

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Delivered

July 18, 2017

Mr. Ryan Cerney, Administrator Good Samaritan Society - Bethany 804 Wright Street Brainerd, MN 56401

Subject: Good Samaritan Society - Bethany - IDR

Provider # 245500 Project # S5500027

Dear Mr. Cerney:

This is in response to your letter of March 3, 2017, in regard to your request of an informal dispute resolution (IDR) for the federal deficiency at tag F431 issued pursuant to the survey event G24W11, completed on February 9, 2017.

The information presented with your letter, the CMS 2567 dated February 9, 2017 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

S/S-D

F431 (E) §483.45(g) Labeling of Drugs and Biologicals

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

The facility asserts their Pharmacy prepared electronically dispensed medication packets for resident use which meets the minimum required information as set forth in F431. The facility asserts the prepackaged medications labeling met the requirements set forth in accordance with currently accepted professional standards such as those set for by Minnesota State Pharmacy Board Rules 6800.3200 Prepackaging and Labeling.

Summary of facts: During an observation of a medication pass on 2/6/17 at 6:14 p.m., licensed practical nurse (LPN)-A prepared medications for R60. R60's medications were retrieved from medication pouches that had been filled by an electronic medication dispensing unit. The first medication pouch label included the resident's name, date of dispensing, evening, and Percocet tablet 5-325 milligrams (mg) and Coumadin 1.5 milligrams (mg) orally daily, description of the medication (i.e.., medication is white and round with number 203 on it), the prescription number, the

Good Samaritan Society - Bethany July 18, 2017 Page 2

name of the pharmacy and name of physician. However, the route of administration was not identified on the packet. The second medication pouch label included the same information: resident name, date and "evening" along with Sinemet 25-100 mg tablet and metformin 500 mg tablet, with a description of the medications, prescription number, physician and pharmacy name. The route of administration was not identified.

During the survey, the facility had provided surveyors with their policy Medication Ordering and Receiving from Pharmacy, Medication Labels dated 6/15. Under letter M of the policy was the following information: "Labels from automated dispensing units placed in the facility must comply with State Board of Pharmacy requirements. At a minimum, the package labeling from automated devices must contain the following:

- 1) Name of resident
- 2) Name of medication as ordered
- 3) Expiration date

Summary of findings: Following review of the CMS 2567, review of additional information received from the facility, and discussion with MDH survey staff, it is determined the facility's automated medication pouch labels meet the minimum required labeling requirements in accordance with the Minnesota Board of Pharmacy rules and the facility policy/procedure.

This is not a valid example of a deficient practice under this regulation and the findings will be removed from the CMS 2567 Statement of Deficiencies. In addition, MN Rule 4658.1345 will be removed from the State Licensure Form.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Gary Nederhoff, Unit Supervisor Licensing and Certification Program Health Regulation Division

Telephone: 507-206-2737 Fax: 507-206-2711

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Lyla Burkman, Bemidji District Office Unit Supervisor

S5500027

PRINTED: 07/18/2017 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BETHANY CAN ID SQUAMARY SYNTEMENT OF DEFICIANCIES STREET ADDRESS, CITY, STATE, ZIP CODE SOW WRIGHT STREET BRAINERD, MN 56401		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
GOOD SAMARITAN SOCIETY - BETHANY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SEP PRECEDED BY FULL TAG) PREFIX TAG		245500 B. WING			02/09/2017			
FREEN TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance with the regulations has been attained in accordance with your verification. F 279 SS=D (d) Use. A facility must maintain all resident assessments completed within the previous of the resident's active record and use the resident's active record and use the resident's active record and use the resident's comprehensive care plan. (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at \$483.10(c)/2 and \$483.10(c)/3, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive			- BETHANY		8	804 WRIGHT STREET		
The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. F 279 483.20(a):483.21(b)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at \$483.10(c)(2) and \$483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLÉTION
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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.

Electronically Signed

03/03/2017

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F 279	(i) The services that or maintain the resphysical, mental, at required under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, included treatment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS rationale in the resident's representationale in the resident's representational entities. (B) The resident's governmentation was associated outcomes. (B) The resident's governments as local contact agence entities, for this purification, as appropriative requirements set for section.	at are to be furnished to attain ident's highest practicable and psychosocial well-being as i3.24, §483.25 or §483.40; and at would otherwise be required i3.25 or §483.40 but are not eresident's exercise of rights luding the right to refuse i83.10(c)(6). I services or specialized es the nursing facility will of PASARR If a facility disagrees with the iARR, it must indicate its ident's medical record. With the resident and the entative (s)- goals for admission and oreference and potential for acilities must document int's desire to return to the sessed and any referrals to cies and/or other appropriate	F 27				

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F 309 SS=D	RN-G stated they u medications on the R44's care plan sho monitoring for signs and interventions rebleeding. The Plan Of Care p 11/16, indicated a c to include medicatio other items, as app 483.24, 483.25(k)(l) FOR HIGHEST WE 483.24 Quality of life Quality of life is a fuapplies to all care a residents. Each residents. Each residents. Each residents on practicable physical well-being, consisted comprehensive assessment of a residents. Basessment of a rethat residents receivaccordance with propractice, the comprehensive, as the comprehensive with propractice, the comprehensive compre	and should have done so. sually included all high risk care plan. RN-G indicated ould have addressed and symptoms of bleeding elated to the event of a solicy and procedure revised are plan would be developed ons and treatments and any ropriate. PROVIDE CARE/SERVICES ELL BEING e indamental principle that and services provided to facility sident must receive and the extrements and plan of care. The fundamental principle that indicate the necessary care and in maintain the highest land, and psychosocial ent with the resident's ressment and plan of care. are fundamental principle that itent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered residents' choices, including	F 2	79		3/13/17
	(k) Pain Manageme	ent.				

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F 309	provided to resident consistent with profithe comprehensive and the residents' go. (I) Dialysis. The fact residents who requiservices, consistent of practice, the compact care plan, and the repreferences. This REQUIREMENT by: Based on observative review, the facility for the	issure that pain management is its who require such services, essional standards of practice, person-centered care plan, goals and preferences. Cility must ensure that ire dialysis receive such it with professional standards in prehensive person-centered residents' goals and interview and document ailed to administer as needed etic) according to physician sident (R16) reviewed who is according to physician sident (R16) reviewed who is according to staff for bed dressing, toilet use and individuals independent with included edema (swelling), etion of fluid that causes and legs), and hypertension	F 30	1. Resident 16's (PRN) Lasix (a order is being followed and adm as ordered by licensed facility stare at risk of the same deficient 3. Licensed staff were educated 3/1/2017 and 3/2/2017 on the administration of (PRN) Lasix (a to ensure the medications are b administered according to the other than the medications and administration of (PRN) Lasix (a to ensure that the medications and administered as prescribed. The will occur at a minimum of 3x/w weeks with results to the QAPI of for further recommendations.	ninistered taff. (a diuretic) practice. I on a diuretic) eing rder. y audit the a diuretic) are being le audits k for 4	

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F 309	included the following redaily weight one to administer PRN Later-Lasix Tablet 40 m needed for increase 212. Notify physicial days of administrating/17. The Report also incomposition of time a day. If eden order. Review of R16's more follow weights: 1/9/17: 212.2 1/12/17: 212.8 1/14/17: 212.5 1/16/17: 212.5 1/16/17: 212.5 1/26/17: 213.5 1/30/17: 212.5 1/31/17: 212.7 2/4/17: 212.8 2/5/17: 213.4 2/6/17: 212.8 The Consultant Phare Reviews included a pharmacist dated 1 make sure the Lasi	lication Review Report ng physician orders: me a day for edema.	F3	09		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 309	check per paramet	document a daily edema er." A hand written note next ation dated 1/16/17, indicated	F 30	9		
a n		Records Dated 1/1/17-1/31/17 indicated R16 had received asix.				
	diuretic therapy for directed staff to mo adverse conseque	e plan identified R16 received edema and hypertension and onitor of interactions and nce of the medication. The cted staff to weigh R16 daily.	C			
	seated in her reclin the recliner was electrousers, compress shoes. The legs of the ankle and R16 not observed to be observed to the top slipper type shoes. have swelling in he much better than it she had special stofeet elevated in her	a.m. R16 was observed her, in her room. The foot of evated. R16 was wearing sion stockings and slipper type of the trouser were raised above is lower legs and ankles were swollen. Slight swelling was of R16's feet above the R16 stated she did at times are lower extremities but it was a used to be. R16 also stated ockings she wore and kept her it recliner. R16 stated she did eation for the swelling.				
	stated he would ha determine when PI administered to R1	p.m. registered nurse RN-F ave to check the order to RN Lasix was to be 6. After consulting the RN-F stated he would give it for				

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F 322 SS=D	RN-F indicated R16 so she did not rece However, RN-F cor as written above an received any PRN I RN-F stated R16 sl Lasix on the days wabove. On 2/8/17, at 2:09 porder for PRN Lasix verified R16 should the days the weight The Medication Adr 5/2016, indicated the medication correctle medications would resident according drug, dose, time, rough 483.25(g)(4)(5) NG RESTORE EATING (g) Assisted nutrition (Includes naso-gas both percutaneous percutaneous endo enteral fluids). Base comprehensive assensure that a reside (4) A resident who alone or with assist methods unless the	2+ or for a weight over 212. 6's current weight was 211.6 ive PRN Lasix that day. Infirmed the previous weights and confirmed R16 had not Lasix in January or February. Incomplete the weights were 213 and when the weights were 213 and that the weight over 212 and have received PRN Lasix on a was over 212 as ordered. Indicate the weight over 212 and have received PRN Lasix on a was over 212 as ordered. Indicate the weight over 212 and have received PRN Lasix on a was over 212 as ordered. Indicate the weight over 212 and have received PRN Lasix on a was over 212 as ordered. Indicate the weight over 212 and have received PRN Lasix on a was over 212 as ordered. Indicate the weight over 212 and have received PRN Lasix on a was over 212 as ordered. Indicate the weight over 213 and have received PRN Lasix on a was over 212 as ordered. Indicate the weight over 213 and have received PRN Lasix on a was over 212 as ordered. Indicate the weight over 213 and have received PRN Lasix on a was over 212 as ordered. Indicate the weight over 215 and have received PRN Lasix on a was over 212 as ordered. Indicate the weight over 213 and have received PRN Lasix on a was over 212 as ordered. Indicate the weight over 213 and have received PRN Lasix on a was over 212 and have received PRN Lasix on a was over 212 and have received PRN Lasix on a was over 212 and have received PRN Lasix on a was over 212 and have received PRN Lasix on a was over 212 and have received PRN Lasix on a was over 212 and have received PRN Lasix on a was over 212 and have received PRN Lasix on a was over 212 and have received PRN Lasix on a was over 212 and have received PRN Lasix on a was over 212 and have received PRN Lasix on a was over 212 and have received PRN Lasix on a was over 212 and have received PRN Lasix on a was over 212 and have received PRN Lasix on a was over 212 and have received PRN Lasix on a was over 212 and have received PRN Lasix on a was over 212 and have received PRN Lasix on a was over 212 and have received PRN Lasix on a was	F 30			3/13/17

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F 322	indicated and consists of the appropriate of the ap	ented to by the resident; and is fed by enteral means oriate treatment and services ale, oral eating skills and to ons of enteral feeding including spiration pneumonia, diarrhea, on, metabolic abnormalities, eal ulcers. NT is not met as evidenced ation, interview and document ailed to ensure medication as directed by facility policy for 04) observed to receive a stons via a percutaneous stomy tube. Agnosis report printed 2/6/17, agnoses as dysphasia g) gastro-esophageal reflux yperlipidemia (abnormally in the blood), chronic kidney are in the blood), chronic kidney are in the blood).	F3	1. Resident 204 now has an orallowing medications to be admin cocktail form via PEG tube. 2. All residents with assisted nutydration who receive their methrough the enteral tube are at same deficient practice. All residents with a same deficient practice. All residents are affected by this currently has for cocktailing medications. 3. All nursing staff were educated 3/1/2017 and 3/2/2017 in regared for orders to cocktail medication via an enteral tube. 4. Staff to audit all residents with nutrition and hydration via enteral tube and the subject of the completed weekly weeks with results to QAPI confurther recommendations.	utrition and dications risk for the idents who ave orders ed on d to the lications h assisted ral tube. for 4	

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F 322	for feeding), howey and justification for and crushed medical or angina), one tablet (antidepressant) arm (treats overactive identified the medical or combined the medical or combined the medical or combined the medical or combined the medical or plastic sleeve pack manual pill crusher together. Once crusinto a 30 cc plastic cc of water. RN-H with the medication pair of gloves and concluded a graduate syringe. At 6:40 p.m. RN-H unclamped and rer syringe and checked up 20 cc of tap wat the tube with the wayringe, withdrew the reinserted the syring and proceeded to prixture with 20 cc followed by another removed the syring and proceeded to prixture with 20 cc followed by another removed the syring and proceeded to prixture with 20 cc followed by another removed the syring and proceeded to prixture with 20 cc followed by another removed the syring and proceeded to prixture with 20 cc followed by another removed the syring and proceeded to prixture with 20 cc followed by another removed the syring and proceeded to prixture with 20 cc followed by another removed the syring and proceeded to prixture with 20 cc followed by another removed the syring the process of the process	rer the report lacked an order cocktailing (mixture of liquid rations) the medications. p.m. registered nurse (RN)-H ash her hands and open a register and open a register of Metoprolol (treats hypertension and of Mirtazapine 7.5 mg and one tablet of Oxybutynin 10 we bladder). The packet rations, however, lacked oute of administration. RN-H recations and placed them into a recomplete of the tablets into a recomplete of the tablets and crushed the tablets medication cup and added 20 proceeded into R204's room and supplies which with tap water and a 60 cc. I exposed R204's g-tube, moved the plug, connected the red for placement. RN-H drew red for p	F3	22			
		othing and exited the room.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING			3) DATE SURVEY COMPLETED		
		245500	B. WING _		02/	02/09/2017	
	PROVIDER OR SUPPLIER	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP CODE 804 WRIGHT STREET BRAINERD, MN 56401	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 322	On 2/6/17, at 6:40 psure if R204 had ar R204's medications	ge 10 sh the tube after each on, per policy directive. o.m. RN-H stated she was not n order to crush and mix all of s together and give them RN-H reviewed R204's	F 3	22			
	and was unable to R204's medications she was taught to a individually and flus	administration record (MAR) find an order to cocktail s. RN-H stated during training administer each medication the between medications.	C				
	(DON) reviewed R2 verified R204 did no medications. The D directed staff to addressparately and flus	c.m. the director of nursing 204's medication orders and of have an order to cocktail on confirmed the facility policy minister each medication in between each medication. er expectation was for staff to					
F 441 SS=D	revised 5/16, direct medication separat tubing between each	e)(f) INFECTION CONTROL,	F 44	41		3/13/17	
	The facility must es	tablish an infection prevention (IPCP) that must include, at owing elements:					

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 441	investigating, and of communicable dise volunteers, visitors, providing services of arrangement based conducted according accepted national simplementation is F. (2) Written standard for the program, who will be for the program, who will be fore they can spropriately; (ii) When and to who communicable diserported; (iii) Standard and trope to be followed to provide for the program of the progra	eventing, identifying, reporting, ontrolling infections and cases for all residents, staff, and other individuals under a contractual di upon the facility assessment of the standards (facility assessment chase 2); Ids, policies, and procedures nich must include, but are not eillance designed to identify able diseases or infections read to other persons in the standards of infections are or infections should be ansmission-based precautions event spread of infections; isolation should be used for a	F 44				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP CO 804 WRIGHT STREET BRAINERD, MN 56401		
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F 441	contact with resider contact will transmit (vi) The hand hygie by staff involved in (4) A system for recunder the facility's lactions taken by the (e) Linens. Person process, and transpared of infection. (f) Annual review. annual review of its program, as necess This REQUIREMED by: Based on observative review, the facility sappropriate infection providing direct result of 1 resident (R65 care. Finding include: R65's quarterly Min 12/27/16, indicated dementia, anxiety a staphylococcal aure indicated R65 was required supervision.	skin lesions from direct hts or their food, if direct to the disease; and the procedures to be followed direct resident contact. Cording incidents identified PCP and the corrective efacility. The must handle, store, port linens so as to prevent the line facility will conduct an IPCP and update their	F 4-	1.Resident 65 s dressing is changed following appropriat control measures. 2.All residents with wounds a not having their dressings changed following appropriate infection measures. 3.Licensed Nursing staff education following appropriate infection measures with dressing changes with dressing changes and on communication r/t resinfections on 3/1/2017 and 3/4.DNS or Designee to randor residents dressing changes. will also review effectiveness communication r/t active infections on the audits will occur	re at risk of anged n control cated on n control nges as it ocedures I infections sidents with (2/2017. mly audit The audits of ctions in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245500	B. WING			02/0	9/2017
	PROVIDER OR SUPPLIER			80	TREET ADDRESS, CITY, STATE, ZIP CODE 04 WRIGHT STREET FRAINERD, MN 56401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	MRSA infection to The plan directed when changing co linens in bags mar	age 13 ated 8/30/16, indicated R65 had wound on the left lower leg. staff to wear gowns and masks ntaminated linens, place soiled ked biohazard and to bag ag tightly before taking to	F 4	41	minimum of 3x/wk for 4 weeks with to the QAPI committee for further recommendations.	results	
	(LPN)-B stated R6 dressing changes be assisting with the room, R65 was obtoom, R65 was on the second to R65. LPN-A plate on the second town R65. LPN-A wore dressing. R65 had leg which were earlighted was from placed was from placed was from placed was cleansed, floor next to her. In donned fresh glow with aerosol saline wound cleaner). Semptied it in the resistance of the second town and cleaner). Semptied it in the resistance of the second with aerosol saline wound cleaner). Semptied it in the resistance of the second with the second cleaner of the second with the se	N-B gathered supplies for the ared the room. LPN-A placed a n front of R65's left leg. She and towel on the floor adjacent ced a box of dressing supplies el and sat on the floor next to gloves as she removed the old if two wounds on his lower left ch approximately 2.5 in diameter. R65 stated the first ressure and the second wound					

