropic medications. An auditing tool could be developed to monitor compliance, with involvement of the facility's consultant pharmacist, to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty -one (21) days.	21540		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to determine if the practice of self-administration of medications was safe for 4 of 4 residents (R45, R1, R17, R46) in the sample who were observed self-administering medications. Findings include: R45's quarterly Minimum Data Set (MDS) dated 3/11/15, indicated R45 was alert and orientated	21565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	04/09/2015

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21565	Continued From page 28	21565		

and had diagnoses including anemia, diabetes mellitus and Bell's palsy. The care plan dated 4/8/15, did not address self-administration of medication.

On 4/6/15, at 5:49 p.m. R45 was observed seated at a dining room table with three tablemates. Registered nurse (RN)-B approached R45 with a souffle cup of medications and eye drops. RN-B then placed the souffle cup of unknown medications on the table and walked away. At no time was RN-B observed to monitor R45 as he took the medications.

R45's physician orders dated 3/26/15, lacked an order to self-administer mediations.

R45's clinical record lacked a self-administration of medication assessment.

R1's annual MDS dated 1/14/15, identified R1 with diagnoses of anemia, hypertension and depression. The MDS indicated R1 was alert and oriented.

The care plan dated 5/13/14, directed the staff to administer medications as ordered. The care plan did not indicate R1 had the ability to self-administer medications.

On 4/6/15, at 6:15 p.m. R1 was observed seated in the dining room. RN-B was observed to approach R1 with a souffle cup of unknown medications. RN-B gave the medications to R1 and then walked away. R1 took the medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	04/09/2015

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21565	Continued From page 29	21565		

on her own. At no time did RN-B observe R1 to ensure she had taken the medications safely.

R1's physician orders dated 4/8/15, did not include an order for self-administration of medications.

R1's clinical record lacked a self-administration as medication assessment.

R17's quarterly MDS dated 2/18/15, indicated R17 was alert and oriented and had diagnoses including congestive heart failure and depression. The care plan dated 4/8/15, did not address self-administration of medications.

On 4/6/15, at 5:50 p.m. R17 was observed seated in the dining room. RN-B approached R17 with a souffle cup of medications. She placed the medications on the table and walked away. RN-B was not observed to stay with R17 until she had taken the medications. R17 was observed to take the medications independently.

The physician order dated 4/7/15, did not address self-administration of the medications.

R17's clinical record lacked a self-administration assessment.

On 4/8/15, at 11:30 a.m. RN-A stated none of the residents in the facility were safe to administer their own medications. She stated the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21565	Continued From page 30	21565		

administering the medications were to stay with the residents to ensure they had taken all of the medications.

On 4/8/15, at 2:00 p.m. the director of nursing (DON) stated none of the residents in the facility were able to self-administer their medications. She verified the staff were to stay with the residents while they received medications.

R46's quarterly MDS dated 3/15/15, indicated R46 had short-term and long-term memory problems, and the following diagnoses: dementia, hypertension, diabetes mellitus and atrial fibrillation (irregular heartbeat).

R46 was observed on 04/06/15, at 5:51 p.m. seated in a wheelchair next to a table in the dining room. At that time, trained medication aide (TMA)-A delivered R46's medications in a medication cup, set the medications down on the table in front of R46, then walked away. TMA-A immediately went to assist another resident prepare for the evening meal. At 5:55 p.m. TMA-A answered the telephone, then started feeding another resident the evening meal. TMA-A did not stay to observe R46 take the medications.

At 6:04 p.m. R46 sat alone at the table, then started putting the medications into his mouth with right hand, one by one until the medication cup was empty.

