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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H1AW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00356

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/06/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE NEII 01/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/09/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 02/10/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/30/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5550

Good Samaritan Society has been designated as a Special Focus Facility (SFF)

On December 18, 2014, the Minnesota Department of Public Safety, and on January 6, 2015, Minnesota Department of Health , Licensing and Certification Program along with the Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard and an abbreviated standard (complaint investigation # H5550007) surveys , both completed on October 24, 2014

We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of December 19, 2014. Based on our PCR, wehave determined that the facility has corrected the deficiencies issued pursuant to our standard survey and abbreviated standard survey, completed on October 24, 2014, as of January 6, 2015.

As a result of the PCR findings, this Department discontinued the Category 1 remedy of State monitoring, effective January 6, 2015.

In addition, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of November 19, 2014. The CMS Region V Office concurred and authorized this Department to notify the facility of the following:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 24, 2015, be rescinded. (42 CFR 488.417 (b))

In our letter of November 19, 2014, we advised the facility that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), the facility was prohibitedfrom conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 24, 2015, due to denial of payment for new admissions. Since the facility attained substantial compliance on January 6, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Refer to the CMS 2567b forms for verification of correction of the health, life safety code and complaint investigation deficiencies.

Effective January 6, 2015, the facility is certified for 52 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245550

February 9, 2015

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

Dear Ms. Sorenson:

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

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

Effective January 6, 2015 the above facility is certified for:

52 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 13, 2015

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

RE: Project Number S5550024, H5550007

Dear Ms. Sorenson:

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

On November 19, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 24, 2015. (42 CFR 488.422)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 24, 2015. (42 CFR 488.417 (b))

Also, we notified you in our letter of , in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 24, 2015.

This was based on the deficiencies cited by this Department for Special Focus Facility survey completed on November 7, 2014, and lack of verification of substantial compliance at the time of our November 19, 2014 notice. The most serious deficiencies in your facility at the time of the Special Focus survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were

required.

This was additionally based on the deficiencies cited by the Office of Health Facility Complaints for an abbreviated standard survey completed on October 24, 2014. The most serious deficiencies in your facility at the time of the abbreviated standard survey were found 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 December 18, 2014, the Minnesota Department of Public Safety, and on January 6, 2015 Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 24, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 19, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 24, 2014, as of January 6, 2015.

On January 6, 2015, the Minnesota Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on October 24, 2014. As a result of the PCR findings, this Department has taken the following action:

- State Monitoring effective November 24, 2015, be discontinued effective January 6, 2015. (42 CFR 488.422)

Additionally, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of November 19, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 24, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 24, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 24, 2015, is to be rescinded.

In our letter of November 19, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 24, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 6, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of

this PCR with the President of your facility's Governing Body.

Enclosed are copies of the Post Certification Revisit Forms, (CMS-2567B) from these visits.

Feel free to contact me if you have questions.

Sincerely,

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245550	A. Building B. Wing	1/6/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/19/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/19/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/19/2014**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **12/19/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **12/19/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/19/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/19/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **12/19/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/19/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	01/13/2015	18618	01/16/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 11/7/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245550	A. Building B. Wing	1/6/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/06/2015**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **01/06/2015**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **01/06/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/06/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MN/mm	01/13/2015	32637	01/06/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/24/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245550	A. Building / B. Wing **01 - MAIN BUILDING 01**	12/18/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **12/15/2014**	ID Prefix	Correction Completed **12/15/2014**	ID Prefix	Correction Completed **12/15/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0038		LSC K0050		LSC K0051	
ID Prefix	Correction Completed **12/15/2014**	ID Prefix	Correction Completed **12/15/2014**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0054		LSC K0144		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	01/13/2015	27200	12/15/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
11/5/2014	YES NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245550	A. Building B. Wing **02 - KITCHEN ADDTION**	12/18/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **12/15/2014**	ID Prefix	Correction Completed **12/15/2014**	ID Prefix	Correction Completed **12/15/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0050		LSC K0054		LSC K0069	
ID Prefix	Correction Completed **12/15/2014**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0144		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	01/13/2015	27200	12/18/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
11/5/2014	