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F 441	supplies in a clear R65's shelf. She p carried them down room. At no time of LPN-B observed to equipment other th observed to bag th room. -At 2:09 p.m. LPN-active infection, the utilize anything modressing change. Shagged the dirty towash the wound properties of the contact of the contact is was to look to see at this time. On 2/9/17, at 9:30 specialist stated and be under contact is was to have a sign personal protective gloves, and masks garbage and yellow at this time, none of were in contact present in contact wireviewed R65's clir R65's last wound contact in the contact wireviewed R65's clir R65's last wound contact in the contact wireviewed R65's clir R65's last wound contact in the contact wireviewed R65's clir R65's last wound contact in the contact wireviewed R65's clir R65's last wound contact wireviewed R65's clir R65's last	_	F 4	41			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 804 WRIGHT STREET BRAINERD, MN 56401		
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F 441	Infections in Center revealed a form winame, room numbinifection, site of in agents, treatment measure, isolation staff to identify if the facility or not. The identify a resolution on 2/8/17, at 9:35 to be on contact is staff were to wear masks during dress were to be contain on 2/9/16, at 9:40 (DON) confirmed I and the staff were precautions during DON stated she wind been removed would have been in the Multidrug-Ress 11/2016, directed a moisture-resistar room surfaces or for to utilize contact programs. On 2/9/17, at 9:45 Multidrug-resistant confirmed the policy of the staff were precautions during the staf	obtained. Inthly Report of Resident er / infection control log, hich identified the resident er, admission dated, date of fection, culture take, causative measures, cautionary precaution and directed the ne infection was acquired in the infection control logs did not not ate. a.m. RN-B confirmed R65 was olation precautions and verified gowns, gloves and possibly sing changes and all linens ed in yellow biohazard bags. a.m. the director of nurses R65's wounds contained MRSA to be utilizing contact the dressing changes. The as not aware the precautions and did not know when they	F 4	141		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP CODE 804 WRIGHT STREET BRAINERD, MN 56401	
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F 465 SS=E	linen changes if the The DON stated Referemained in place to during dressing characters was used bed which would care on 2/9/17, at 12:35 been hospitalized a infections. However R65 had been cleared from the en cleared from the was unaware from the was unaware from the floor during the have bagged the limprior to leaving the wound status had reference to leaving t	dressing changes and during dressing had not fallen off. 65's dressings typically out gowns should be worn anges since aerosol wound to directly wash the wound ause potential splatter. a.m. LPN-B stated R65 had and had been cleared of all er, RN-A interjected and stated ared of osteomyelitis, but had om the MRSA. LPN-A stated and the worn a gown, not sat on dressing change and would have worn a gown, not sat on dressing change and would hens in a yellow biohazard bag froom. LPN-B stated R65 not been communicated. AL/SANITARY/COMFORTABL Ental Conditions Ovide a safe, functional, ortable environment for the public. Es, in accordance with State, and local laws and ng smoking, smoking areas, or that also take into account	F 46		3/13/17 e had

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	review, the facility f wheelchairs and ca and/or a clean and residents (R125, R3 wheelchairs and ed dirty and in need of Findings include: On 2/6/2017, at 6:3 the dining room sea was leaning over thand spit onto the w floor. The right whe food debris and a direct of the wheelchair brak tattered and peeling wheelchair was not exposing the white On 2/7/17, at 10:14 his room, seated in right side of the whore crumbs adhered to On 2/7/17, at 10:47	ailed to maintain resident re equipment in good repair sanitary condition for 6 of 6 35, R128, R106, R236) whose juipment were observed to be cleaning and/or repair. O p.m. R125 was observed in ated in a wheelchair. R125 is right arm rest of the chair heel of the wheelchair and the ried white substance. 3 a.m. R35's wheelchair was range colored tape adhered to be handles. The tape was g. The left arm rest of R35's ed to be cracked and peeling foam padding. a.m. R128 was observed in an electric wheelchair. The eelchair seat cushion and right side of the chair and the d to have dried food debris and	F 4	-65	their wheelchairs and cushions clear Resident R35 had tape and armres replaced. Resident R106 had knee cleaned. Resident R236 had armre replaced. 2. All residents are at risk for havin soiled w/c's and are at risk for havin these items in need of repair. Resiwith braces are at risk of having the braces covered in food debris. All wheelchairs were audited for clean and to determine if they were in nerepair. All braces were audited for cleanliness as well. Those items identified as in need of repair or in cleaning have been repaired and/ocleaned. 3. The system currently in place for cleaning the wheelchairs and brace least weekly and checking for damathat time has been reviewed and re-enforced. All Nursing staff educated at that time on how report wheelchairs and braces in necleaning and/or repair. 4. DNS or Designee to randomly at wheelchair and brace cleanliness a repair a minimum of 3x/wk for 4 we with results to the QAPI committee further recommendations.	bt brace est grang dents est liness ed of rest at age at ated on 017. All to eed of udit and eeks	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP CODE 804 WRIGHT STREET BRAINERD, MN 56401		
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F 465	dining room, seated coffee with friends. wheelchair was obsteam at the bottom length of the armre. On 2/9/17 at 3:13 penvironmental serv	p.m. R236 was observed in the d in a wheelchair, drinking The right arm of the served to have a rip on the which ran almost the entire st. o.m. the director of rices (DES) stated nursing staff	F 46	5		
	wheelchairs and br confirmed environn responsible for mai working order/repa station had a work work order for whe or other issues. Disservices staff comp At the time of the to unavailable, however the wheelchair brail was not able to be work order should leading to the wheelchair arm responsible indicated the	or the cleaning of resident aces. However, DES nental services would be intaining wheelchairs in good ir. DES indicated each nursing order book and could submit a elchairs with ripped armrests ES indicated environmental pleted work orders everyday. Our, R35 and R236 were rer, DES indicated the tape on kes would create a surface that cleaned. DES also indicated a have been placed and tears in its would have been repaired, wheelchairs would be aired as soon as possible.				
	(DON) confirmed n for the cleaning of a DON indicated each cleaned on their bat DON also indicated equipment, such as as needed basis ar assistants to let the	o.m. the director of nursing pursing staff were responsible resident wheelchairs. The harmonic resident's wheelchair was ath day and as needed. The day other resident shaces, were cleaned on an and would expect the nursing estation directors know of any as a grangements could be				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY MPLETED	
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F 492 SS=B	aforementioned observed wheelchair was dirt R106's knee brace cleaning, the tape of handles was put on enhance visibility he tattered and needed confirmed the arm repair. The DON all and cushion were of the station 2 bath indicated wheelchat during the night how of the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment were prospected by Compliance with Laws and Profession The facility must opcompliance with all local laws, regulation accepted profession that apply to professuch a facility. (c) Relationship to Compliance of the such a facility.	The DON confirmed the servations and verified R125's y and needed to be cleaned, was soiled and required on R35's wheelchair brake by the therapy department to owever, it was worn and do to be replaced and rest was cracked and required so verified R128's wheelchair lirty and required cleaning. schedule dated 12/22/16, ir cleaning was to be done are of the 1st scheduled bath 25's wheelchair was to be y and R128's wheelchair was onday. No further policies or repair of resident ovided. PLY WITH LOCAL LAWS/PROF STD	F 49			3/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			804 V	ET ADDRESS, CITY, STATE, ZIP CODE WRIGHT STREET INERD, MN 56401		
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F 492	the applicable provergulations, including pertaining to nondiscreding to nondiscreding to nondiscrimination of CFR part 84); nondiscreding the subjects of research and abuse (42 CFI individually identified CFR parts 160 and provisions may resonon-compliance with This REQUIREME by: Based on docume facility failed to enswho requested a discredity failed to enswho requested a discreding included: R105's SNF (skilled Determination of Cothe facility determination of C	visions of other HHS Ing but not limited to those scrimination on the basis of conal origin (45 CFR part 80); on the basis of disability (45 discrimination on the basis of col); nondiscrimination on the r, national origin, sex, age, or part 92); protection of human ch (45 CFR part 46); and fraud R part 455) and protection of cable health information (45 d 164). Violations of such other sult in a finding of th this paragraph. NT is not met as evidenced ent review and interview, the sure 1 of 4 residents (R105) emand bill was not billed for decision was pending.	F 4	1 rep 2 a a a 3 2 w T re si w a co b re m 4 w	I. Resident 105 had their payment eimbursed as the demand bill was ending. All residents who request a demarce at risk and these residents have udited to ensure a bill was not ser. Additional training occurred on /23/2017on billing practices for resolved to the demand bill requests ubmission of claims to Medicare. Were trained on the policy and process it relates to the determination of continued stay notice and the need ill the resident if a demand bill has equested until a determination has nade. Facility to audit all demand bills freeks and bring results to the QAF committee for further recommenda	and bill e been ht. sidents and Staff redures to not been been for 4	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 492	discharged from the R105's billing state and 2/9/17, were reamount owed and opast due, would be charges. The state "Because you requivour bill, we filed a decision. Please patime. If Medicare deadditional amount of Medicare deadditional amount of the R10-A condemand bill on 12/2 not supposed to be final medicare decision.	ments dated 1/20/17, 2/1/17 eviewed. All indicated an dates payment was due and if subject to late payment ment dated 2/9/17, read: ested a Medicare Review of demand bill to Medicare for a any the statement amount at this ecides in our favor an	F 4	,			
	have received the s "interim billing" noti R105's bill had bee	statement which included the ce statement. AR-A explained in paid in full on 2/1/17, and a a refund was sent out on					



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Delivered

July 18, 2017

Mr. Ryan Cerney, Administrator Good Samaritan Society - Bethany 804 Wright Street Brainerd, MN 56401

Subject:

Provider # 245500 Project # S5500027

Dear Mr. Cerney:

This is in response to your letter received on March 3, 2017, in regard to your request for an informal dispute resolution (IDR) for the federal deficiencies at tag F1620 where corresponding correction orders were issued pursuant to the survey completed on February 9, 2017.

The information presented with your letter, the CMS and State 2567s dated February 9, 2017, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of Licensing and Certification staff have been carefully considered and the following determination has been made:

State Tag ID Prefix – F1620 Labeling of Drugs

Choose from the following:

- This is not a valid correction order and will be removed from the 2567 State Form.
- The revised 2567 State Form is attached.

This concludes the Minnesota Department of Health informal dispute resolution process where corresponding correction orders were issued.

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

Good Samaritan Society - Bethany July 18, 2017 Page 2

Sincerely,

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

Email: Kamala.Fiske-Downing@state.mn.us

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Lyla Burkman, Bemidji District Office Unit Supervisor

PRINTED: 07/18/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00087 02/09/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **804 WRIGHT STREET GOOD SAMARITAN SOCIETY - BETHANY BRAINERD, MN 56401** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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:

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 03/03/17

Electronically Signed

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00087		B. WING		02/	09/2017
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BETHANY		HT STREET D, MN 5640			
(X4) ID PREFIX TAG		TEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 000	Continued From particles of Health you electronically. It is necessary for State enter the word "cornitext. You must then State licensure product of the corrected prior to element of the correction of the foliasued. Please indicorrection that you and identify the date of the state Licensing federal software. The assigned to Minnes Nursing Homes. The assigned tag in column entitled "ID statute/rule out of computer of the statement of the statement, evidence by." Follow are the Suggested In the	Ith orders being Although no plate Statutes/Rule ected" in the beindicate in the decess, under the edate your orderectronically subject of Health. 2/8/17, and 2/8 staff, visited the lowing correction cate in your eleman end of Health is Correction Order the when they will ent of Health is Correction Order number appears Prefix Tag." The ompliance is listent of Deficiencies Comply" porticulation of the "This Rule is nowing the survey Method of Correction. RD THE HEAD IN OF CORRECTION OF	n of correction es, please ox available for electronic heading ers will be mitting to the 2/17, surveyors he above on orders are ctronic plan of hese orders, be completed. documenting ers using e been es/rules for in the far left he state ted in the es" column on of the includes the e state statute of met as ors findings ection and ING OF THE ES, CTION." THIS ICIES ONLY.	2 000			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPLETED	
		00087	B. WING		02/0	9/2017
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- RETHANY	RD, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 555	MN Rule 4658.0405 Plan of Care; Devel	5 Subp. 1 Comprehensive lopment	2 555			3/13/17
	must develop a con each resident withir completion of the con assessment as deficomprehensive plan by an interdisciplina attending physician responsibility for the appropriate staff in the resident's needs practicable, with the	elopment. A nursing home inprehensive plan of care for in seven days after the comprehensive resident ined in part 4658.0400. The in of care must be developed ary team that includes the interest, a registered nurse with the resident, and other disciplines as determined by its interest, and its includes the participation of the resident, guardian or chosen				
	by: Based on interview facility failed to deve of anticoagulant me	ent is not met as evidenced v and document review, the elop interventions for the use edication (Coumadin) for 1 of 5 ose medication regimens were		Corrected		
	Findings include:					
	12/20/16, indicated	imum Data Set (MDS) dated R44 was cognitively intact which included atrial				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00087	B. WING		02/0	9/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- BETHANY	HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROID DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 555	Continued From pa	ge 3	2 555			
	commonly causes phypertension. The received anticoagul	ular, often rapid heart rate that boor blood flow) and MDS also indicated R44 lation (prevent or reduce d, prolonging the clotting ily.				
	R44's undated Medication Review Report included an order for Coumadin 1.25 milligrams (mg) by mouth one time a day every Sunday, Monday, Tuesday, Wednesday, Friday and Saturday and 2.5 mg every Thursday for atrial fibrillation.					
	diagnoses which in of anticoagulants, h related to the use o	e Plan indicated R44 had cluded long term (current) use lowever, lacked interventions f the medication and ntial adverse effects of the				
	confirmed R44's ca use of Coumadin a RN-G stated they u medications on the R44's care plan sho monitoring for signs	o.m. registered nurse (RN)-G re plan did not address the nd should have done so. sually included all high risk care plan. RN-G indicated ould have addressed s and symptoms of bleeding elated to the event of a				
	11/16, indicated a c	policy and procedure revised are plan would be developed ons and treatments and any ropriate.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		00087	B. WING		02/0	9/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- RETHANY	HT STREET D, MN 5640				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 555	Continued From pa	ge 4	2 555				
2 830	The director of nurs staff to develop a cainterventions for all monitoring program to assure ongoing a interventions in response (21) days TIME PERIOD FOR one (21) days MN Rule 4658.0520 Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the resident must remain in the subpart of th	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			3/13/17	
	review, the facility fa	on, interview and document ailed to administer as needed etic) according to physician		Corrected			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/IDENTIFICATION	SUPPLIER/CLIA TION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
				A. BUILDING.			
		00087		B. WING		02/0	9/2017
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BETHANY		HT STREET D, MN 5640			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 5		2 830			
	orders for 1 of 1 res received PRN Lasis		eviewed who				
	Findings include:						
	R16's annual Minim 1/10/17 indicated R required extensive mobility, transfers, personal hygiene a eating.	t16 was cognit assistance of t dressing, toilet	ively intact and two staff for bed t use and				
	R16's undated Diagnosis Report indicated R16 had diagnoses which included edema (swelling), lymphedema (collection of fluid that causes swelling in the arms and legs), and hypertension (high blood pressure).						
	R16's undated Med included the followi						
	daily weight one to Administer PRN La Lasix Tablet 40 m needed for increase 212. Notify physicial days of administrat 1/9/17. The Report also incomonitor bilateral love time a day. If edent order.	six if above 21 illigrams (mg) ed (2+) edema an if no weight ion. The order cluded a nursir wer extremities	by mouth as a for weight over a change after 3 r start date was and order to a for edema one				
	Review of R16's mo	edical record r	evealed the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BUILDING.						
		00087		B. WING		02/0	09/2017	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- BETHANY		HT STREET D, MN 5640				
(X4) ID PREFIX TAG		ATEMENT OF DEFIC Y MUST BE PRECE SC IDENTIFYING IN	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 830	Continued From pa	age 6		2 830				
	1/9/17: 212.2 1/12/17: 212.8 1/14/17: 212.5 1/16/17: 212.7 1/21/17: 213.6 1/24/17: 212.2 1/25/17: 212.5 1/26/17: 213.5 1/30/17: 212.5 1/31/17: 212.7 2/4/17: 212.8 2/5/17: 213.4 2/6/17: 212.8							
	The Consultant Ph. Reviews included a pharmacist dated 1 make sure the Las parameter is follow parameter. Would check per paramet to the recommenda "noted" with staff in	a recommendate /12/17, which red /1/16/17, which red /	tion from the read: "Please based edema aily edema titten note next					
	R16's Medication F and 2/1/17-2/28/17 no PRN doses of L	indicated R16						
	R16's undated care diuretic therapy for directed staff to mo adverse consequel care plan also direct	edema and hy nitor of interac nce of the med	pertension and tions and ication. The					
	On 2/8/17, at 12:59	a.m. R16 was	observed					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUF IDENTIFICATION		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				A. BOILDING.			
		00087		B. WING		02/0	9/2017
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BETHANY		HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEI MUST BE PRECEDEI SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From parseated in her reclinathe recliner was electrousers, compressions. The legs of the ankle and R16's not observed to be observed to the top slipper type shoes. have swelling in he much better than it she had special stofeet elevated in her not take any medic. On 2/8/17, at 1:37 points stated he would have determine when Pradministered to R1 electronic record, Fedema measuring RN-F indicated R16 so she did not recell However, RN-F cord as written above ar received any PRN IRN-F stated R16 stasix on the days wabove. On 2/8/17, at 2:09 porder for PRN Lasix verified R16 should the days the weight.	er, in her room. vated. R16 was ion stockings and the trouser were s lower legs and a swollen. Slight s of R16's feet abo R16 stated she r lower extremitie used to be. R16 ckings she wore recliner. R16 sta ation for the swel o.m. registered no ve to check the o RN Lasix was to b c. After consultir RN-F stated he wo 2+ or for a weight ive PRN Lasix the firmed the previous d confirmed R16 Lasix in January of conditions in January of conditions in January of the receiver of the weights o.m. RN-G confirm of for a weight over have received P was over 212 as ministration Policy	wearing d slipper type eraised above ankles were swelling was ove the did at times es but it was also stated and kept herated she did lling. urse RN-Forder to be any the ould give it for to over 212. It was 211.6 at day. Bus weights and not or February. Wed PRN were 213 and and med R16's er 212 and are RN Lasix on a ordered.	2 830			
	medication correctl						

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED
		00087	B. WING		02/0	9/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- RETHANY	GHT STREET RD, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830 2 930	medications would resident according drug, dose, time, round staff to comprehensinterventions to enscare in a manner to well-being. A monit established in orde assessment and e in response to resident to the control of the control	be administered to the to the "Six Rights" [patient, oute, documentation]. THOD FOR CORRECTION: sing or designee could direct sively assess and implement sure residents are provided or promote their highest toring program could be er to assure ongoing effective care plan interventions				3/13/17
	Nasogastric, Gastro Subp. 7. Nasogast and feeding syringes. Based o assessment, a nurs B. a resident v gastrostomy tube o appropriate treatme aspiration pneumor dehydration, metab nasal-pharyngeal u possible, normal fe	ostomy tubes tric tubes, gastrostomy tubes, on the comprehensive resident sing home must ensure that: who is fed by a nasogastric or or feeding syringe receives the ent and services to prevent nia, diarrhea, vomiting, polic abnormalities, and ulcers and to restore, if				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00087		B. WING		02/0	9/2017
NAME OF	PROVIDER OR SUPPLIER	S	TREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- RETHANY		HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 930	Continued From pa	ige 9		2 930			
	review, the facility f was administered a 1 of 1 resident (R20	ion, interview and docu ailed to ensure medica as directed by facility po 04) observed to receive ons via a percutaneous stomy tube.	tion blicy for a		Corrected		
	Findings include:						
	identified R204's di (difficulty swallowin disease (GERD), h	agnosis report printed 2 agnoses as dysphasia g) gastro-esophageal r yperlipidemia (abnorma s in the blood), chronic Il diabetes mellitus.	eflux ally				
		inimum Data Set (MDS R204 had a feeding tub ally altered diet.					
	directed staff to adu a percutaneous end (G-Tube/PEG) tube for feeding), however and justification for	Review Report dated 2 minister 204's medication doscopic gastrostomy e (tube place into the streer the report lacked an cocktailing (mixture of ations) the medications	ons via omach order liquid				
	was observed to was sealed packet cont 50 milligrams (mg) angina), one tablet	o.m. registered nurse (I ash her hands and ope aining one tablet of Me (treats hypertension ar of Mirtazapine 7.5 mg and one tablet of Oxybuty	n a toprolol nd				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BUILDING.			
	00087		B. WING		02/0	9/2017
NAME OF PROVIDER OR SUPI	LIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD SAMARITAN SOC	ETY - BETHANY		HT STREET D, MN 5640			
PREFIX (EACH DEFIC	Y STATEMENT OF DEF ENCY MUST BE PREC OR LSC IDENTIFYING	EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
identified the radirections for a combined the 30 cubic centing plastic medical plastic sleeve manual pill crutogether. Once into a 30 cc place of water. Risk with the medicing pair of gloves included a grasyringe. -At 6:40 p.m. Funclamped an syringe and chap 20 cc of tage the tube with the syringe, withdown reinserted the and proceeded mixture with 2 followed by an removed the streadjusted 204 RN-H failed to individually an individual medical medical and was unab R204's m	ractive bladder). The edications, however, be a contraction of admining and particular to the contraction of	ver, lacked istration. RN-H islaced them into a me tablets into a me tablets into a the tablets laced the tablets up and added 20 or R204's room ands, donned a olies which er and a 60 cc of Councillant of Councillant of Councillant of Councillant of the graph of the tube, it is the graph of the g	2 930			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICAT	SUPPLIER/CLIA ION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00087		B. WING		02/0	9/2017
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- BETHANY		HT STREET D, MN 5640			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 930	Continued From paindividually and flus On 2/6/17, at 6:51 p	h between me	or of nursing	2 930			
	(DON) reviewed R2 verified R204 did no medications. The D directed staff to adr separately and flust The DON verified h follow facility policy.	ot have an order on confirmed to minister each no in in between ea er expectation	er to cocktail he facility policy nedication ach medication.				
	The facility Medicat revised 5/16, direct medication separat tubing between each	ed staff to adm ely via G-tube	inister each				
	SUGGESTED MET DON or designee c revise policies and residents with tube medications admini according to facility could educate all ap and procedures. Th develop monitoring compliance.	ould develop, r procedures to feedings have stered separat policy. The DO opropriate staff the DON or desi	eview, and/or ensure their ely and DN or designee on the policies gnee could				
	TIME PERIOD FOF (21) days.	R CORRECTIC	N: Twenty-one				
21375	MN Rule 4658.0800 Program) Subp. 1 Infec	tion Control;	21375			3/13/17
	Subpart 1. Infection	n control progi	ram. A nursing				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00087		B. WING		02/0	9/2017
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY	804 WRIG	DRESS, CITY, S HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Continued From pa home must establis control program des sanitary environmen	sh and maintain a signed to provide		21375			
	This MN Requirements by: Based on observation review, the facility so appropriate infection providing direct resistant (R65 care.	on, interview and taff failed to ens n control measur ident contact wo	d document ure res while und care for		Corrected		
	Finding include:						
	R65's quarterly Min 12/27/16, indicated dementia, anxiety a staphylococcal aure indicated R65 was i required supervision pressure ulcer whice	R65 had diagnound methicillin research (MRSA). The independent with methods with transfers a	ses including sistant e assessment bed mobility, and had a				
	R65's care plan dat MRSA infection to w The plan directed si when changing con linens in bags mark linens and close ba- laundry.	vound on the left taff to wear gowi taminated linens ed biohazard an	lower leg. ns and masks n, place soiled d to bag				
	On 2/8/17, at 11:21 (LPN)-B stated R65 dressing changes to be assisting with the	i liked to be invol o his left lower le	ved with the g and would				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00087	B. WING		02/	09/2017
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- RETHANY	EET ADDRESS, CITY, S' WRIGHT STREET INERD, MN 56401			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21375	room, R65 was obswheelchair. R65 was antiseptic wipes to and his over the be-At 11:25 a.m. LPN dressing and preparatowel on the floor in then placed a seconto R65. LPN-A place on the second tower R65. LPN-A wore of dressing. R65 had leg which were eaccentimeters (cm) in wound was from property was from an abscerous from an abscerous from an abscerous floor next to her. Ledonned fresh glove with aerosol saline wound cleaner). Significant floor next to her. Ledonned fresh glove with aerosol saline wound cleaner). Significant floor next to her. Ledonned fresh glove with aerosol saline wound cleaner). Significant floor next to her. Ledonned fresh glove with aerosol saline wound cleaner). Significant floor next to her the applied a new dressing them down room. At no time duples in a clear property floor	served seated in his ore gloves while he used clean the scissors, tweezed table. I-B gathered supplies for the tred the room. LPN-A place of front of R65's left leg. Should not seed a box of dressing supplied and sat on the floor next gloves as she removed the two wounds on his lower left happroximately 2.5 and diameter. R65 stated the ressure and the second words.	he sed a he sent blies to e old left bund he			

Minnesota Department of Health

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00087		B. WING		02/0	9/2017
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BETHANY		HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIE Y MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Continued From pa	ige 14		21375			
	wash the wound pr	ior to leaving the	room.				
	On 2/8/16, at 2:10 pstated R65 had a have to look to see at this time.	istory of MRSA a	nd she would				
	On 2/9/17, at 9:30 a specialist stated and be under contact is was to have a sign personal protective gloves, and masks garbage and yellow at this time, none owere in contact pre R65's care plan and isolation due to MR to use gloves, gown in direct contact wit reviewed R65's clin R65's last wound contified MRSA. Sisolation precaution culture was to be or	ry resident with Molation. She state on the door, a subsequipment inclusion along with red by bags for linens. If the residents in a cautions. RN-B doonfirmed R65 and possible residents and possible record and coulture obtained of the stated in orders to be removed.	IRSA would ted the room upply cart of ding gowns, ags for She stated the facility reviewed was to be in the staff were masks when ite. RN-B confirmed n 9/25/16, er for contact				
	Review of the Mon Infections in Center revealed a form wh name, room number infection, site of infe agents, treatment r measure, isolation staff to identify if the facility or not. The identify a resolution	r / infection contrict identified the er, admission dat ection, culture tal measures, cautio precaution and de infection control	ol log, resident ed, date of ke, causative nary lirected the cquired in the				
	On 2/8/17, at 9:35 at to be on contact iso staff were to wear g	olation precaution	ns and verified				

Minnesota Department of Health

STATE FORM 6899 G24W11 If continuation sheet 15 of 20

Minnesota Department of Health

_	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPI IDENTIFICATION N		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00087		B. WING		02/	09/2017
	PROVIDER OR SUPPLIER	- BETHANY	804 WRIG	DRESS, CITY, S GHT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC / MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21375	Continued From particles were to be contained. On 2/9/16, at 9:40 at (DON) confirmed Rand the staff were to precautions during DON stated she was had been removed would have been restand to utilize contact predictions a moisture-resistand room surfaces or flet to utilize contact predicting known to organism. On 2/9/17, at 9:45 at Multidrug-resistant confirmed the policic DON stated R65 we precautions during linen changes if the The DON stated R67 remained in place to during dressing characteristic was used bed which would calculate the policic on 2/9/17, at 12:35 been hospitalized at infections. However, R65 had been cleared from the policic on the policic on the policic on the policic during dressing characteristic productions. However, R65 had been cleared from the policic on the polici	sing changes and a sed in yellow biohaza a.m. the director of 165's wounds conta to be utilizing conta the dressing changes and did not know vernoved. Stant Organisms pot and did not know vernoved. Stant Organisms pot aff to place soiled to container and not boor. It also directe ecautions when in contain the multidres organisms policy a yellow had not been followed and the contain the follow ould only require contain the multidres of dressing changes are dressing had not foot gowns should be anges since aeroso to directly wash the ause potential splate a.m. LPN-B stated a.m. LPN-B stated a.m. LPN-B stated are of osteomyelities of the MRSA. LPI a.m. the MRSA are of the continuation of the ware of the ware of the continuation of the ware of the ware of the ware of the ware of	nurses ined MRSA of les. The lecautions when they olicy dated laundry in on the d the staff contact with laug resistant wed the laund during allen off. It wound le wound ler. It R65 had led of all le and stated with MRSA led on, not sat on large ined sat on laund le wound ler.	21375			

Minnesota Department of Health

STATE FORM 6899 G24W11 If continuation sheet 16 of 20

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N			E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00087		B. WING		02/0	9/2017
	PROVIDER OR SUPPLIER			DRESS, CITY, S	STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- BETHANY		D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 16		21375			
	have bagged the lin prior to leaving the wound status had n	room. LPN-B state	d R65				
	Suggested methods nursing or designed policies and proced care with staff. The designee could ther as part of the facility to ensure ongoing of	e could review infectures while providing director of nursing a develop an auditiry's quality assurance	tion control g wound or ng system				
	Time period for corr	rection: Twenty one	e (21) days.				
21695	MN Rule 4658.1415 Housekeeping, Ope		nce	21695			3/13/17
	Subp. 4. Housekeep provide housekeepi necessary to mainta comfortable interior ceilings, registers, f and furnishings.	ain a clean, orderly, , including walls, flo	e services and oors,				
	This MN Requirements by: Based on observation review, the facility for wheelchairs and cate and/or a clean and residents (R125, R3 wheelchairs and equirty and in need of	on, interview and do ailed to maintain res re equipment in goo sanitary condition fo 35, R128, R106, R2 uipment were obse	ocument sident od repair or 6 of 6 (36) whose rved to be		Corrected		
	Findings include:						

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00087	B. WING		02/0	9/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BFTHANY	HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21695	Continued From pa	ige 17	21695			
	the dining room sea was leaning over th and spit onto the w floor. The right whe	50 p.m. R125 was observed in atted in a wheelchair. R125 he right arm rest of the chair heel of the wheelchair and the right was observed coated in liried white substance.				
	noted to have an or the wheelchair brak tattered and peeling	3 a.m. R35's wheelchair was range colored tape adhered to be handles. The tape was g. The left arm rest of R35's led to be cracked and peeling foam padding.				
	his room, seated in right side of the who crevices along the	a.m. R128 was observed in an electric wheelchair. The eelchair seat cushion and right side of the chair and the d to have dried food debris and the surfaces.				
		a.m. R106's left knee brace covered in a food debris.				
	dining room, seated coffee with friends. wheelchair was obs	o.m. R236 was observed in the d in a wheelchair, drinking The right arm of the served to have a rip on the which ran almost the entire st.				
		o.m. the director of ices (DES) stated nursing staff or the cleaning of resident				

Minnesota Department of Health

STATE FORM 6899 G24W11 If continuation sheet 18 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00087	B. WING		02/0	9/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- RETHANY	IGHT STREET ERD, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21695	wheelchairs and br confirmed environn responsible for mai working order/repa station had a work work order for wheel or other issues. Disservices staff compatt the time of the tounavailable, however the wheelchair brakewas not able to be work order should have been been been been been work order should have been been been been been been been be	aces. However, DES nental services would be intaining wheelchairs in good ir. DES indicated each nursi order book and could submit elchairs with ripped armrests ES indicated environmental oleted work orders everyday. our, R35 and R236 were er, DES indicated the tape of kes would create a surface the cleaned. DES also indicated have been placed and tears i its would have been repaired wheelchairs would be aired as soon as possible. o.m. the director of nursing ursing staff were responsible resident wheelchairs. The h resident's wheelchair was th day and as needed. The d any other resident is braces, were cleaned on ar and would expect the nursing e station directors know of an e so arrangements could be The DON confirmed the servations and verified R125 by and needed to be cleaned, was soiled and required on R35's wheelchair brake h by the therapy department to owever, it was worn and d to be replaced and rest was cracked and require so verified R128's wheelchai dirty and required cleaning.	at a a a a a a a a a a a a a a a a a a			

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION :	(X3) DATE COMP	SURVEY LETED
		00087	B. WING		02/0	9/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- RETHANY	GHT STREET RD, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 19	21695			
	indicated wheelchal during the night hou of the week and R1 cleaned on Tuesday to be cleaned on M	schedule dated 12/22/16, ir cleaning was to be done urs of the 1st scheduled bath 25's wheelchair was to be y and R128's wheelchair was onday. No further policies or repair of resident ovided.				
	administrator could to report damaged equipment and ens maintained in a san administrator then o	could develop and auditing acility's quality assurance				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty One				

6899

Minnesota Department of Health STATE FORM

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	ARE/MEDICAID CERTIFICATION TO BE COMPLETED BY THE ST		ID: G24W Facility ID: 00087
MEDICARE/MEDICAID PROVIDER NO. (L1) 245500 2.STATE VENDOR OR MEDICAID NO. (L2) 078040500	3. NAME AND ADDRESS OF FACILITY (L3) GOOD SAMARITAN SOCIETY - (L4) 804 WRIGHT STREET (L5) BRAINERD, MN	BETHANY (L6) 56401	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 03/27/2017 (L34)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESR 02 SNF/NF/Dual 06 PRTF 10 NF	02 (L7) D 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS: (L10) 0 Unaccredited	03 SNF/NF/Distinct 07 X-Ray 11 ICF/ 04 SNF 08 OPT/SP 12 RHC		12/31
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 114 (L18) 13.Total Certified Beds 114 (L17) 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 114 (L37) (L38) (L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLICA	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On:1. Acceptable POC X B. Not in Compliance with Program Requirements and/or Applied Waivers: ICF IID (L42) (L43) BLE SHOW LTC CANCELLATION DATE):	And/Or Approved Waivers Of	6. Scope of Services Limit 7. Medical Director
17. SURVEYOR SIGNATURE Lyla Burkman, Unit Supervisor	Date : 03/27/2017 (L19)	18. STATE SURVEY AGENCY Mark Meath, E	Enforcement Specialist 06/27/2017 (L20)
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 Finar	ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGREEM OF PARTICIPATION BEGINNING 01/01/1988		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure	
(1.27)	(L25) VE SANCTIONS of Admissions: (L44) spension Date: (L45)	02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	
(L28)	. INTERMEDIARY/CARRIER NO. 00140 (L31) DETERMINATION OF APPROVAL DATE 04/06/2017	30. REMARKS	

(L33)

DETERMINATION APPROVAL

(L32)



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245500

May 22, 2017

Mr. Ryan Cerney, Administrator Good Samaritan Society - Bethany 804 Wright Street Brainerd, MN 56401

Dear Mr. Cerney:

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 March 13, 2017 the above facility is certified for:

114 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 114 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

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered May 21, 2017

Mr. Ryan Cerney, Administrator Good Samaritan Society - Bethany 804 Wright Street Brainerd, MN 56401

RE: Project Number S5500027

Dear Mr. Cerney:

On February 22, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 9, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On March 27, 2017, the Minnesota Department of Health completed a Post Certification Revisit (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 February 9, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 13, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 9, 2017, effective March 13, 2017 and therefore remedies outlined in our letter to you dated February 22, 2017, will not be imposed.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REV	/ISIT					
245500 _{Y1}	B. Wing		Y2	3/27/2017	Y3					
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE								
GOOD SAMARITAN SOCIETY	- BETHANY	804 WRIGHT STREET								
		BRAINERD, MN 56401								

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

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix	F0279 483.20(d);483.2	Correction (21(b)(1)	ID Prefix	F0309 483.24, 483.25(k)(l)	Correction	ID Prefix	F0322 483.25(g)(4)(5)		Correction
Reg. # LSC		Completed 03/13/2017	Reg. #		O3/13/2017	Reg. # LSC			O3/13/2017
ID Prefix		Correction	ID Prefix		Correction	ID Prefix	-		Correction
Reg. # LSC	483.45(b)(2)(3)(Completed 03/13/2017	Reg. #	483.80(a)(1)(2)(4)(e)(f)	O3/13/2017	Reg. # LSC	483.90(i)(5)		Completed 03/13/2017
ID Prefix	F0492	Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	483.70(b)(c)	Completed 03/13/2017	Reg. #		Completed	Reg. # LSC			Completed
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC		-	LSC			
ID Prefix Reg. #		Completed	ID Prefix Reg. #		Correction	ID Prefix Reg. #			Correction Completed
LSC REVIEWI	ED BY	REVIEWED BY	LSC	SIGNATURE OF	SURVEYOR	LSC		DATE	
STATE A	GENCY X	(INITIALS) LB/mm REVIEWED BY	05/22/201 DATE		280)35		03/27	/2017
CMS RO (INITIALS) FOLLOWUP TO SURVEY COMPLETED ON 2/9/2017		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO						s 🗆 no	

Form CMS - 2567B (09/92) EF (11/06)

Page 1 of 1

EVENT ID:

G24W12

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: G24W

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00087 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 2 (L8) (L3) GOOD SAMARITAN SOCIETY - BETHANY (L1)245500 1. Initial 2. Recertification (L4) 804 WRIGHT STREET 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 56401 078040500 (L2)(L5) BRAINERD, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7)8. Full Survey After Complaint (L9) 05 HHA 09 ESRD 13 PTIP 01 Hospital 22 CLIA 6. DATE OF SURVEY 02/09/2017 (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC (L10) 12 RHC 16 HOSPICE 12/31 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): ____ 2. Technical Personnel То (b): Program Requirements Scope of Services Limit Compliance Based On: ___ 3. 24 Hour RN Medical Director 4. 7-Day RN (Rural SNF) 1. Acceptable POC 8. Patient Room Size 12. Total Facility Beds 114 (L18) ___ 5. Life Safety Code ___ 9. Beds/Room 13. Total Certified Beds 114 (L17) **X** B. Not in Compliance with Program Requirements and/or Applied Waivers: (L12)* Code: 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID (L15)1861 (e) (1) or 1861 (j) (1): 114 (L37) (1.38)(L39) (L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL Lisa Carey, HFE NEII 03/17/2017 Mark Meath, Enforcement Specialist 04/06/2017 (L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) RIGHTS ACT: X 1. Facility is Eligible to Participate 3. Both of the Above: Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE **VOLUNTARY** INVOLUNTARY 01/01/1988 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L24)(L41)(L25)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal A. Suspension of Admissions: 07-Provider Status Change 00-Active (L44)(L27)B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 00140 (L28) (L31)31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 22, 2017

Mr. Ryan Cerney, Administrator Good Samaritan Society - Bethany 804 Wright Street Brainerd, Minnesota 56401

RE: Project Number S5500027

Dear Mr. Cerney:

On February 9, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Email: Lyla.burkman@state.mn.us

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 21, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions

are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 9, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 9, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

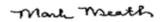
Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,



Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 03/17/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245500	B. WING			02/	09/2017
	OVIDER OR SUPPLIER	- BETHANY		80	TREET ADDRESS, CITY, STATE, ZIP CODE 04 WRIGHT STREET RAINERD, MN 56401		
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F 000 III a D e a a for b F 279 4 SS=D C 4 ((a a m)	NITIAL COMMENT The facility's plan of as your allegation of Department's acceptance of the bottom of the orm. Your electronic period as verificated of the bottom of the orm. Your electronic period as verificated of the second of the compartment of the bottom of the orm. Your electronic period as verificated of the second of the second of the second of the second of the assessments compared to the second of the assessments of th	of correction (POC) will serve frompliance upon the otance. Because you are our signature is not required first page of the CMS-2567 created submission of the POC will ion of compliance. acceptable electronic POC, ander facility may be conducted to ontial compliance with the en attained in accordance with		000	CROSS-REFERENCED TO THE APPROP		
(I C e s ir to a	b) Comprehensive 1) The facility must comprehensive perseach resident, conset forth at §483.10 includes measurable o meet a resident's and psychosocial necomprehensive ass	Care Plans I develop and implement a son-centered care plan for istent with the resident rights (c)(2) and §483.10(c)(3), that e objectives and timeframes medical, nursing, and mental eeds that are identified in the essment. The comprehensive	IATURE		TITLE		(X6) DATE

Electronically Signed 03/03/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONS	(X3) DATE SURVEY COMPLETED				
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F 279	care plan must des (i) The services that or maintain the resiphysical, mental, ar required under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclustreatment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS rationale in the resident's representational in the resident's representation of the passible of the passi	t are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative (s)-goals for admission and preference and potential for acilities must document at's desire to return to the sessed and any referrals to ites and/or other appropriate	F 2	79				

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 279	facility failed to dev of anticoagulant me residents (R44) wh reviewed. Findings include: R44's quarterly Mir 12/20/16, indicated and had diagnoses fibrillation (an irregicommonly causes hypertension. The received anticoagu	w and document review, the elop interventions for the use edication (Coumadin) for 1 of 5 ose medication regimens were limum Data Set (MDS) dated R44 was cognitively intact which included atrial ular, often rapid heart rate that boor blood flow) and MDS also indicated R44 lation (prevent or reduce d, prolonging the clotting	F 279	1. Resident 44's care plan was to include interventions r/t the anticoagulant medication (Coulncluding the potential adverse the medication. 2. All residents on anticoagula are at risk for having their care the identification of anticoagul medications (Coumadin). All had their care plans reviewed updated to include the use of anticoagulant medications (Councluding the potential adverse the medication on 2/10/2017. 3. Licensed nursing staff were on care planning the use of armedications (Coumadin) to er plan has interventions listed r/anticoagulant medication (Counced for the potential adverse need for the potential adverse	use of umadin). e effects of effects of effects of ent therapy e plans lack ant residents and effects of educated effects of educated effects of educated effects of the use of umadin). et on the		
	included an order fr (mg) by mouth one Monday, Tuesday, Saturday and 2.5 m fibrillation. R44's undated Can diagnoses which in of anticoagulants, it related to the use of monitoring for pote medication.	dication Review Report for Coumadin 1.25 milligrams time a day every Sunday, Wednesday, Friday and fing every Thursday for atrial e Plan indicated R44 had cluded long term (current) use however, lacked interventions of the medication and intial adverse effects of the co.m. registered nurse (RN)-G		the medication to be listed on plan. This took place on 3/1/2 3/2/2017. 4. DNS or Designee to randor care plans for the residents or anticoagulation medications (0 to ensure that the care plan in related to the use of the medicate the monitoring for potential ad effects. The audits will occur minimum of 3x/wk for 4 weeks to the QAPI committee for furt recommendations.	the care 2017 and nly audit the 1 Coumadin) terventions cation and verse for a 5 with results		
		o.m. registered nurse (RN)-G ure plan did not address the					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG		E SURVEY MPLETED	
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F 279	RN-G stated they u medications on the R44's care plan sho monitoring for signs	ge 3 nd should have done so. sually included all high risk care plan. RN-G indicated ould have addressed s and symptoms of bleeding elated to the event of a	F 27	79		
F 309 SS=D	11/16, indicated a control to include medication other items, as app	PROVIDE CARE/SERVICES	F 30	09		3/13/17
	applies to all care a residents. Each re- facility must provide services to attain or practicable physica well-being, consiste	e undamental principle that and services provided to facility sident must receive and the e the necessary care and r maintain the highest I, mental, and psychosocial ent with the resident's sessment and plan of care.				
	provided to residen consistent with prof the comprehensive	ent. Isure that pain management is ts who require such services, essional standards of practice, person-centered care plan, goals and preferences.				
	residents who requ services, consisten	cility must ensure that ire dialysis receive such t with professional standards aprehensive person-centered				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 309	by: Based on observat review, the facility fa (PRN) Lasix (a diurn orders for 1 of 1 res received PRN Lasix Findings include: R16's annual Minim 1/10/17 indicated R required extensive a mobility, transfers, o personal hygiene ar eating. R16's undated Diag had diagnoses which lymphedema (colled swelling in the arms (high blood pressur R16's undated Med included the followin daily weight one ti Administer PRN LasiLasix Tablet 40 min needed for increase 212. Notify physicia	esidents' goals and IT is not met as evidenced ion, interview and document ailed to administer as needed etic) according to physician ident (R16) reviewed who i. Ium Data Set (MDS) dated 16 was cognitively intact and assistance of two staff for bed dressing, toilet use and and was independent with inosis Report indicated R16 th included edema (swelling), ction of fluid that causes and legs), and hypertension e). ication Review Report and physician orders: me a day for edema.	F 30	1. Resident 16's (PRN) Lasix (a corder is being followed and admin as ordered by licensed facility staf 2. All residents on (PRN) Lasix (a are at risk of the same deficient proceed in the same deficient proceder in th	istered f. diuretic) ractice. n iuretic) ng er. audit the iuretic) being audits or 4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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F 309	The Report also incomonitor bilateral low time a day. If edem order.	bluded a nursing order to ver extremities for edema one na noted refer to PRN Lasix	F 3	09			
	Review of R16's me follow weights: 1/9/17: 212.2 1/12/17: 212.8 1/14/17: 212.5 1/16/17: 212.7 1/21/17: 213.6 1/24/17: 212.2 1/25/17: 212.5 1/30/17: 212.5 1/31/17: 212.7 2/4/17: 212.8 2/5/17: 213.4 2/6/17: 212.8	edical record revealed the					
	Reviews included a pharmacist dated 1 make sure the Lasi parameter is follow parameter. Would check per paramete to the recommenda "noted" with staff in R16's Medication R	ecords Dated 1/1/17-1/31/17 indicated R16 had received					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	FIPLE CONSTRUC		(X3) DATE SURVEY COMPLETED		
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F 309	diuretic therapy for directed staff to mo adverse consequer care plan also directed staff to mo adverse consequer care plan also directed staff to mo adverse consequer care plan also directed staff to motion and staff to seat the recliner was electrousers, compress shoes. The legs of the ankle and R16's not observed to be observed to the top slipper type shoes. have swelling in her much better than it she had special sto feet elevated in her not take any medicated of the would have determine when PF administered to R16 electronic record, R16 electronic record, R16 edema measuring and RN-F indicated R16 so she did not received any PRN I RN-F stated R16 she received any PRN I RN-F stated R16 she received staff to motion adverse consequences.	e plan identified R16 received edema and hypertension and nitor of interactions and lice of the medication. The sted staff to weigh R16 daily. a.m. R16 was observed er, in her room. The foot of vated. R16 was wearing ion stockings and slipper type the trouser were raised above to lower legs and ankles were swollen. Slight swelling was of R16's feet above the R16 stated she did at times r lower extremities but it was used to be. R16 also stated ckings she wore and kept her recliner. R16 stated she did ation for the swelling.	F3	09				