R46's Medication Administration Record (MAR) dated 4/6/15, indicated (TMA)-A had administered Coumadin 3 mg, Lipitor 10 mg, Glipizide 5 mg and Metoprolol 50 mg for p.m. medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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21565	Continued From page 31 R46's physician orders dated 3/18/15, did not include an order for self-administration of medications. On 04/09/15, at 1:39 p.m. the DON confirmed R46 had not been assessed to self-administer medications and did not have a physician order to self-administer medications. The DON stated R46 would not be safe or appropriate to administer own medications, and stated the staff member should have stayed with the resident until the medications taken. The Resident Self-Administration of Medication procedure dated 7/2014, directed the staff to ensure any resident who wished to self-administer their medications to be assessed by the interdisciplinary team and have a current physician's order prior to self-administering the medications. SUGGESTED METHOD OF CORRECTION: The director of nurses could inservice staff regarding the process for determination of resident capability to safely self-administer medications. An audit could be conducted to identify and assess residents who have the capability to participate in self-administration. This could be part of the quality assurance plan. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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21880	Continued From page 32	21880		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21880	Continued From page 33 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to investigate and promptly resolve a grievance related to missing personal property and oral hygiene for 1 of 1 residents (R27) reviewed for personal property. Findings include: R27's annual Minimum Data Set dated 1/21/15, identified she had significant cognitive impairment, and diagnoses which included but were not limited to dementia, anxiety, and depression. On 4/07/2015, at 11:21 a.m. family member (FM)-B, who was the daughter of R27, was interviewed and stated that she had provided the facility a written grievance related to missing clothing, dirty clothes being found in R27's closet, and lack of oral care for R27 on 3/27/15, and the facility had not acknowledged and followed up on the grievance. A Suggestion or Concern form dated 3/27/15, was provided by the administrator and it identified that (FM)-B had made a written grievance on 3/27/15, which identified the following for R27: -missing clothing including two pairs of slacks, olive green and blue denim; -two missing shirts; -dirty clothes found in R27's closet, and another residents clothes were found in R27's closet; and	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 34 -R27 lacked appropriate oral care. The response to the grievance was made by the facility administrator dated 3/30/15, and identified that instead of contacting the FM-B who made the written grievance, the administrator spoke with FM-C (a different daughter to R27 who was an employee of the facility). FM-C stated that there was lint on a velour jacket and FM-B was "obsessed" with R27's clothing, and the missing slacks were found and returned. There was no evidence that the facility administrator spoke to FM-B who had made the written grievance, and attempted to resolve all of the grievances FM-B had made. During interview with the administrator on 4/08/2015, at 11:09 a.m. she established she was in charge of following up on all grievances due to the facility not currently having a social worker. The administrator confirmed she had not spoken to FM-B regarding her grievances, but rather spoke to FM-C who thought that the only concern was related to lint on R27's velour jacket. The administrator stated she should have followed the facility's policy for grievances and contacted FM-B and made an attempt to resolve FM-B's grievances. The policy and procedure for Grievances, Complaints or Concerns dated February 2013, was reviewed and identified the following: "An investigation must be completed on all grievances. The investigation may be informal, but must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint...The social services director then will report the findings to the individuals filing the concern and to the center administrator."	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	04/09/2015

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GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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21880	Continued From page 35 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review, and/or revise policies and procedures to ensure resident/family grievances were appropriately addressed in a timely manner. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21880		

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245550	**GOOD SAMARITAN SOCIETY - WARREN**	*K4 **04/08/2015**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 2

NUMBER OF THIS BUILDING 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW

ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW

ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K29: [3] K56: [3]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1	A2	A3	A4	A5
[ ]	[X]	[ ]	[ ]	[ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A.	B.	C.
[X]	[ ]	[ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245550	**GOOD SAMARITAN SOCIETY - WARREN**	*K4 **04/08/2015**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 2

NUMBER OF THIS BUILDING 02

B

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW

ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW

ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

*K7 [13] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K29: [3] K56: [3]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1	A2	A3	A4	A5
[ ]	[X]	[ ]	[ ]	[ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A.	B.	C.
[X]	[ ]	[ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY