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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FMJ6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00961

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245314**

2.STATE VENDOR OR MEDICAID NO.
(L2) **841820900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WINTHROP**
(L4) **506 HIGH STREET**
(L5) **WINTHROP, MN** (L6) **55396**

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 **04/25/2012** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:

X 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: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	37			
(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 :
Gloria Derfus, Unit Supervisor 04/27/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 06/07/2012 (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
05/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Uploaded 06/14/12 DB

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/18/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN # 24-5314

At the time of the standard survey completed March 8, 2012, the facility was not in substantial compliance and the most serious deficiencies were 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 are required. The facility was given an opportunity to correct before remedies were imposed.

On April 20, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 25, 2012, the Minnesota Department of Public Safety completed a PCR by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on March 8, 2012, effective April 15, 2012. Therefore, the remedies outlined in our letter dated March 16, 2012, will not be imposed. See attached CMS-2567B forms for the results of the April 20, 2012 revisit and April 25, 2012 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5314 June 7, 2012

Ms. Lori Bussler, Administrator
Good Samaritan Society - Winthrop
506 High Street
Winthrop, Minnesota 55396

Dear Ms. Bussler:

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 April 15, 2012 the above facility is certified for:

37 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 37 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 27, 2012

Ms. Lori Bussler, Administrator
Good Samaritan Society - Winthrop
506 High Street
Winthrop, Minnesota 55396

RE: Project Number S5314021

Dear Ms. Bussler:

On March 16, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 8, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 20, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 25, 2012 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 8, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 15, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 8, 2012, effective April 15, 2012 and therefore remedies outlined in our letter to you dated March 16, 2012, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3792 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5314r112.rtf

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
245314	A. Building B. Wing	4/20/2012

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **04/15/2012**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/15/2012**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **04/15/2012**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **04/15/2012**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **04/15/2012**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/sd	04/27/12	18623	04/20/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/8/2012			

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
245314	A. Building B. Wing 01 - MAIN BUILDING 01	4/25/2012

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

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 Reg. # NFPA 101 LSC K0052	Correction Completed 04/15/2012	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/sd	04/27/12	22373	04/25/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/7/2012				

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 A. Building B. Wing	(Y3) Date of Revisit
245314	02 - 2006 ADDITION	4/25/2012

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

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 K0052	04/15/2012	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		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/sd	04/27/12	22373	04/25/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
3/7/2012	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FMJ6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00961

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245314**

2.STATE VENDOR OR MEDICAID NO.
(L2) **841820900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WINTHROP**
(L4) **506 HIGH STREET**
(L5) **WINTHROP, MN** (L6) **55396**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/08/2012** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **39** (L18)

13.Total Certified Beds **39** (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	IMR
	39			
(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 :
Sandra Christle, HFE NE II 04/04/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/17/2012 (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
05/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Uploaded 04/18/2012 DB FMJ6

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN # 24-5314

At the time of the standard survey completed March 8, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 5141

March 16, 2012

Ms. Lori Bussler, Administrator
Good Samaritan Society - Winthrop
506 High Street
Winthrop, Minneosta 55396

RE: Project Number S5314021

Dear Ms. Bussler:

On March 8, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 17, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 17, 2012 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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 remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 8, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 8, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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:

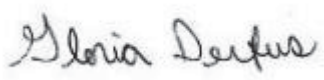
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3792 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5314s12.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING _____ B. WING _____	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

(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 COMPIANCE. UPON RECEIPT OF AN ACCEPTABLE POC AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANIAL COMPLAINCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATON.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by the provisions of Federal and Sate Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those	F 156		

RECEIVED
MAR 30 2012
COMPLIANCE MONITORING DIVISION
LICENSING AND CERTIFICATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lori Kruger RN	Director of Nursing	3/29/12

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

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F 156	Continued From page 1 other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control	F 156	F 156 Identified those residents who were required to receive the Notice of Medicare Provider Non-Coverage form. Verified that each resident did receive the Notice of Medicare Provider Non-Coverage form in a timely manner. On 3-27-12 reviewed with the Medicare nurse the policy and procedure for the Notice of Medicare Provider Non-Coverage form. The Medicare nurse verbalized understanding of the policy and procedure of the Notice of Medicare Provider Non-Coverage form. Audits of completed Notice of Medicare Provider Non-Coverage forms will be completed weekly x 4, then monthly x 2 to ensure they were done timely. Results will be forwarded to the Quality Committee for further recommendations Date of Completion: 4-15-12	

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F 156	Continued From page 2 unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to provide the required Notice of Medicare beneficiary's rights to appeal and	F 156		

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F 156	Continued From page 3 expedited appeal upon termination of Medicare benefits for 1 of 3 residents (R47) in the sample who was reviewed for Liability and Beneficiary Rights. Findings include: R47 was not provided the Notice of Medicare Provider Non-coverage letter to inform the beneficiary of their right to request a review of services following termination of Medicare Part A services for coverage reasons. R47 went to the physician on 12/20/11, with orders to discharge to home on 12/21/11. A nursing note dated 12/20/11, timed at 4:00 p.m. also indicated R47 had a referral to discharge to home on 12/21/11. A nursing note dated 12/21/11, indicated R47 went home at 4:00 p.m. on 12/21/11. The Medicare coordinator verified 12/20/11, was a Tuesday and did not know why R47 was not given an appropriate notice of Medicare coverage. The Medicare coordinator indicated there would of been time to provide the Medicare denial notice to R47 since the discharge was not until 4:00 p.m. and was on a week day. The appeal notice would have informed the resident of her right to a review of Medicare coverage. During the Liability Notice & Beneficiary Appeal Rights Review conducted at 1:30 p.m. on 3/5/12, the Medicare coordinator verified R47 did not receive the appropriate denial of Medicare coverage form required when the resident's Medicare coverage was discontinued on 12/21/11. The Medicare coordinator stated if a resident went home over the weekend they may	F 156		

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F 156	Continued From page 4 not get a denial of Medicare coverage notice. The policy for Notice of Medicare Provide Non-Coverage (with a revised date of April 2009) was reviewed. The policy read, "A Medicare provider is required to inform any beneficiary receiving Medicare Part A or Part B services from skilled nursing facilities that their coverage is ending."	F 156		
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		

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

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F 329	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify parameters for an as needed (PRN) narcotic medication for 1 of 4 residents (R6) sample who had utilized the PRN medication. Findings include: R6 was admitted on 4/24/10, with diagnoses which included status post fall, atrial fibrillation and pain. R6 had an order to receive 0.25ml (milliliters) to 0.05 ml of Roxanol (narcotic pain medication used to relieve moderate to severe pain) PRN without parameters for use. R6 had a significant change minimum data set (MDS) dated 2/6/12, that identified R6 was unable to complete the pain assessment interview. Per staff assessment for pain it was identified R6 had indicators of pain or possible pain observed daily. The care area assessment (CAA) dated 2/6/12, identified R6 was a poor reporter of pain and did not clearly verbalize needs or understanding. Staff were to anticipate and watch for signs and symptoms of non verbal pain. The care plan with a date of 5/12/10, identified R6 to have back pain with a history of shingles. Approaches included treatments as ordered, medications as ordered, and observe for adverse side effects. R6 had a physician's order on 2/3/12, for Roxanol 20 mg/ml (milligrams/milliliters) give 0.25 to 0.05 ml sublingual every 1-2 hours PRN. Upon review	F 329	F 329 Review of pain regimen for resident # 6 was completed on 3-7-12 with resident's Hospice nurse. The pain regimen for resident # 6 was adjusted per M.D. order on 3-7-12 with specific parameters for the PRN narcotic medication. Identified other residents who receive PRN narcotic medications. Each PRN narcotic will be reviewed with that resident's M.D. All residents requiring PRN medications will have parameters defined within the physician order. Education was provided to licensed staff on 3-26-12 on the need for residents to have parameters for all PRN medications including PRN narcotic medications. Audits of residents who receive PRN medications including PRN narcotic medications will be completed weekly x 4 then monthly x 2 to ensure that parameters have been defined and medication given as ordered. Results will be forwarded to the Quality Committee for further recommendations. Date of Completion: 4-15-12	

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F 329	Continued From page 6 of February's 2012 medication administrator record (MAR), R6 was noted to receive the PRN dose of Roxanol 21 times. One time the dose was given at 0.25 ml, the other 20 times the dose was given at 0.05ml. R6 did not receive the PRN Roxanol in the month of March 2012. Review of the nursing notes revealed R6 had pain on 2/6/12, 2/8/12, 2/10/12. There was no indication of what the pain level was at when PRN was given. A nursing note on at 11:15 a.m. on 2/23/12, identified R6 was on hospice services and had an order for Roxanol to be scheduled and then was changed to PRN for "unknown reasons"...the note went onto reveal, "will continue to keep Roxanol PRN at this time and continue to reassess". An interview was conducted with license practical nurse (LPN)-A on 3/6/12, at 10:35 a.m. LPN-A was asked how she knew how much Roxanol to give R6. LPN-A stated when R6's pain was high, LPN-A would give a higher dose. LPN-A further replied it will also be talked about in report and passed on to the next shift. LPN-A stated she would ask R6 to rate the pain level and then give the higher dose of Roxanol when the pain was higher (5 or greater on a 1-10 scale). LPN-A reviewed the MAR for February 2012 and verified pain was identified on 2/4/12, 6 out of 10 on the pain scale. All other entries on the MAR indicated Roxanol was for back pain and did not give intensity of pain. An interview was conducted with the director of nursing (DON) on 3/7/12, at 10:55 a.m. The DON did not think there were parameters identified for nursing staff to follow in regards to	F 329		

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F 329	Continued From page 7 the PRN Roxanol. Upon review of the physician's orders and MAR, the DON verified there were no parameters for nursing staff to follow when administrating the PRN Roxanol. A policy was requested in regards to PRN usage in the facility, the DON verified on 3/8/12, at 8:00 a.m. there was not a policy.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not ensure 2 of 8 cutting boards dry to prevent contamination and the facility did not ensure 2 of 8 cutting boards that were in good repair and had a cleanable surface. This had the potential to impact the 29 residents in the facility and all visitors or staff that purchased a meal at the facility. Findings include: The facility did not properly dry one of eight cutting boards (which led to another cutting board being wet) to prevent contamination and the	F 371	F 371 Damaged cutting boards were removed from the kitchen on 3-5-12. New cutting boards were ordered on 3-26-12. All staff will be trained on proper procedures for dry storage and drying of cutting boards. Weekly audits will be performed for 4 weeks to ensure compliance and then monthly for 6 months. The Dietary manager will monitor. Results will be forwarded to the Quality Committee for further recommendations. Date of Completion: 4-15-12	

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F 371	Continued From page 8 facility did not replace 2 of 8 cutting boards that were in ill-repair. At 1:00 p.m. on 3/5/11, a tour of the kitchen noted two of eight cutting boards was wet and stored flat, on top of the other seven cutting boards, which caused the next cutting board to be wet as well. The two cutting boards were stored and ready for use that was verified by the DD at the time of the tour. The DD also acknowledged the boards were wet. Two of eight cutting boards had grooves, were pitted and were permanently stained brown. Both cutting boards no longer had a cleanable surface. Both cutting boards were stored and ready for use that was verified by the DD at the time of the tour. The DD acknowledged the boards were not cleanable.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the consultant pharmacist failed to identify	F 428	F 428 Education provided to the consulting pharmacist on 3-16-12 on the need to identify parameters for PRN narcotic medications as well as all PRN medications Review of pain regimen for resident # 6 was completed on 3-7-12 with resident's Hospice nurse. The pain regimen for resident # 6 was adjusted per M.D. order on 3-7-12 with specific parameters for the PRN narcotic medication. The consulting pharmacist completed the monthly drug regimen review on 3-16-12 and identified those residents with a PRN narcotic medication order. Each drug regimen review form will be addressed with that resident's M.D. to ensure specific parameters for the PRN narcotic medication.	

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F 428	Continued From page 9 parameters for an as needed (PRN) narcotic for 1 of 4 residents (R6) sampled that had identified pain. Findings include: R6 was admitted on 4/24/10, with diagnoses which included status post fall, atrial fibrillation and pain. R6 had an order to receive 0.25 ml (milliliters) to 0.05 ml of Roxanol (narcotic pain medication used to relieve moderate to severe pain) PRN without parameters for use. R6 had a significant change minimum data set (MDS) dated 2/6/12, identified R6 was unable to complete the pain assessment interview. Per staff assessment for pain it was identified R6 had indicators of pain or possible pain observed daily. The care area assessment (CAA) dated 2/6/12, identified R6 was a poor reporter of pain and did not clearly verbalize needs or understanding. Staff were to anticipate and watch for signs and symptoms of non verbal pain. The care plan with a date of 5/12/10, identified R6 to have back pain with a history of shingles. Approaches included treatments as ordered, medications as ordered, and observe for adverse side effects. R6 had a physician's order on 2/3/12, for Roxanol 20 mg/ml (milligrams/milliliters) give 0.25 to 0.05 ml sublingual every 1-2 hours PRN. Upon review of February's 2012 medication administrator record (MAR), R6 was noted to receive the PRN dose of Roxanol 21 times. One time the dose was given at 0.25 ml, the other 20 times the dose was given at 0.05ml. R6 did not receive the PRN	F 428	A monthly drug review regimen will be done on all residents with PRN medication orders to ensure that parameters of PRN medications has been defined within the physician order. Audits will be completed monthly x 3 months on the pharmacy drug reviews to ensure that PRN narcotic medication parameters are identified. Audit results will be forwarded to the Quality Committee for further recommendations. Date of completion: 4-15-12	

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F 428	Continued From page 10 Roxanol in the month of March 2012. An interview was conducted with the director of nursing (DON) on 3/7/12, at 10:55 a.m. The DON did not think there were parameters identified for nursing staff to follow in regards to the PRN Roxonal. Upon review of the physician's orders and MAR, verified there were no parameters for nursing staff to follow when administrating the PRN Roxanol. An interview was conducted with the consultant pharmacist on 3/8/12, at 9:20 a.m. The consultant pharmacist indicated a guideline for pain medication would be safer to start at a lower dose (0.25 ml) then the higher dose (0.5 ml). The consultant pharmacist stated she would typically check the medications and orders. If there was an order that was PRN and it was used frequently or with out specific parameters, she would suggest to have the medication scheduled and have parameters given. The consultant pharmacist verified she did not see R6 had used the PRN Roxanol times in February 2012 with out specific parameter dose orders. A policy was requested in regards to PRN usage in the facility, the DON verified on 3/8/12, at 8:00 a.m. there was not a policy.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431		

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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 431	Continued From page 11 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the stock supply of Tubersol (used to test for tuberculosis{TB}) was properly labeled. This had the potential to affect newly admitted residents which included 3 of 29 (R55, R56, and R57) residents currently residing in the facility.	F 431	F 431 The Tubersol vials were removed from the Medication room fridge and new Tubersol vial reordered on 3-7-12. Identified those residents that could have received Tubersol from undated vials. Addressed with M.D. and directions to readminister Tubersol were obtained. Licensed staff were educated on 3-26-12 on the importance to date the Tubersol vials when opened and discard unused portion after 30 days. Outdated medication will be removed from the medication refrigerator. Medications will be checked weekly if outdated and discarded when needed. The pharmacy will send Tubersol vials with "date opened" stickers on them for licensed nursing staff to write the date on the stickers when the vial is opened. Audits will be completed weekly x 4, then monthly x 2 to ensure that Tubersol vials are being dated when opened. Audit results will be forwarded to the Quality Committee for further recommendations. Date of completion 4-15-12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING _____ B. WING _____	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

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F 431	Continued From page 12 Findings include: Two Tubersol vials were not correctly dated when opened. The medication storage areas were inspected at 12:58 p.m. on 3/5/12, in the presence of the licensed practical nurse (LPN)-B. There were two open house stock Tubersol vials in the refrigerator, that were opened, but were not labeled with the date when they was opened. Both vials were sent from the pharmacy on 1/13/12. The LPN-B verified the missing opening dates and stated staff were supposed to date multi-dose vials when they first open them. LPN-B also stated stock Tubersol was administered to new residents. At 10:15 a.m. on 3/7/12, the director of nursing (DON) stated stock Tubersol was administered to new residents. The DON also stated Tubersol expired 30 days after opening, and staff was expected to write the date on the vial when they opened it. Medical record review at 11:00 a.m. on 3/8/12, revealed the following: R55 received the first step of the tuberculosis skin test (TST) on 2/22/12, and the second step on 3/2/12. R56 received the first step of the TST on 2/26/12. R57 received the first step of the TST on 3/6/12. At 11:30 a.m. on 3/8/12, the DON verified the above listed residents were potentially tested for tuberculosis with expired Tubersol injection.	F 431		

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	245314	A. BUILDING _____ B. WING _____	03/08/2012

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F 431	Continued From page 13 An interview was conducted at 9:15 a.m. on 3/8/12, with the consultant pharmacist (CP), who stated the Tubersol vials had to be dated when opened, and were good only for 30 days after opening. The Recommended Minimum Medication Storage Parameters Policy dated 10/6/11, indicated for Tubersol injection directed staff to, "Date when opened and discard unused portion after 30 days."	F 431		

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

F 314020

PRINTED: 03/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety on March 7, 2012. At the time of this survey, Building 01 of Good Samaritan Society Winthrop 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 Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 ST. Paul, MN 55101-5145	K 000	POC ok PS 4-4-12 RECEIVED MAR 30 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lori Bussler	Administrator	4/3/12

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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K 000	Continued From page 1 Pat.Sheehan@state.mn.us Fax: 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Winthrop was constructed as follows: The original building was built in 1965, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st addition was built in 1966, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd addition was built in 1994, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 3rd addition was built in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 4th addition was built in 2006, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The original 1965 building and the 1966, 1994 and 1995 Additions are identified as Building 01,	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 2 and were surveyed at Chapter 19 Existing Health Care Occupancies. The 2006 Addition is identified as Building 02, and was surveyed at Chapter 18 New Health Care Occupancies. Two (2) Form CMS-2786R booklets were completed. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The resident rooms in the 2006 addition have hard-wired, automatic smoke detection which are connected to a nurse call system. The facility has a capacity of 39 beds and had a census of 30 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - A fire alarm system required for life safety shall be installed, tested,	K 052	K052 Environmental Service Supervisor contacted the contractor, Protection Systems, and was assured that the testing had been completed on the manual fire alarm boxes and heat detectors in question. The contractor will provide the documentation to include as an addendum to the fire alarm system test report. This will be completed by 4-15-12. The Environmental Services Supervisor will monitor. The maintenance director will measure distance of all smoke detectors from the HVAC units. Detectors which are not in compliance will be moved. This will be completed by 4-15-12. Environmental Services Supervisor will monitor.	4-15-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 052	Continued From page 3 and maintained in accordance with NFPA 70 National Electrical Code (1999 edition) and NFPA 72 National Fire Alarm Code (1999 edition). The system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70 (99) and NFPA 72 (99) and NFPA 101 Life Safety Code (2000 edition), Chapter 9, Section 9.6.1.4. This STANDARD is not met as evidenced by: Based upon observation and interview, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 19, Section 19.3.4.1. and NFPA 72 (1999 edition) Sections 2-3.5.1, 2-3.6.6.2. and Sections 7-3.2 and 7-5.2.2 and Table 7-3.1. FINDINGS INCLUDE: On 3/7/12 between 11:00 AM and 2:00 PM, through observation and documentation review the following practices were confirmed: A). Two (2) smoke detectors on the West Wing Corridor were located within 3-feet of HVAC openings, and were not in conformance with the requirements at NFPA 72 (1999) Chapter 2, Section 2-3.6.6.2; B). The facility's most recent Fire Alarm Inspection and Testing Form dated 10/5/11 did not include all of the required information for an annual fire alarm system test report. Specifically, in the Alarm Initiating Devices and Circuit Information section, the report identified nine (9) manual fire alarm boxes and ten (10) heat detectors in the system. However, the Initiating and Supervisory Device Tests and Inspections section of the form did not specify the location of	K 052		