	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED		
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F 309	order for PRN Lasiz verified R16 should the days the weight The Medication Adr	o.m. RN-G confirmed R16's for a weight over 212 and have received PRN Lasix on was over 212 as ordered.	F 30	09		
F 322 SS=D	medication correctly medications would resident according drug, dose, time, ro	te purpose was to administer y and timely and directed be administered to the to the "Six Rights". [patient, ute, documentation]. TREATMENT/SERVICES - is SKILLS	F 32	22		3/13/17
	both percutaneous percutaneous endo enteral fluids). Bas	tric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and ed on a resident's essment, the facility must				
	alone or with assist methods unless the demonstrates that e	nas been able to eat enough ance is not fed by enteral resident's clinical condition enteral feeding was clinically ented to by the resident; and				
	receives the approprious to restore, if possible prevent complication but not limited to assume vomiting, dehydrationand nasal-pharynges	s fed by enteral means priate treatment and services le, oral eating skills and to ms of enteral feeding including piration pneumonia, diarrhea, on, metabolic abnormalities, eal ulcers. NT is not met as evidenced				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 322	review, the facility fill was administered at 1 of 1 resident (R20 cocktail of medicati endoscopic gastros. Findings include: R204's Medical Dialidentified R204's dialidentified R204's dialidentified R204's dialidentified R204's dialidentified R204's mallowing disease (GERD), high elevated lipid levels disease, and Type R204's quarterly Mit 1/20/17, indicated Fill was on a mechanical R204's Medication directed staff to adra a percutaneous end (G-Tube/PEG) tube for feeding), however and justification for and crushed medical Con 2/6/17, at 6:31 gives observed to was ealed packet contained.	gnosis report printed 2/6/17, agnoses as dysphasia g) gastro-esophageal reflux yperlipidemia (abnormally in the blood), chronic kidney II diabetes mellitus.	F 3:	1. Resident 204 now has a allowing medications to be in cocktail form via PEG tu 2. All residents with assiste hydration who receive their through the enteral tube are same deficient practice. All are affected by this current for cocktailing medications 3. All nursing staff were ed 3/1/2017 and 3/2/2017 in red for orders to cocktail given via an enteral tube. 4. Staff to audit all residents nutrition and hydration via Audits to be completed we weeks with results to QAP further recommendations.	e administer ube. ed nutrition r medicatio re at risk fo Il residents tly have ord s. ducated on regard to the medication s with assist enteral tube	n and ons or the who ders he ns sted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
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F 322	(antidepressant) arm (treats overactividentified the medical directions for use/rocombined the medical 30 cubic centimeter plastic medication oplastic sleeve pack manual pill crusher together. Once crusinto a 30 cc plastic cc of water. RN-H with the medication pair of gloves and gincluded a graduate syringe. -At 6:40 p.m. RN-H unclamped and rensyringe and checked up 20 cc of tap wat the tube with the wasyringe, withdrew the reinserted the syring and proceeded to pmixture with 20 cc of followed by another removed the syring readjusted 204's cle RN-H failed to admindividually and flus individual medication. On 2/6/17, at 6:40 psure if R204 had ar R204's medications through the g-tube current medication.	od one tablet of Oxybutynin 10 we bladder). The packet cations, however, lacked bute of administration. RN-H cations and placed them into a	F3	22			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 322	R204's medications she was taught to a individually and flus On 2/6/17, at 6:51 p (DON) reviewed R2 verified R204 did no medications. The D directed staff to adr separately and flus	s. RN-H stated during training administer each medication sh between medications. c.m. the director of nursing 204's medication orders and ot have an order to cocktail con confirmed the facility policy minister each medication h in between each medication. Her expectation was for staff to	F3	22			
F 431 SS=E	revised 5/16, direct medication separat tubing between each 483.45(b)(2)(3)(g)(ILABEL/STORE DR The facility must prodrugs and biological them under an agres §483.70(g) of this punicensed personnel aw permits, but on supervision of a lice (a) Procedures. At pharmaceutical ser that assure the accidispensing, and additional supervision, and additional supervision of a lice (b) and the supervision of a lice (a) Procedures. At pharmaceutical ser that assure the accidispensing, and additional supervision of a lice (b) and the supervision of a lice (c) and the supervision of a lice (d) and the supervision of a lice (d	n) DRUG RECORDS, EUGS & BIOLOGICALS ovide routine and emergency als to its residents, or obtain ement described in eart. The facility may permit nel to administer drugs if State ly under the general ensed nurse. facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and	F 4	31			3/13/17
	(b) Service Consult	t the needs of each resident. ation. The facility must e services of a licensed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245500	B. WING		02/0	9/2017	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	DCIETY - BETHANY 804 WRIGHT STREET BRAINERD, MN 56401 MARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 431	disposition of all co detail to enable and (3) Determines that that an account of a maintained and per (g) Labeling of Drug Drugs and biological labeled in accordant professional principal appropriate access instructions, and the applicable. (h) Storage of Drug (1) In accordance with facility must sto locked compartment controls, and perminave access to the (2) The facility must permanently affixed controlled drugs list Comprehensive Drug Control Act of 1976 abuse, except when package drug distritional quantity stored is more be readily detected This REQUIREMENT.	ystem of records of receipt and ntrolled drugs in sufficient accurate reconciliation; and all controlled drugs is riodically reconciled. gs and Biologicals. gls used in the facility must be not with currently accepted oles, and include the ory and cautionary e expiration date when as and Biologicals. yith State and Federal laws, re all drugs and biologicals in the sunder proper temperature to only authorized personnel to keys. It provide separately locked, a compartments for storage of the din Schedule II of the ug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the minimal and a missing dose can but the sudenced.	F 43				
	review, the facility f	tion, interview and document ailed to ensure electronically ion packets were properly		1. Residents R60, 106, and 204's medications are now packaged individually with route and special			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245500	B. WING _		02/	09/2017	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP CODE 804 WRIGHT STREET BRAINERD, MN 56401			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 431	(R60, R106, R 204) accurately labeled medication packets Findings include: On 2/6/17, at 6:14 processes (LPN)-A was obser R60. The physicial directed LPN-A to a medications: -Coumadin 1.5 mill humalog insulin injustimes a day related additional 5 units posupper hetformin 500 mg metoprolol tartate with food calcium Citrate +E meals her consistency tablet 60 her cocet 5-325 mg hedication cart. The administration record remove three 2 by medication cart. The name, the date of 2 as "evening" and a was in the packet.	ons for use for 3 of 3 residents observed to not have electronically dispensed	F 43	instructions listed on the label. Medications are being administe according to the physicians orde 2. All residents are at risk of this occurring. Pharmacy has been individually packaging medicatio adding the route and special inst to the package to ensure the prolabeling is in place since 3/7/201 3. Licensed Nursing staff were e on medication labeling, timing of medication administration, and administration of medication acc the order on 3/1/2017 and 3/2/20 Pharmacy altered packaging of medications obtained from the ADispensing Unit to include the rospecial instructions on the packa 4. DNS/Designee to randomly at medication labels to ensure that medication labels to ensure that medication is being labeled apprincluding the missing items of rospecial instructions. DNS/Designalso audit timeliness of medication administration. The audits will ominimum of 3x/wk for 4 weeks we to the QAPI committee for further recommendations.	ns and tructions oper 7. ducated ording to 017. utomated oute and age. udit the topriately ute and nee to on occur for a vith results		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245500	B. WING _		02	/09/2017	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BETHANY				STREET ADDRESS, CITY, STATE, ZIP CODE 804 WRIGHT STREET BRAINERD, MN 56401	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 431	the pharmacy and on the packet, how including the route packet. LPN-A pla When questioned not on the label, RI question, responde follow the direction each medication for each medication packets. LPN-A exmedications were packets in the 100 explained the day a packages for the eand she would be	age 13 scription number, the name of the name of the physician was rever, the directions for use were not identified on the ced the tablet in a soufflé cup. Why the directions for use were N-D, who overheard the ed by stating the staff were to s in the electronic MAR for She confirmed the directions in were not on the printed explained the packet printed and dispensed from a dounit medication room. She shift nurse had printed the vening shift medication pass printing the night shift of the end of her shift.	F 43	1			
	and evening. The 25-100 mg tablet of and yellow along we physician and pharmetformin 500 mg identified as number the prescription nuidentified. The second staff how to administrate the packet of and evening as time indicated the packet tartate 100 mg deswith number 47 staff.	t contained R60's name, date, packet contained one Sinemet escribed as round a logo 539 with the prescription number, remacy identification, a table was also in the package er 102, round and white with mber, pharmacy and physician cond package did not direct the ister the medications. LPN-A dications in the soufflé cut. International R60's name, date, we indicated to administer. It age contained metoprolol coribed as a round blue table amped on it, parmidpexole tified as a white oblong tablet.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245500	B. WING	·····	02	/09/2017
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BETHANY				STREET ADDRESS, CITY, STATE, ZIP CODE 804 WRIGHT STREET BRAINERD, MN 56401	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 431	described as a rour stamped on it. The prescription number pharmacist and the did not identify the CLPN-A was observed remove the metoprotect the soufflé cup, left in the packet and remedication cart. LP medications in the packet and remedications in the packet and remedication package as the bed at 6:20 p.m. LPN-A from a bottle of medication and unalog insulin packet and eaten her administer R60's medicate and other packages or bottles upon the medication pack, bottle or from confirmed she had after R60 had eater after the meal. Upoconfirmed the Siner administer the medication and insister the medication pack, bottle or from confirmed she had after R60 had eater after the meal. Upoconfirmed the Siner administer the medication packet.	on it and oxybutynin 10 mg ER and peach tablet with M 010 er package identified the r, the pharmacy, the prescribing physician but it direction for each medication. It do open the third packet, colol tartrate tablet, place it into the two additional medications eturned the packet to the N-A stated the other two packet would be administered dication pass. She stated for netoprolol was in the same litime medications. Obtained a cranberry tablet dication, the coumadin tablet et (which contained a full cluding directions for use) and en and proceeded to go to	F 4	31		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245500	B. WING _		02	/09/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 804 WRIGHT STREET BRAINERD, MN 56401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 431	Continued From p	age 15	F 43	1			
	the staff to adminismeal as per the ph	prescription label did not direct ster the sinemet before the hysician orders. She stated she her medications after she had					
	the 100 unit medic medication dispen of the room. LPN- to the machine and print the 300 wing evening shift. Wh change the time of LPN-A stated whe the medications we administered at the medications were appropriate time, the pharmacy and have reprogrammed. L	O p.m. LPN-B was observed in action room. An AlixaRX sing machine was in the center A logged into a computer next d programmed the machine to unit medications for the nen questioned as to how to f the medication packages, n a package was opened, all of ithin that package were to be e same time. If the not being dispensed at the he nurse on duty was to call the re the dispensing machine PN-A stated she was not aware ith the time of R60's evening					
	medication packet machine did not id directions for use to package dispense	p.m. LPN-A confirmed the s dispensed from the AlixaRX entify the route or the for each medication in the d. She stated the staff were to or the directions to give.					
	confirmed the pres from the AlixaRX r route or the directi	p.m. registered nurse (RN)-A scription labels on the packets nachine did not include the ons for the medication use.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245500	B. WING _		02	/09/2017	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP C 804 WRIGHT STREET BRAINERD, MN 56401		-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 431	be given before me been repackaged a meal with the rest of confirmed R60's pr the staff as to when medications.	A stated R60's Sinemet was to eals and therefore should have and not administered after the of her medications. She rescription label did not direct	F 43	.1			
	(DON) stated that i medications accord were to be confirm adminsitration whimedication, right doright time and right three checks: read container and compremoving the container and placing the moup/syringe and just medications. The Eadministered medications for use when placing the prephysician's order in directions for use when the place when the prephysician's order in directions for use when the place whe	n order for the staff to pass ding to the facility policy, they ing the six rights of medication ch included the right ose, right resident, right route, documentation and to perform the label on the medication pare with the MAR when ainer from the supply drawer, nedication in an administration at before administering the DON confirmed the staff who cations did not have the ability escription label to the in the MAR because the were not on the prescription infirmed she would have to acy for further directions.					
	prepare the following administration via a gastrostomy (G-Tu the stomach for feetone tablet of Meto (treats hypertensione tablet of Mirta (antidepressant)	a percutaneous endoscopic be/PEG) tube (tube place into eding): prolol 50 milligrams (mg) n and angina)					

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	PROVIDER OR SUPPLIER	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP C 804 WRIGHT STREET BRAINERD, MN 56401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 431	plastic packet appricontained the above identified the medications for use a medication was to combined the Meto Oxybutynin, into a spoured the tablets inserted the packet crushed the tablets crushed tablets into cup and added 20 204's room, washe gloves and gathered graduate with tap weat 6:40 p.m. RN-H unclamped and rered the G-tube, connect proper placement, water into syringe awithdrew the syring and proceeded to report, poured the Moxybutynin mixed of g-tube, poured 30 cmedication cup and open ended syringe from the tubing and read exited the room. On 2/6/17, at 6:40 sure if R204 had an R204's medications.	hands and open a sealed oximately 2 by 3 inches which re medications. The packet cations, however, lacked and the route to which the be administered. RN-H oprolol, Mirtazapine and 30 cc plastic medication cup, into a plastic sleeve packet, a into a manual pill crusher and a together. RN-H placed the coa 30 cc plastic medication cc of water. RN-H entered d hands, donned a pair of ed supplies which included a vater and 60 cc syringe exposed R204's g-tube, moved the plug on the end of cted the syringe and confirmed RN-H drew up 20 cc of tap and flushed tube. RN-H ge and withdrew the plunger reinsert the syringe into g-tube letoprolol, Mirtazapine, and with 20 cc of water into the cc of water into a 30 cc d poured the water into the ex. RN-H -unattached the open in the g-tube, closed the port on dijusted 204's clothing and	F 43				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245500	B. WING		02	/09/2017	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		STREET ADDRESS, CITY, STATE, 804 WRIGHT STREET BRAINERD, MN 56401			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 431	cocktail R204's memedication packets Mirtazapine and Oxuse and route of act staff used the MAR directives. RN-H stamedication packets information. RN-H swhen administering On 02/09/17, at 8:2 to obtain a sealed reasured approxing contained three medications: 1- Lisi 6-pink, 1-Metformit-white-1 metoprolol packet lacked direct the packet and places small souffle cup to stated the labels did use on the packet to stated the labels did use on the packet to stated the labels did use on the packet to stated the labels did use on the packet to stated the labels did use on the packet to stated the labels did use on the packet to stated the labels did use on the packet to stated the labels did use on the packet to stated the labels did use on the packet to stated the right time in administration was electronically dispendent to verify the right time in administered, LPN-MAR to see how the administered because compare the MAR of the right time in administered because the market seed to state the labels did use on the packet to state	as unable to find an order to dications. RN-H verified the containing R204's Metoprolol, bybutynin lacked directions for ministration. RN-H stated, the to check for administration ated she was unaware the lacked the direction and route stated she checked the MAR	F 4	31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245500	B. WING		0:	2/09/2017	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP COI 804 WRIGHT STREET BRAINERD, MN 56401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 431	service technician technician that delifacility, stocked the machines and assi problems regarding process. The FST dispensed medicat and printed the me individual packets at tablets into the indiwere then sealed a reviewed the medic R204 and verified to routes were not ide was unaware the pfor use. The FST scapability to label the directions for use at example, when a remedications were didentified the routes and the directions of lack of of	12:40 p.m. AlixaRX pharmacy (FST), stated she was the vered the medications to the pharmacy medication sted the facility with any the medication administration explained the machine ions by shift, three times daily dication labels on the and dispensed the medication vidual packets. The packets and dispensed. The FST cation packets provided for the directions for use and antified. The FST stated she ackets lacked the directions tated the machine had the me packets to include the administration routes for esident went out on leave, the dispensed into packets that is to administer the medications for use. The FST confirmed the fifth packets created an dication administration for use on the packets for verification and this lack of information on kets was a concern and she ther supervisor and to the	F4	131			
	from the AlixaRx m directions for use of stock medications	medication packets dispensed achine lacked the routes and f the medications and the acked specific information for se and the staff were unable					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245500	B. WING			02/	09/2017
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		804 WRIGH	DRESS, CITY, STATE, ZIP CODE HT STREET ID, MN 56401	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC EACH CORRECTIVE ACTION SHOULI DSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	order to ensure acc administration. The the pharmacy in ord issues. The DON vi medication adminis The facility Medicat revised 5/16, direct medications due, a medication adminis	ections for use with the MAR in	F 4	31			
	right time and right three checks: read container and comp removing the conta when placing the m	documentation and to perform the label on the medication pare with the MAR when iner from the supply drawer, edication in an administration t before administering the					
F 441 SS=D	from Pharmacy Me 06/15, indicated ea label included: Res directions for use, r prescriber's name, medication, expirat prescription number storage requiremer Example: "Take on before or 2 hours a 483.80(a)(1)(2)(4)(6) PREVENT SPREA	e)(f) INFECTION CONTROL, D, LINENS	F 4	11			3/13/17
	(a) Infection preven	tion and control program.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245500	B. WING _		02	/09/2017
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP CO 804 WRIGHT STREET BRAINERD, MN 56401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	and control program a minimum, the following services to arrangement based conducted accordinaccepted national simplementation is F (2) Written standard for the program, whilmited to: (i) A system of surv possible communic before they can sprifacility; (ii) When and to who communicable diserported; (iii) Standard and transition to be followed to profit (iv) When and how resident; including the involved, and (B) A requirement to the followed to profit (B) A requirement to the followed to profit (B) A requirement to the followed to profit (C) and (C) A requirement to the followed to profit (C) and (C) A requirement to the followed to profit (C) and (C) A requirement to the followed to profit (C) and (C) A requirement to the followed to profit (C) A requiremen	tablish an infection prevention in (IPCP) that must include, at owing elements: eventing, identifying, reporting, ontrolling infections and asses for all residents, staff, and other individuals under a contractual if upon the facility assessment ing to §483.70(e) and following standards (facility assessment include, but are not include, but are not eillance designed to identify able diseases or infections ead to other persons in the include	F 44	11		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245500	B. WING _		02/0	09/2017
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP CODE 804 WRIGHT STREET BRAINERD, MN 56401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	must prohibit emplodisease or infected contact with resider contact will transmi (vi) The hand hygie by staff involved in (4) A system for required the facility's lactions taken by the lactions. (f) Annual review annual review of its program, as necess this REQUIREMENT by: Based on observative review, the facility sappropriate infection providing direct result of 1 resident (R65 care. Finding include:	ces under which the facility byees with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact. cording incidents identified PCP and the corrective a facility. The facility will conduct an IPCP and update their	F 44	1.Resident 65□s dressing is be changed following appropriate in control measures. 2.All residents with wounds are not having their dressings change following appropriate infection comeasures. 3.Licensed Nursing staff educate following appropriate infection comeasures with dressing change relates to proper isolation proce based on residents individual integration and on communication r/t reside infections on 3/1/2017 and 3/2/24.DNS or Designee to randomly	at risk of ged ontrol ed on ontrol s as it dures fections ents with 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245500	B. WING			02/0	09/2017
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		80	TREET ADDRESS, CITY, STATE, ZIP CODE D4 WRIGHT STREET RAINERD, MN 56401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	R65's care plan day MRSA infection to a The plan directed symbol changing cor- linens in bags mark- linens and close balaundry. On 2/8/17, at 11:21 (LPN)-B stated R65 dressing changes the assisting with the room, R65 was obseined wheelchair. R65 was antiseptic wipes to and his over the betwel on the floor in then placed a seconto R65. LPN-A place on the second tower R65. LPN-A wore godressing. R65 had	independent with bed mobility, in with transfers and had a ch was unstageable. Ited 8/30/16, indicated R65 had wound on the left lower leg. Itaff to wear gowns and masks intaminated linens, place soiled ked biohazard and to bag ing tightly before taking to a.m. licensed practical nurse is liked to be involved with the ohis left lower leg and would be dressing. Upon entering the served seated in his ore gloves while he used clean the scissors, tweezers	F4	41	residents dressing changes. The a will also review effectiveness of communication r/t active infections facility. The audits will occur for a minimum of 3x/wk for 4 weeks with to the QAPI committee for further recommendations.	in the	
	centimeters (cm) in wound was from pr was from an absce -At 11:30 a.m. LPN basin of water and leg was cleansed, I floor next to her. L	diameter. R65 stated the first ressure and the second wound					