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00356	A. Building B. Wing	1/6/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **01/06/2015**	ID Prefix **20895** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **01/06/2015**	ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **01/06/2015**
ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **01/06/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MN/mm	01/13/2015	32637	01/06/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/24/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: H1AW

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

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/07/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

13.Total Certified Beds 52 (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Yvonne Switajewski, HFE NEII — 12/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 12/30/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 12/30/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5550

Good Samaritan Society Warren has been designated as a Special Focus Facility (SFF)

On November 7, 2014 a standard survey was completed at this facility. The most seroius deficiency was widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F). The facility has been given an opportunity to corrected before remedies woudl be impose. Refer to the CMS 2567 along with facility's plan of correction.

Certified Mail # 7013 2250 0001 6356 6559

November 20, 2014

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

RE: Project Number S5550024, H5550007

Dear Ms. Sorenson:

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

On November 6, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on October 24, 2014. The abbreviated standard 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 November 7, 2014, the Minnesota Departments of Health and Public Safety completed a standard survey to verify that your facility had achieved and maintained compliance with federal certification deficiencies. This standard survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F). As a result of our finding that the facility has not achieved substantial compliance. This Department is imposing the following Category 1 remedy:

- State Monitoring effective November 25, 2015. (42 CFR 488.422)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 24, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 24, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 24, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Good Samaritan Society - Warren is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 24, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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, from **the abbreviated standard survey completed October 24, 2014**), i.e., the plan of correction should be directed to:

Michelle Ness, Supervisor
Office of Health Facility Complaints
Division of Compliance Monitoring
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
michelle.ness@state.mn.us

Phone: (651) 201-4217 Fax: (651) 281-9796

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag, from the **standard survey completed November 7, 2014**), i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
lyla.burkman@state.mn.us

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff, Office of Health Facility Complaints staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 24, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of

payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 24, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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 April 24, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