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K 052	Continued From page 4 these devices nor verification of the visual inspection and functional test results for these initiating devices on the fire alarm system. In a fire emergency, these deficient practices could adversely affect 39 of 39 residents, staff and visitors.	K 052		

GOOD SAMARITAN SOCIETY - WINTHROP MN

Count	Loop Address	Device Type	Description	Day & Night Sensitivity	Drift Compensation 0 - 10	Sensitivity Reading	Sensitivity Pass	Sensitivity Fail	Functional Test Pass	Functional Test Fail	Damper Test
4		Thermal Detector	SOILED UTILITY BY ADMINISTRATION						✓		
5		Thermal Detector	BASEMENT LUNCHROOM						✓		
6		Thermal Detector	BASEMENT STORAGE						✓		
7		Thermal Detector	BASEMENT OFFICE						✓		
8		Thermal Detector	BASEMENT OFFICE STORAGE						✓		
		Total 8									
1		Manual Station	BACK ENTRY BY LAUNDRY						✓		
2		Manual Station	LAUNDRY ROOM						✓		
3		Manual Station	HALL BY ROOM 127						✓		
4		Manual Station	HALL BY ROOM 132 (EXIT)						✓		
5		Manual Station	HALL BY ROOM 138						✓		
6		Manual Station	BY NURSES STATION						✓		
7		Manual Station	HALL BY ROOM 101						✓		
8		Manual Station	DINING ROOM						✓		
9		Manual Station	BASEMENT BY STAIRS						✓		
		Total 9									
1		Supervisory	KITCHEN ANSUL TRIPPED						✓		
		Total 1									
1		Supervisory	SPRINKLER SYSTEM TAMPER						✓		
2		Supervisory	SOUNDER BASE POWER LOSS						✓		
3		Supervisory	CO DETECTOR						✓		
		Total 3									
1		Waterflow	SPRINKLER SYSTEM WATERFLOW						✓		
		Total 1									

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

F5314020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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DC: 04.17.2012
EXIT: 03.08.2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lori Ruger RN	Director of Nursing	3/29/12

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K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with NFPA 70 National Electrical Code (1999 edition) and NFPA 72 National Fire Alarm Code (1999 edition). The system shall have an approved maintenance and	K 052	K052 Environmental Service Supervisor contacted the contractor, Protection Systems, and was assured that the testing had been completed on the manual fire alarm boxes and heat detectors in question. The contractor will provide the documentation to include as an addendum to the fire alarm system test report. This will be completed by 4-15-12. The Environmental Services Supervisor will monitor. The maintenance director will measure distance of all smoke detectors from the HVAC units. Detectors which are not in compliance will be moved. This will be completed by 4-15-12. Environmental Services Supervisor will monitor.	4-15-12

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K 052	Continued From page 3 testing program complying with the applicable requirements of NFPA 70 (99) and NFPA 72 (99) and NFPA 101 Life Safety Code (2000 edition), Chapter 9, Section 9.6.1.4. This STANDARD is not met as evidenced by: Based upon observation and interview, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 19, Section 19.3.4.1. and NFPA 72 (1999 edition) Sections 2-3.5.1, 2-3.6.6.2. and Sections 7-3.2 and 7-5.2.2 and Table 7-3.1. FINDINGS INCLUDE: On 3/7/12 between 11:00 AM and 2:00 PM, during a review of available documentation provided by facility staff, it was noted that the facility's most recent Fire Alarm Inspection and Testing Form dated 10/5/11 did not include all of the required information for an annual fire alarm system test report. Specifically, in the Alarm Initiating Devices and Circuit Information section, the report identified nine (9) manual fire alarm boxes and ten (10) heat detectors in the system. However, the Initiating and Supervisory Device Tests and Inspections section of the form did not specify the location of these devices nor verification of the visual inspection and functional test results for these initiating devices on the fire alarm system. In a fire emergency, these deficient practices could adversely affect 39 of 39 residents, staff and visitors.	K 052		