AND BLAN OF CORRECTION INTERPRETATION NUMBERS		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245500	B. WING		02	2/09/2017
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP C 804 WRIGHT STREET BRAINERD, MN 56401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 441	wound cleaner). Silemptied it in the rest LPN-B returned to applied a new drest-At 11:40 a.m. LPN supplies in a clear process of the process	wound wash (compressed ne gathered the wash basin, stroom and washed her hands. R65, donned fresh gloves and	F4	41		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP CO 804 WRIGHT STREET BRAINERD, MN 56401	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	R65's last wound condentified MRSA. Sisolation precaution culture was to be on the Mondentified MRSA is isolation precaution culture was to be on the Mondentified MRSA. Sisolation in Center revealed a form who mame, room number infection, site of infragents, treatment in measure, isolation staff to identify if the identify a resolution. The identify a resolution on 2/8/17, at 9:35 at to be on contact isolatify were to wear good masks during dress were to be contained. On 2/9/16, at 9:40 and the staff were the precautions during DON stated she was had been removed would have been resolution. The Multidrug-Resing 11/2016, directed sa moisture-resistant room surfaces or flatoutilize contact presidentification.	ical record and confirmed alture obtained on 9/25/16, whe stated in order for contact is to be removed, a second obtained. Ithly Report of Resident in first infection control log, ich identified the resident er, admission dated, date of ection, culture take, causative measures, cautionary precaution and directed the enfection was acquired in the infection control logs did not a date. Ithly Report of Resident er, infection control log, ich identified the resident er, admission dated, date of ection, culture take, causative measures, cautionary precaution and directed the enfection control logs did not infection control logs did not enfection precautions and verified gowns, gloves and possibly sing changes and all linens end in yellow biohazard bags. In the director of nurses in the director contained MRSA in the director of nurses in th	F 44			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245500	B. WING _		02	/09/2017	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP CODE 804 WRIGHT STREET BRAINERD, MN 56401	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 441	Multidrug-resistant confirmed the policic DON stated R65 who precautions during linen changes if the The DON stated R67 remained in place is during dressing characteristic during dressing dressing characteristic during dressing dress	a.m. the DON reviewed the organisms policy and y had not been followed. The rould only require contact dressing changes and during dressing had not fallen off. S5's dressings typically out gowns should be worn anges since aerosol wound to directly wash the wound ause potential splatter. a.m. LPN-B stated R65 had not had been cleared of aller, RN-A interjected and stated and had been cleared of aller, RN-A interjected and stated ared of osteomyelitis, but had om the MRSA. LPN-A stated aware of the continued of have worn a gown, not sat on dressing change and would hens in a yellow biohazard bag froom. LPN-B stated R65 had not been communicated. AL/SANITARY/COMFORTABL ental Conditions ovide a safe, functional, ortable environment for	F 44			3/13/17	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245500	B. WING		02/09/2017	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP CODE 804 WRIGHT STREET BRAINERD, MN 56401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	by: Based on observareview, the facility of wheelchairs and cand/or a clean and residents (R125, Rwheelchairs and edirty and in need of findings include: On 2/6/2017, at 6:3 the dining room sewas leaning over thand spit onto the willoor. The right wheelchair brait attered and peelin wheelchair was not exposing the white On 2/7/17, at 10:14 his room, seated in right side of the whorevices along the	ents. NT is not met as evidenced tion, interview and document failed to maintain resident are equipment in good repair sanitary condition for 6 of 6 35, R128, R106, R236) whose quipment were observed to be f cleaning and/or repair. 30 p.m. R125 was observed in ated in a wheelchair. R125 he right arm rest of the chair sheel of the wheelchair and the sel was observed coated in dried white substance. 53 a.m. R35's wheelchair was range colored tape adhered to ke handles. The tape was g. The left arm rest of R35's ted to be cracked and peeling foam padding. 4 a.m. R128 was observed in an electric wheelchair. The seelchair seat cushion and right side of the chair and the d to have dried food debris and	F 46	1. Residents R125 and R128 have their wheelchairs and cushions cle Resident R35 had tape and armres replaced. Resident R236 had armre replaced. 2. All residents are at risk for havin soiled w/c's and are at risk for havin these items in need of repair. Res with braces are at risk of having the braces covered in food debris. All wheelchairs were audited for clean and to determine if they were in ne repair. All braces were audited for cleanliness as well. Those items identified as in need of repair or in cleaning have been repaired and/or cleaned. 3. The system currently in place for cleaning the wheelchairs and brace least weekly and checking for dam that time has been reviewed and re-enforced. All Nursing staff educated at that time on how report wheelchairs and braces in no cleaning and/or repair. 4. DNS or Designee to randomly a wheelchair and brace cleanliness as repair a minimum of 3x/wk for 4 we with results to the QAPI committee further recommendations.	aned. st brace est g ng idents e liness ed of r r es at age at cated on 017. All to eed of udit and eeks	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245500	B. WING _		02	/09/2017	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP (804 WRIGHT STREET BRAINERD, MN 56401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 465	On 2/7/17, at 2:19 dining room, seated coffee with friends. wheelchair was obseam at the bottom length of the armre. On 2/9/17 at 3:13 penvironmental serviver responsible for wheelchairs and bronfirmed environmental services or other issues. Disservices staff compatt the time of the total confirmed of the total confirmed services.	a.m. R106's left knee brace e covered in a food debris. b.m. R236 was observed in the d in a wheelchair, drinking The right arm of the served to have a rip on the which ran almost the entire st. b.m. the director of rices (DES) stated nursing staff or the cleaning of resident aces. However, DES nental services would be intaining wheelchairs in good ir. DES indicated each nursing order book and could submit a elchairs with ripped armrests ES indicated environmental oleted work orders everyday. bur, R35 and R236 were	F 46	,			
	the wheelchair brak was not able to be work order should I wheelchair arm res DES indicated the examined and repa On 2/9/17 at 3:30 p (DON) confirmed n for the cleaning of DON indicated eac cleaned on their ba	er, DES indicated the tape on ses would create a surface that cleaned. DES also indicated a nave been placed and tears in its would have been repaired. wheelchairs would be aired as soon as possible. o.m. the director of nursing ursing staff were responsible resident wheelchairs. The h resident's wheelchair was ith day and as needed. The dany other resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245500	B. WING _		02/09/2017	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP CODE 804 WRIGHT STREET BRAINERD, MN 56401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	as needed basis an assistants to let the unclean equipment made for cleaning. aforementioned obswheelchair was dirt R106's knee brace cleaning, the tape chandles was put on enhance visibility hotattered and needed confirmed the arm repair. The DON alsand cushion were of the Station 2 bath and services and services are confirmed to the arm of the station 2 bath and services are services as the services are services are services as the services are	s braces, were cleaned on an and would expect the nursing station directors know of any so arrangements could be The DON confirmed the servations and verified R125's y and needed to be cleaned, was soiled and required on R35's wheelchair brake by the therapy department to owever, it was worn and do to be replaced and rest was cracked and required so verified R128's wheelchair lirty and required cleaning.	F 46	5		
F 492 SS=B	during the night hou of the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment were pro 483.70(b)(c) COMF FEDERAL/STATE/L (b) Compliance with Laws and Profession The facility must oper compliance with all local laws, regulation accepted profession	PLY WITH LOCAL LAWS/PROF STD In Federal, State, and Local	F 49	2		3/13/17

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		245500	B. WING _		02	/09/2017	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP C 804 WRIGHT STREET BRAINERD, MN 56401			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 492	(c) Relationship to 0 In addition to comp forth in this subpart the applicable provi regulations, includir pertaining to nondiscrimination of CFR part 84); nond age (45 CFR part 9 basis of race, color disability (45 CFR part 9 basis of race, color disability (45 CFR part 9 basis of research and abuse (42 CFF individually identifia CFR parts 160 and provisions may resund non-compliance with This REQUIREMEN by: Based on document facility failed to ension who requested a deservices while the complete the facility determination of Country and the facility and the facility	Dither HHS Regulations. Iliance with the regulations set a facilities are obliged to meet sions of other HHS and but not limited to those scrimination on the basis of anal origin (45 CFR part 80); and the basis of disability (45 iscrimination on the basis of 1); nondiscrimination on the anational origin, sex, age, or part 92); protection of human and (45 CFR part 46); and fraud a part 455) and protection of ble health information (45 164). Violations of such other all tin a finding of the this paragraph. Note that the paragraph is not met as evidenced and the review and interview, the paragraph is not met as evidenced and the part of 4 residents (R105) are and bill was not billed for decision was pending.	F 4	1. Resident 105 had their preimbursed as the demand pending. 2. All residents who request are at risk and these reside audited to ensure a bill was 3. Additional training occurr 2/23/2017on billing practice who have requested a dem Training also occurred on 2 related to the demand bill resubmission of claims to Me were trained on the policy a as it relates to the determin continued stay notice and the bill the resident if a demand requested until a determina made.	t a demand bill ents have been a not sent. Ted on es for residents and bill. 1/28/2017 equests and edicare. Staff and procedures eation of the need to not dibill has been		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245500	B. WING	B. WING			02/09/2017	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY	STREET ADDRESS, CITY, STATE, ZIP CODE 804 WRIGHT STREET BRAINERD, MN 56401					
(X4) ID PREFIX TAG				(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 492	Medicare decision. bill is submitted. Yo services which coul	You will be informed when the u are not required to pay for d be Medicare until a has been made." R105 was	F 4	92	4. Facility to audit all demand bills tweeks and bring results to the QAF committee for further recommendate	기		
	and 2/9/17, were re amount owed and of past due, would be charges. The stater "Because you reque your bill, we filed a decision. Please pa	ments dated 1/20/17, 2/1/17 viewed. All indicated an dates payment was due and if subject to late payment ment dated 2/9/17, read: ested a Medicare Review of demand bill to Medicare for a sy the statement amount at this ecides in our favor an would be due.						
	member (AR)-A condemand bill on 12/2 not supposed to be final medicare decis R105 was sent the have received the s"interim billing" notic R105's bill had bee	o.m. accounts receivable staff afirmed R105 requested a 20/16, and stated R105 was billed for services until the sion was made. AR-A stated wrong statement and should statement which included the ce statement. AR-A explained in paid in full on 2/1/17, and a a refund was sent out on						

Printed: 02/13/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING (X3) DATE SURVEY COMPLETED

245500

B. WING

02/09/2017

NAME OF PROVIDER OR SUPPLIER

COOD CAMADITAN COCIETY

STREET ADDRESS, CITY, STATE, ZIP CODE

804 WRIGHT STREET

GOOD		RIGHT STREET IERD, MN 56401				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
K 000	INITIAL COMMENTS	K 000				
	FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Good Samaritan Society Bethany 01 Main Building was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.					
	The facility was inspected as one building. Good Samaritan Society Bethany is a 1-story building without a basement. The building was constructed at six different times. The original building was constructed in 1969, is 1- story and was determined to be of Type II(000) construction. In 1974, two, 1-story additions were constructed, one to the south west and one to the east side of the original building, that were determined to be of Type II(111) construction and are separated with 2- hour fire barriers form the existing building. In 1980 an 1- story addition was constructed to the south and east of the 1974 south addition, was determined to be Type II (111) construction and is separated with a 2- hour fire barrier. In 1983 a small 1- story connecting link was added to the south of the 1980 addition to connect the facility to an apartment building and was determined to be Type V (000) construction. This link is not separated from the facility but a 2-hour fire barrier is between the link and the apartment building. In 1994 the Physical Therapy 1- story addition was added to the north of the original building and was determined to be Type II		A			
LABORATO	DRY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE		

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.

Printed: 02/13/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A BUILDING 01 - MAIN BUILDING

(X3) DATE SURVEY COMPLETED

(X4) DATE SURVEY

(X5) MULTIPLE CONSTRUCTION

A BUILDING 01 - MAIN BUILDING

(X6) DATE SURVEY

(X7) DATE SURVEY

(X7) DATE SURVEY

(X8) DATE SURVEY

(X9) DATE SURVEY

(X9) DATE SURVEY

(X9) DATE SURVEY

(X1) PROVIDER OF PROVIDER STREET ADDRESS, CITY, STATE, ZIP CODE

(X1) PROVIDER OF SUPPLIER

(X1) PROVIDER OF SUPPLIER

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

(X9) DATE SURVEY

(X9) DATE SURVEY

(X9) DATE SURVEY

(X1) PROVIDER OF PROVIDER OF SUPPLIER

(X1) PROVIDER OF SUPPLIER

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

(X3) DATE SURVEY

(X4) DATE SURVEY

(X5) DATE SURVEY

(X6) DATE SURVEY

(X7) DATE SURVEY

(X8) DATE SURVEY

(X9) DATE

עטטע א	AMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401				
X4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL I OR LSC IDENTIFYING INFORMATION)	L ES REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
K 000	Continued From page 1		K 000			
	(111) construction. In 1998 an 1- story a was constructed to the north of the 1960 and 1974 addition, was determined to b V(111) construction and is separated by fire barrier. The main level is divided into smoke zones by 30 minute and 90 minute barriers.	D building e Type a 2-hour o 11				
	The entire building is protected by a complete automatic fire sprinkler system installed with quick response heads in the 1998 addition ar standard response heads in all other areas. Tacility has a fire alarm system with smoke detection in the corridors, spaces open to the corridor system, in common areas and in all sleeping rooms that is monitored for automat fire department notification. The facility has a capacity of 114 beds and has census of 94 at the time of the survey.					
	The requirement at 42 CFR, Subpart 48 MET.	33.70(a) is				



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 22, 2017

Mr. Ryan Cerney, Administrator Good Samaritan Society - Bethany 804 Wright Street Brainerd, Minnesota 56401

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5500027

Dear Mr. Cerney:

The above facility was surveyed on February 6, 2017 through February 9, 2017 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 <u>only a suggestion</u> 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.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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

Good Samaritan Society - Bethany February 22, 2017 Page 2

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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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 Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us.

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 eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 04/07/2017 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ B. WING 00087 02/09/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **804 WRIGHT STREET GOOD SAMARITAN SOCIETY - BETHANY BRAINERD, MN 56401** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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

INITIAL COMMENTS:

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota

notice of assessment for non-compliance.

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 03/03/17

STATE FORM G24W11 If continuation sheet 1 of 29

TITLE

(X6) DATE

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00087	B. WING		02/09/2017	
	NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BETHANY 804 WRIG BRAINER					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Department provider and the folissued. Please indicorrection that you and identify the dat Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of column entitled "	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 2/8/17, and 2/9/17, surveyors is staff, visited the above lowing correction orders are cate in your electronic plan of have reviewed these orders, e when they will be completed. The order of Health is documenting correction Orders using an umbers have been noted state statutes/rules for the order of Deficiencies" column to Comply" portion of the nis column also includes the	2 000			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						SURVEY LETED	
				A. BOILDING.			
		00087		B. WING		02/0	9/2017
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BETHANY		HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIEN / MUST BE PRECEDED SC IDENTIFYING INFOI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2		2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.						
2 555	MN Rule 4658.0409 Plan of Care; Deve		ehensive	2 555			3/13/17
	Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative.						
	This MN Requirements by: Based on interview facility failed to devof anticoagulant meresidents (R44) whereviewed.	and document re elop interventions edication (Coumac	eview, the for the use din) for 1 of 5		Corrected		
	Findings include:						
	R44's quarterly Min 12/20/16, indicated and had diagnoses	R44 was cognitiv	ely intact				

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STATE FORM 6899 G24W11 If continuation sheet 3 of 29

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILBIIVG.			
		00087	B. WING		02/0	9/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- RETHANY	HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 555	Continued From pa	ige 3	2 555			
	commonly causes hypertension. The received anticoagu	ular, often rapid heart rate that boor blood flow) and MDS also indicated R44 lation (prevent or reduce d, prolonging the clotting ily.				
	included an order for (mg) by mouth one Monday, Tuesday,	lication Review Report or Coumadin 1.25 milligrams time a day every Sunday, Wednesday, Friday and ng every Thursday for atrial				
	R44's undated Care Plan indicated R44 had diagnoses which included long term (current) use of anticoagulants, however, lacked interventions related to the use of the medication and monitoring for potential adverse effects of the medication.					
	confirmed R44's cause of Coumadin a RN-G stated they umedications on the R44's care plan shomonitoring for signs	o.m. registered nurse (RN)-G are plan did not address the nd should have done so. isually included all high risk care plan. RN-G indicated buld have addressed as and symptoms of bleeding elated to the event of a				
	11/16, indicated a c	policy and procedure revised care plan would be developed cons and treatments and any propriate.				

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Minnesota Department of Health STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00087	B. WING		02/09/2017	
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - BETHANY			HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 555	Continued From pa	ge 4	2 555			
2 830	The director of nurse staff to develop a care interventions for all monitoring program to assure ongoing a interventions in response (21) days TIME PERIOD FOR one (21) days MN Rule 4658.0520 Proper Nursing Care Subpart 1. Care in receive nursing care custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the control of the cont	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident	2 830			3/13/17
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to administer as needed etic) according to physician		Corrected		

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
1						
		00087	B. WING		02/0	9/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- RETHANY	GHT STREET RD, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 5	2 830			
	orders for 1 of 1 resident (R16) reviewed who received PRN Lasix.					
	Findings include:					
	1/10/17 indicated F required extensive mobility, transfers,	num Data Set (MDS) dated R16 was cognitively intact and assistance of two staff for bed dressing, toilet use and nd was independent with				
	R16's undated Diagnosis Report indicated R16 had diagnoses which included edema (swelling), lymphedema (collection of fluid that causes swelling in the arms and legs), and hypertension (high blood pressure).					
		dication Review Report ng physician orders:				
	Administer PRN LaLasix Tablet 40 m needed for increase 212. Notify physici days of administrat 1/9/17. The Report also incompositor bilateral love	ime a day for edema. six if above 212. illigrams (mg) by mouth as ed (2+) edema for weight over an if no weight change after 3 ion. The order start date was cluded a nursing order to wer extremities for edema one na noted refer to PRN Lasix				
	Review of R16's m	edical record revealed the				

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Minnesota Department of Health STATE FORM

AND BLAN OF CORRECTION \ \ \ \ IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
00087				B. WING			09/2017
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY	804 WRIG	DRESS, CITY, S GHT STREET D, MN 5640			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa 1/9/17: 212.2 1/12/17: 212.8 1/14/17: 212.5 1/16/17: 212.7 1/21/17: 213.6 1/24/17: 212.5 1/26/17: 213.5 1/30/17: 212.5 1/31/17: 212.7 2/4/17: 212.8 2/5/17: 213.4 2/6/17: 213.4 2/6/17: 212.8 The Consultant Pha Reviews included a pharmacist dated 1, make sure the Lasi: parameter is followed parameter. Would check per parameter to the recommenda "noted" with staff ini R16's Medication R and 2/1/17-2/28/17 no PRN doses of Lasi R16's undated care diuretic therapy for directed staff to mo adverse consequencare plan also directed to the care plan also directed the care plan also direct	armacist Drug F recommendati /12/17, which re x PRN weight bed. Also has ed document a da er." A hand writ tion dated 1/16 tials next to it. ecords Dated 1 indicated R16 I asix. plan identified edema and hyp nitor of interact ice of the medicated staff to weight	on from the ead: "Please based dema illy edema ten note next i/17, indicated in a received pertension and ions and cation. The gh R16 daily.	2 830			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00087	B. WING		02/0	9/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	,		
GOOD S	AMARITAN SOCIETY	- BETHANY	HT STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	D, MN 5640 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE	
2 830	Continued From particles and the recliner was electrousers, compressions. The legs of the ankle and R16's not observed to the top slipper type shoes. have swelling in her much better than it she had special sto feet elevated in her not take any medicated. On 2/8/17, at 1:37 processed to the top slipper type shoes. The legislation of the top slipper type shoes. The had special sto feet elevated in her not take any medicated to R10 electronic record, Redema measuring 20 RN-F indicated R16 so she did not recelled However, RN-F corrus written above and received any PRN IRN-F stated R16 should show above. On 2/8/17, at 2:09 proder for PRN Lasix verified R16 should should be received R16 should should should should be received R16 should should should should should should be received R16 should	ge 7 er, in her room. The foot of vated. R16 was wearing ion stockings and slipper type the trouser were raised above is lower legs and ankles were swollen. Slight swelling was of R16's feet above the R16 stated she did at times in lower extremities but it was used to be. R16 also stated ckings she wore and kept her recliner. R16 stated she did ation for the swelling.	2 830	DEFICIENCY)			
	5/2016, indicated th	ministration Policy dated ne purpose was to administer y and timely and directed					

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STATE FORM 6899 G24W11 If continuation sheet 8 of 29

AND DIANI OF CODDECTION IDENTIFICATION NI IMPED:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
00087			B. WING		02/0	02/09/2017	
NAME OF PROVIDER OR SUPPLIER STREET ADD 804 WRIG				DRESS, CITY, S SHT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCY MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	medications would resident according drug, dose, time, round staff to comprehensinterventions to enscare in a manner to well-being. A monite established in order assessment and erin response to reside the staff to comprehensinterventions to enscare in a manner to well-being. A monite established in order assessment and erin response to reside the staff of the staff o	be administered to the "Six Rights" oute, documentation of the "Six Rights" oute, documentation of the "Six Rights" oute, documentation of the sing or designee of sively assess and sure residents are open on their higher or to assure ongoing fective care plan in the their care needs. CORRECTION: Subp. 7 B. Rehamston of the comprehenses of the	[patient, on]. ECTION: ould direct implement provided hest ld be g nterventions Twenty one b - omy tubes, ive resident is ure that: sogastric or eceives the prevent ting, and	2 930			3/13/17
	This MN Requireme	ent is not met as o	evidenced				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		
	00087		B. WING		02/0	9/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- RETHANY	GHT STREET RD, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 930	Continued From pa	age 9	2 930			
	review, the facility f was administered a 1 of 1 resident (R20	ion, interview and document failed to ensure medication as directed by facility policy for 04) observed to receive a ions via a percutaneous stomy tube.		Corrected		
	Findings include:					
	R204's Medical Diagnosis report printed 2/6/17, identified R204's diagnoses as dysphasia (difficulty swallowing) gastro-esophageal reflux disease (GERD), hyperlipidemia (abnormally elevated lipid levels in the blood), chronic kidney disease, and Type II diabetes mellitus.					
	R204's quarterly Minimum Data Set (MDS) dated 1/20/17, indicated R204 had a feeding tube and was on a mechanically altered diet.					
	directed staff to adu a percutaneous end (G-Tube/PEG) tube for feeding), however and justification for	Review Report dated 2/6/17, minister 204's medications via doscopic gastrostomy e (tube place into the stomach ver the report lacked an order cocktailing (mixture of liquid cations) the medications.				
	was observed to was sealed packet cont 50 milligrams (mg) angina), one tablet	p.m. registered nurse (RN)-H ash her hands and open a aining one tablet of Metoprolol (treats hypertension and of Mirtazapine 7.5 mg nd one tablet of Oxybutynin 10				

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PRINTED: 04/07/2017 FORM APPROVED

Minnesota Department of Health

AND BLAN OF CORRECTION TO TRENTIFICATION NUMBER:			ADED: '				DATE SURVEY COMPLETED	
		00087	B. WIN	IG		02/	09/2017	
	PROVIDER OR SUPPLIER	- BETHANY	STREET ADDRESS, 804 WRIGHT ST	REET				
GOOD	AMAINTAN OOOILTT	DETHAN	BRAINERD, MN	56401				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	-ULL PRE	FIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
2 930	mg (treats overactive identified the medical directions for use/rocombined the medical 30 cubic centimeter plastic medication of plastic sleeve packer manual pill crusher together. Once crusinto a 30 cc plastic cc of water. RN-H pwith the medication pair of gloves and gincluded a graduate syringe. -At 6:40 p.m. RN-H unclamped and rem syringe and checker up 20 cc of tap water the tube with the was syringe, withdrew the tube with the was syringe, withdrew the reinserted the syring and proceeded to proceeded	ve bladder). The pack ations, however, lack oute of administration cations and placed th	s into a s into a s into a s into a et into a ets e tablets idded 20 s room aned a ch 60 cc be, ected the H drew d flushed he yringe, e port ocktail ube H he tube, room. is e. was not nix all of em t's (MAR) ail training	0				

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STATE FORM 6899 G24W11 If continuation sheet 11 of 29

AND DUAN OF CODDECTION DENTIFICATION NUMBER.		,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	00087		B. WING		02/0	9/2017	
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 02/0	70/2011
GOOD S	AMARITAN SOCIETY	- BETHANY		HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCY MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 930	Continued From pa individually and flus		ations.	2 930			
	On 2/6/17, at 6:51 p (DON) reviewed R2 verified R204 did no medications. The D directed staff to adr separately and flush The DON verified h follow facility policy.	204's medication on thave an order to ton confirmed the minister each med in in between each er expectation was	rders and o cocktail facility policy ication medication.				
	The facility Medicat revised 5/16, direct medication separate tubing between each	ed staff to adminis ely via G-tube and	ter each				
	SUGGESTED MET DON or designee or revise policies and presidents with tube medications admini according to facility could educate all ap and procedures. The develop monitoring compliance.	ould develop, revieus procedures to ensification feedings have the stered separately policy. The DON corporiate staff on the DON or designed.	ew, and/or ure ir and or designee the policies ee could				
	TIME PERIOD FOF (21) days.	R CORRECTION:	Twenty-one				
21375	MN Rule 4658.0800 Program	Subp. 1 Infection	Control;	21375			3/13/17
	Subpart 1. Infection	on control program	. A nursing				

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STATE FORM 6899 G24W11 If continuation sheet 12 of 29

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.				
		00087		B. WING		02/0	9/2017
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- BETHANY		HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIE Y MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21375	Continued From pa	nge 12		21375			
	home must establish and maintain an infection control program designed to provide a safe and sanitary environment.						
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility staff failed to ensure appropriate infection control measures while providing direct resident contact wound care for 1 of 1 resident (R65) observed during wound care.				Corrected		
	Finding include:						
	R65's quarterly Minimum Data Set (MDS) dated 12/27/16, indicated R65 had diagnoses including dementia, anxiety and methicillin resistant staphylococcal aureus (MRSA). The assessment indicated R65 was independent with bed mobility, required supervision with transfers and had a pressure ulcer which was unstageable.						
	R65's care plan day MRSA infection to v The plan directed s when changing cor linens in bags mark linens and close bat laundry.	wound on the left staff to wear gowr staminated linens sed biohazard an	lower leg. ns and masks , place soiled d to bag				
	On 2/8/17, at 11:21 (LPN)-B stated R65 dressing changes the assisting with the control of the co	5 liked to be invol o his left lower le	ved with the g and would				

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Minnesota Department of Health

AND DUAN OF CODDECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00087		B. WING		02/	09/2017
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
				HT STREET			
GOOD S	AMARITAN SOCIETY	- BETHANY		D, MN 5640			
(X4) ID PREFIX TAG		TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21375	room, R65 was obs wheelchair. R65 was antiseptic wipes to and his over the bee- At 11:25 a.m. LPN dressing and prepa towel on the floor in then placed a secor to R65. LPN-A place on the second tower R65. LPN-A wore got dressing. R65 had leg which were each centimeters (cm) in wound was from prowas from an abscess-At 11:30 a.m. LPN-basin of water and leg was cleansed, Lfloor next to her. Lfdonned fresh gloves with aerosol saline wound cleaner). Shemptied it in the rest LPN-B returned to Fapplied a new dress-At 11:40 a.m. LPN-supplies in a clear prome. At no time did LPN-B observed to	erved seated in pre gloves while clean the scisso d table. I-B gathered suppred the room. In the front of R65's lend towel on the field a box of dreat and sat on the gloves as she rest two wounds on the approximately diameter. R65 essure and the sessure and washed the sessure and	plies for the PN-A placed a eft leg. She floor adjacent ssing supplies floor next to moved the old his lower left 2.5 stated the first second wound dipped it into a eg. Once the e towel on the sanitizer, he wound out ompressed wash basin, hed her hands. Sh gloves and id. wound placed on eels and he soiled utility dressing was rotective	21375	DEFICIENC	r)	
	equipment other that observed to bag the roomAt 2:09 p.m. LPN-E active infection, the utilize anything more dressing change. Spagged the dirty tow	e towel prior to le B stated R65 did refore, she did r e than gloves di She confirmed si	eaving R65's I not have an not need to uring the had not				

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STATE FORM 6899 G24W11 If continuation sheet 14 of 29

AND BLAN OF CORRECTION TO THE THEORY OF THE PROPERTY OF THE PR		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00087		B. WING		02/0	9/2017
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BETHANY		HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIE Y MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Continued From pa	age 14		21375			
	wash the wound pr	ior to leaving the	room.				
	On 2/8/16, at 2:10 p.m. registered nurse (RN)-A stated R65 had a history of MRSA and she would have to look to see if he needed any precautions at this time.						
	at this time. On 2/9/17, at 9:30 a.m. RN-B/infection control specialist stated any resident with MRSA would be under contact isolation. She stated the room was to have a sign on the door, a supply cart of personal protective equipment including gowns, gloves, and masks along with red bags for garbage and yellow bags for linens. She stated at this time, none of the residents in the facility were in contact precautions. RN-B reviewed R65's care plan and confirmed R65 was to be in isolation due to MRSA infection and the staff were to use gloves, gowns and possible masks when in direct contact with R65's wound site. RN-B reviewed R65's clinical record and confirmed R65's last wound culture obtained on 9/25/16, identified MRSA. She stated in order for contact isolation precautions to be removed, a second culture was to be obtained.						
	Review of the Mon Infections in Center revealed a form wh name, room number infection, site of infe agents, treatment r measure, isolation staff to identify if the facility or not. The identify a resolution	r / infection contrict identified the er, admission dat ection, culture tal measures, cautio precaution and de infection control	ol log, resident ted, date of ke, causative nary lirected the cquired in the				
	On 2/8/17, at 9:35 at to be on contact iso staff were to wear g	olation precaution	ns and verified				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00087	B. WING		02/0	9/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- BETHANY	HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21375	masks during dress were to be contained On 2/9/16, at 9:40 a (DON) confirmed R and the staff were to precautions during DON stated she was had been removed would have been resulting to utilize contact predictions during drainage known to organism. On 2/9/17, at 9:45 a Multidrug-resistant confirmed the policy DON stated R65 we precautions during linen changes if the The DON stated R65 we precautions during linen changes if the The DON stated R65 we precautions during linen changes if the The DON stated R65 we precautions during linen changes if the The DON stated R65 we precautions during linen changes if the The DON stated R65 we precautions during linen changes if the The DON stated R65 we precautions during linen changes if the The DON stated R65 we was used bed which would call the policy of the properties of the was unaware R65 had been clear of the was unaware R65 and had she been and had she been as a line of the properties were and had she been as a line of the properties were resulted to the proper	sing changes and all linens and in yellow biohazard bags. a.m. the director of nurses 65's wounds contained MRSA or be utilizing contact the dressing changes. The is not aware the precautions and did not know when they	21375	DELITION TO		

Minnesota Department of Health

STATE FORM 6899 G24W11 If continuation sheet 16 of 29

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00087	B. WING	·····	02/09/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- BETHANY	HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21375	Continued From page 16		21375			
	prior to leaving the	nens in a yellow biohazard bag room. LPN-B stated R65 not been communicated.				
	Suggested methods of correction: The director of nursing or designee could review infection control policies and procedures while providing wound care with staff. The director of nursing or designee could then develop an auditing system as part of the facility's quality assurance program to ensure ongoing compliance.					
	Time period for corr	rection: Twenty one (21) days.				
21620	MN Rule 4658.1345	5 Labeling of Drugs	21620			3/13/17
	Drugs used in the rin accordance with	oursing home must be labeled part 6800.6300.				
	by: Based on observati review, the facility for dispensed medicati labeled with direction (R60, R106, R 204)	ent is not met as evidenced on, interview and document ailed to ensure electronically on packets were properly ons for use for 3 of 3 residents observed to not have electronically dispensed		corrected		
	Findings include:					
	(LPN)-A was observed. The physician	o.m. licensed practical nurse wed to prepare medications for ns orders dated 1/17/17, administer the following				

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STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00087	B. WING		02/0	9/2017
NAME OF					1 02/0	9/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S HT STREET	STATE, ZIP CODE		
GOOD S	SAMARITAN SOCIETY	- BETHANY	D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	Continued From pa	ige 17	21620			
	medications:					
	-humalog insulin inj times a day related additional 5 units per supper -Metformin 500 mg -metoprolol tartate with food -Calcium Citrate +E meals -Cranberry tablet 60 -Percocet 5-325 mg	igrams (mg) po (orally) daily ject 5 units subcutaneous two I to diabetes and give an er carbohydrate at lunch and po two times a day 100 mg po twice a day give 0 315-250 mg po give one with 00 mg po three times a day g po three times a day g po tab before meals and at				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPF IDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00087		B. WING		02/0	9/2017
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY	804 WRIG	DRESS, CITY, S AHT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCY MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21620	Continued From pare medication room. Some shad printed the shift medication pass the night shift medical shift. The second packet and evening. The pare medication pass the night shift medical shift.	She explained the ne packages for the ss and she would leations prior to the contained R60's r	e evening be printing e end of her name, date,	21620			
	25-100 mg tablet de and yellow along wi physician and pharmetformin 500 mg tidentified as numbe the prescription nuridentified. The secretaff how to administ placed the two medians.	escribed as round th the prescription macy identification table was also in the 102, round and wher, pharmacy arond package did neter the medication	a logo 539 number, , a ne package white with nd physician ot direct the ns. LPN-A				
	The third packet co and evening as time indicated the packat tartate 100 mg described 0.5 mg ident with PX2 stamped of described as a rour stamped on it. The prescription number pharmacist and the did not identify the CLPN-A was observed remove the metoprothe soufflé cup, left in the packet and remedication cart. LP medications in the packet medications.	e indicated to admige contained metocribed as a round lamped on it, parmicified as a white object of the package identified as a white object of the package identified as a white object of the pharmacy, the prescribing physical direction for each red to open the third object of the two additional of the packet would be acket would be acket would be acket of the packet of the packet would be acket of the packet of the p	inister. It opprofol of the table dipexole long tablet in 10 mg ER in M 010 and the ne cian but it medication. It packet, place it into medications to the er two diministered e stated for				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		E SURVEY PLETED
		00087	B. WING		02/	09/2017
	PROVIDER OR SUPPLIER	- RETHANY 804 WF	ADDRESS, CITY, S RIGHT STREET ERD, MN 5640	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES OF THE AP	ULD BE	(X5) COMPLETE DATE
21620	package as the bed At 6:20 p.m. LPN-A		21620			
	from a bubble pack prescription label in a humalog insulin p R60's room. -At 6:22 p.m. LPN-A R60 had eaten her administer R60's m -At 6:34 p.m. LPN-A	et (which contained a full cluding directions for use) are and proceeded to go to A spoke with R60, confirmed meal and proceeded to				
	AlixaRX electronic is machine and other packages or bottles upon the medication pack, bottle or from confirmed she had after R60 had eater after the meal. Upon	medication dispensing medications were in bubble s. She stated it just depende n whether it came in a blister the AlixaRX machine. She administered humalog insuling the meal and the Sinemet on review of the MAR, LPN-A	1			
	administer the med the insulin was to be She confirmed the p the staff to administ meal as per the phy	met order directed the staff to ication before the meal and e administered after the mea prescription label did not direter the sinemet before the ysician orders. She stated sher medications after she had	I. ct			
	the 100 unit medical medication dispension of the room. LPN-Ato the machine and print the 300 wing under the subject of the machine and print the subject of	p.m. LPN-B was observed in ation room. An AlixaRX ing machine was in the center of logged into a computer next programmed the machine to unit medications for the packing materials. Pharmac	er t			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUF IDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00087		B. WING		02/0	09/2017
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY	804 WRIG	DRESS, CITY, S AHT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEI MUST BE PRECEDEI SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21620	Continued From pate technician (PT)-A at packaging materials questioned as to homedication package package was open within that package the same time. If the dispensed at the apduty was to call the dispensing machine stated she was not the time of R60's extended in the dispension dispensed in the dispension dispensed in the dispension dispensed in the time of R60's extended in the staff the directions to give the staff at the staff on the AlixaRX more repackaged at meal with the rest of confirmed R60's protections.	ssisted LPN-A to a in the machine. We to change the es, LPN-A stated ed, all of the medications were to be admined medications were to be admined aware of any provening medication. The LPN-A confined from the Alixa route or the direct on the package were to check the e. The cription labels on achine did not in the package were to follow the stated R60's sinuals and therefore and not administed ther medications escription label did not in the package were to follow the stated R60's sinuals and therefore and not administed ther medications escription label did not in the package were to follow the stated R60's sinuals and therefore and not administed therefore and not admini	When time of the when a lications nistered at ere not being the nurse on ave the LPN-A ablems with the ns. The time of the when the nurse on ave the LPN-A ablems with the ns. The time of the time of the nurse (RN)-A the packets clude the packets clude the ation use. The directions emet was to be should have the nurse of the nu	21620			
	On 2/9/17, at 8:13 a (DON) stated that in medications accord were to be confirming	n order for the staing to the facility	aff to pass policy, they				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING:			
00087		B. WING		02/0	9/2017
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - BETHANY		HT STREET D, MN 5640			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
adminsitration which included the right medication, right dose, right resident, rig right time and right documentation and to three checks: read the label on the medicontainer and compare with the MAR who removing the container from the supply of when placing the medication in an admir cup/syringe and just before administering medications. The DON confirmed the standministered medications did not have to compare the prescription label to the physician's order in the MAR because the directions for use were not on the prescriabel. The DON confirmed she would had contact the pharmacy for further direction. On 2/6/17, at 6:31 p.m. RN- H was obseing prepare the following medication for administration via a percutaneous endos gastrostomy (G-Tube/PEG) tube (tube positive the stomach for feeding): -one tablet of Metoprolol 50 milligrams (reats hypertension and angina) -one tablet of Mirtazapine 7.5 mg (antidepressant) -one tablet of Oxybutynin 10 mg (treats of bladder) RN-H washed her hands and open a seaplastic packet approximately 2 inches by inches, which contained the above meding the packet identified the medications, he lacked directions for use and the route to the medication was to be administered. I combined the Metoprolol, Mirtazapine ar Oxybutynin, into a 30 cc plastic medication poured the tablets into a plastic sleeve poinserted the packet into a manual pill crucrushed the tablets together. RN-H place	o perform cation nen drawer, nistration g the taff who he ability le ription ve to n. rved to scopic lace into mg) overactive laled / 3 cations. owever, o which RN-H and on cup, lacket, lisher and	21620			

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PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER		E CONSTRUCTION		E SURVEY PLETED
GOOD SAMARITAN SOCIETY - BETHANY 804 WRIGHT STREET BRAINERD, MN 56401 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X COMPRESS) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			00087	B. WING		02/	09/2017
GOOD SAMARITAN SOCIETY - BETHANY BRAINERD, MN 56401 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X COMPRESS) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPRESS)	NAME OF	PROVIDER OR SUPPLIER	STR	EET ADDRESS, CITY, S	STATE, ZIP CODE		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	GOOD S	SAMARITAN SOCIETY	- BETHANY				
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DA DEFICIENCY	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
crushed tablets into a 30 cc plastic medication cup and added 20 cc of water. RN-H entered 204's room, washed hands, donned a pair of gloves and gathered supplies which included a graduate with tap water and 60 cc syringe at 6:40 p.m. RN-H exposed R204's g-tube, unclamped and removed the plug on the end of the G-tube, connected the syringe and confirmed proper placement. RN-H drew up 20 cc of tap water into syringe and flushed tube. RN-H withdrew the syringe and flushed tube. RN-H withdrew the syringe and flushed tube. RN-H withdrew the syringe and or of water into the g-tube, poured the Metoprolol, Mirtazapine, and Oxybutynin mixed with 20 cc of water into the g-tube, poured 30 cc of water into a 30 cc medication cup and poured the water into the open ended syringe. RN-H -unattached the open ended syringe from the g-tube, closed the port on the tubing and readjusted 204's clothing and exited the room. On 2/6/17, at 6:40 p.m. RN-H stated she was not sure if R204 had an order to crush and mix all of R204's medications and give them together through the g-tube. RN-H reviewed R204's current MAR and was unable to find an order to cocktail R204's medications. RN-H stated she was not sure if well and oxybutynin lacked directions for use and route of administration. RN-H stated, the staff used the MAR to check for administration directives. RN-H stated she was unaware the medication packets lacked the direction and route information. RN-H stated she checked the MAR when administering medications. On 02/09/17, at 8:29 a.m. LPN-C was observed	21620	crushed tablets into cup and added 20 cup and 20 c	a 30 cc plastic medication of cc of water. RN-H entered thands, donned a pair of d supplies which included atter and 60 cc syringe exposed R204's g-tube, noved the plug on the end ted the syringe and confir RN-H drew up 20 cc of tand flushed tube. RN-H e and withdrew the plunguinsert the syringe into gretoprolol, Mirtazapine, and with 20 cc of water into the cc of water into the cc of water into the cc. RN-H -unattached the containing the containing and sand give them together RN-H reviewed R204's as unable to find an order dications. RN-H verified the containing R204's Metopsybutynin lacked directions ministration. RN-H stated to check for administration and stated she was unaware the lacked the direction and stated she checked the Mirections.	on distriction on the corolol, so for distriction of the corolol, so for distriction on the corolol, so for distriction o			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUP IDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00087		B. WING		02/	09/2017
	PROVIDER OR SUPPLIER	- BETHANY	804 WRIG	DRESS, CITY, S HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21620	Continued From parapproximately 2 incontained three meidentified R106's nature medications: 1- Lisi 6-pink, 1-Metformin-white-1 metoprolol packet lacked direct the packet and places mall souffle cup to stated the labels did use on the packet to MAR for directions. Sure why the adminadministration was electronically dispension to verify the rigand the right time madministered, LPN-MAR to see how the administered because compare the MAR of packet label to ensure the medication. On 02/08/2017, at 1 service technician (technician that deliving facility, stocked the	ches by 3 inches we dication tablets. Tame, date, and the nopril tablet- 5 men tablet 500 mg- retablet -round m 3 tion for use. LPN-ced the medication administer to R1 d not have the direction route or not identified on the need packet. When the toute, the right need to the medication was to C stated she just the medication was to C stated she just the medications we use she was unabled in the control of the new the state of the new the new the state of the new the state of the new	The packet of following ground round H 102 82-pink. The Copened ns into a 06. LPN-C ections for only to the e was not directions for he en asked right dose be looked at the re to be alle to nedication inistration of X pharmacy was the ions to the	21620			
	machines and assis problems regarding process. The FST edispensed medicati and printed the medindividual packets at tablets into the individual packets are then sealed at reviewed the medic R204 and verified the routes were not ide	sted the facility wing the medication as explained the made ons by shift, three dication labels on and dispensed the vidual packets. The dispensed. The ation packets proped directions for united the control of the co	th any administration chine etimes daily the emedication ne packets ne FST evided for use and				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00087	B. WING		02/0	9/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BETHANY	HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
21620	for use. The FST st capability to label the directions for use at example, when a remedications were didentified the routes and the directions of opportunity for medinaccuracy. The FS should be indicated purposes and state the medication pack would bring this to he pharmacist.	ackets lacked the directions ated the machine had the period period administration routes for esident went out on leave, the ispensed into packets that to administer the medications or use. The FST confirmed the the packets created an ication administration. To verfied the directions for use on the packets for verification did this lack of information on kets was a concern and she her supervisor and to the	21620			
	medication packets machine lacked the of the medications a lacked specific information use and the staff we directions for use waccurate medication stated she contacted and correct the issufacility policy for menot followed. The facility Medicat revised 5/16, directed medications due, at medication administ medication, right doright time and right three checks: read	a.m. the DON verified the dispensed from the AlixaRx routes and directions for use and the stock medications mation for intended resident ere unable to compare the ith the MAR in order to ensure a administration. The DON of the pharmacy in order to try les. The DON verified the idication administration was dispersed staff to review the MAR for and to follow the "Six Rights" of tration which included the right lese, right resident, right route, documentation and to perform the label on the medication pare with the MAR when				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY
ANDILENA	OF CONTILOTION	IDENTIFICATION NOMBELL.	A. BUILDING:		OOW	LEILD
		00087	B. WING		02/0	9/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- RETHANY	HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	Continued From pa	ge 25	21620			
	when placing the m	iner from the supply drawer, nedication in an administration at before administering the				
	The AlixaRX Medication Ordering and Receiving from Pharmacy Medication Labels policy dated 06/15, indicated each prescription medication label included: Resident's name, Specific directions for use, medication name, strength, prescriber's name, date dispensed, quantity of medication, expiration date of medication, prescription number, Accessory labels indicating storage requirements and special procedures. Example: "Take on empty stomach, one hour before or 2 hours after meals.					
	nursing or designed policies and proced labeling. Staff could related to the policie	s of correction: The director of e could review and revise dures related to medication d be provided education es and a monitoring system o ensure compliance.				
	Time period for core	rection: Twenty one (21) days.				
21695	MN Rule 4658.1415 Housekeeping, Ope	5 Subp. 4 Plant eration, & Maintenance	21695			3/13/17
	provide housekeep necessary to mainta comfortable interior	reping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, fixtures, equipment, lighting,				

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STATEMENT OF DEFICIENCIES (X1)

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				A. BOILDING.			
		00087		B. WING		02/0	9/2017
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- RETHANY		HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 26		21695			
	by: Based on observati review, the facility f wheelchairs and ca and/or a clean and residents (R125, R3 wheelchairs and eq	ent is not met as evider on, interview and docum ailed to maintain resider re equipment in good re sanitary condition for 6 of 35, R128, R106, R236) valuipment were observed cleaning and/or repair.	nent nt epair of 6 whose		Corrected		
	Findings include:						
	the dining room sea was leaning over th and spit onto the wi floor. The right whe	0 p.m. R125 was observated in a wheelchair. R1 eright arm rest of the cheel of the wheelchair arel was observed coated ried white substance.	25 hair nd the				
	noted to have an or the wheelchair brak tattered and peeling	3 a.m. R35's wheelchair ange colored tape adher the handles. The tape ways. The left arm rest of Red to be cracked and perfoam padding.	ered to as 135's				
	his room, seated in right side of the who crevices along the	a.m. R128 was observe an electric wheelchair. eelchair seat cushion ar- right side of the chair an d to have dried food deb the surfaces.	The nd d the				
	On 2/7/17, at 10:47	a.m. R106's left knee b	race				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED							
		00087	B. WING		02/0	0/2017						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE O2/09/2017												
GOOD SAMARITAN SOCIETY - BETHANY 804 WRIGHT STREET BRAINERD, MN 56401												
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE							
21695	was observed to be On 2/7/17, at 2:19 p dining room, seated	ige 27 c covered in a food debris. c.m. R236 was observed in the d in a wheelchair, drinking The right arm of the	21695									
	wheelchair was obs	served to have a rip on the which ran almost the entire st.										
	environmental service were responsible for wheelchairs and broconfirmed environmental services station had a work work order for wheeled or other issues. Deservices staff compatible that the time of the tounavailable, however the wheelchair brake was not able to be work order should have welchair arm respectively.	ices (DES) stated nursing staff or the cleaning of resident aces. However, DES nental services would be ntaining wheelchairs in good ir. DES indicated each nursing order book and could submit a elchairs with ripped armrests ES indicated environmental pleted work orders everyday. Our, R35 and R236 were er, DES indicated the tape on aces would create a surface that cleaned. DES also indicated a nave been placed and tears in ts would have been repaired. Wheelchairs would be aired as soon as possible.										
	(DON) confirmed in for the cleaning of r DON indicated eac cleaned on their ba DON also indicated equipment, such as	n.m. the director of nursing ursing staff were responsible resident wheelchairs. The h resident's wheelchair was th day and as needed. The l any other resident s braces, were cleaned on an and would expect the nursing										

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED					
		00087		B. WING		02/	09/2017				
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BETHANY STREET ADDRESS, CITY, STATE, ZIP CODE 804 WRIGHT STREET BRAINERD, MN 56401											
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE				
21695	assistants to let the unclean equipment made for cleaning. aforementioned obswheelchair was dirt R106's knee brace cleaning, the tape of handles was put on enhance visibility hot tattered and needer confirmed the arm repair. The DON alsand cushion were of the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment were prospectively and consistency of the stationary of the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment were prospectively of the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment were prospectively of the week and R1 cleaned on the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment were prospectively of the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment were prospectively of the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment and ensight and the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment and ensight and the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment were prospectively on the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment were prospectively on the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment were prospectively on the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment were prospectively on the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment were prospectively on the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment were prospectively on the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment were prospectively on the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment were prospectively on the week and R1 cleaned on Tuesda to be cleaned on M regarding cleaning equipment were prospectively on the week and R1 cleaned on Tuesda to be cleaned on Tuesda to be cleaned on Tu	station directors is so arrangements. The DON confirm servations and very and needed to be was soiled and reson R35's wheelchard by the therapy decover, it was word to be replaced a rest was cracked as overified R128's lirty and required cours of the 1st sche 25's wheelchair way and R128's wheelchair way and R128's wheelchair or repair of reside to be ovided. THOD OF CORRETINGENERAL INTERIOR OF CORRETINGENERAL STATES OF THE COULD A C	could be ed the ed the rified R125's re cleaned, quired air brake epartment to an and required wheelchair cleaning. 2/22/16, be done eduled bath ras to be elchair was policies ant electron the need care ement is the auditing trance	21695							
	TIME PERIOD FOR (21) days	TOUTHEUTION.	rwenty One								

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