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

Enclosure

cc: Licensing and Certification File

5550s15+ohfcltr

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	11/07/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Good Samaritan Society-Warren is a Special Focus Facility (SFF) and a certification survey was conducted on 11/4/14, 11/5/14, 11/6/14, and 11/7/14. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279	Approved c revisions 12/12/14 SB	12/19/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	12/3/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 1 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a care plan which addressed fall risk for 1 of 3 residents (R33) reviewed for accidents, failed to develop a care plan which addressed positioning needs for 1 of 3 residents (R20) observed for positioning and identified at risk for developing a pressure related ulcer and failed to develop a care plan to identify pain and pain management interventions for 1 of 1 resident (R20) who experienced pain. Findings include: R33's diagnosis report dated 11/6/14, revealed R33 had diagnoses which included dementia and anxiety. R33's annual Minimum Data Set (MDS) dated 6/9/14, revealed R33 had severe cognitive impairment, required extensive assist with activities of daily living (ADL's) and was a potential risk for falls. R33's Falls Care Area Assessment (CAA's) dated 6/24/14, revealed R33 had a decrease in functional ability in which she needed physical assistance from staff to maintain balance during transition (moving from one spot to another). The CAA also revealed R33 was impulsive at times, tried to ambulate by herself and needed reorientation to place and time. The CAA care plan consideration revealed R33 would remain free from falls and injury.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 2 R33's quarterly MDS dated 9/3/14, revealed R33 had severe cognitive impairment, needed extensive assistance with ADL's and was unsteady during transition in which she needed staff to maintain balance during transitions. R33's falls data collection tool dated 5/13/14, revealed R33 had a total score of 20 (the facility form identified a score of 12 or more was a high risk for falls). R33's fall risk evaluation dated 10/18/14, revealed R33 had a fall in the facility in which she was found on the floor. The facility form also revealed R33 had a history of falls and had fallen in the past week. The evaluation further revealed R33 was very weak in her legs which increased risk for falls and needed closer watching. R33's care plan date printed 11/05/14, lacked any mention that R33 was at risk for falls and needed closer monitoring. On 11/06/14, 11:27 a.m. a Registered Nurse (RN)-A confirmed R33 was at risk for falls and verified R33's care plan lacked any mention of falls or risk for falling. RN-B stated R33's fall risk should be addressed on her care plan. On 11/06/14, 1:24 p.m. the director of nursing (DON) verified R33's care plan lacked any mention of falls. The DON also stated she expected R33's care plan to have falls addressed due to R33 was at risk for falls and had recently fallen in the facility.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 3 R20 was identified at risk for the development of a pressure ulcer and her care plan lacked interventions for a turning and repositioning schedule. R20's Diagnosis Report dated 11/7/14, identified R20's diagnoses as anxiety, diabetes, dementia, anemia, osteoporosis and malnutrition. R20's quarterly MDS dated 10/6/14, indicated R20 had severe cognitive impairment and required extensive assist with bed mobility, transferring, walking and personal hygiene. The MDS also indicated R20 was at risk for the development of a pressure ulcer and suggested a turning and repositioning program to be in place. R20's Braden Scale Assessment dated 10/22/14, identified R20 at risk for the development of a pressure ulcer and the intervention guide suggested R20 should be frequently turned and also have a planned turning schedule. R20's care plan dated 8/13/14, identified a focus area for self-care activities and directed staff to assist her with bed mobility, toileting, ambulation and transfers. However, R20's care plan lacked a focus area for her identified risk for pressure ulcer development nor had in place interventions to help minimize her risk for development of a pressure ulcer. On 11/5/14, at 4:31 p.m. RN-A verified R20 was at risk for the development of a pressure ulcer. RN-A stated R20 should be repositioned every two hours and as needed. In addition, RN-A confirmed R20's care plan lacked a focus area for her risk for development of a pressure ulcer, nor did her care plan provide the staff direction on	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 4 when R20 should be turned or repositioned. RN-A and the DON verified R20's care plan should have included a focus area and interventions to help minimize her risk for the development of a pressure ulcer. The Pressure Ulcer Management policy revision date 1/2011, specified a comprehensive pressure ulcer management program would consist of skin assessments and interventions identified on the care plan. R24's care plan was not developed to include pain and pain management interventions related to a left hip fracture. R24's admission MDS dated 10/13/14, indicated R24's diagnoses included a left hip fracture, Parkinson's disease and arthritis. The MDS indicated R24 had mild cognitive impairment, speech was clear and was able to be understood and understand others, required extensive assist with dressing, bed mobility, transfers and was non-ambulatory. The MDS also indicated R24 had occasional pain which had not limited day to day activities nor sleep and R24 was not on a scheduled pain medication regimen and had received as needed (PRN) pain medication in the five day MDS reference period. R24's physician order dated 10/7/14, indicated Percocet 5-325 milligrams (mg) 1 tablet PRN for pain management related to pain in join pelvic region and thigh. R24's Cognitive Loss/Dementia CAA dated 10/20/14, indicated R24 had occasional pain	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 5 issues and was offered pain medication as ordered. R24's Pain Assessment dated 10/22/14, indicated R24 was at risk for pain and recommended a pain management plan that included Percocet every 6 hours PRN. The assessment also indicated R24 had occasional aching in hip or increased pain with movement in the past 5 days with moderate intensity. PRN pain medication was effective in relieving the pain. R24's pain control goal was to be comfortable with movement. R24's current MAR dated 11/2014, indicated R24 received Tylenol 650 milligrams (mg) three times a day for joint pelvic region and thigh pain which started on 10/24/14. On 11/4/14, at 6:00 p.m. R24 stated her left leg hurt whenever she moved it and also had pain in the left leg during her daily PT sessions. On 11/6/14, at 3:10 a.m. RN-A verified R24's care plan lacked identification of pain, pain symptoms and pain management interventions. The Care Plan policy revision date 1/2009, indicated each resident would have an individualized comprehensive care plan which would be reviewed, evaluated and updated as needed. In addition, the care plan would assure that each resident received appropriate care and services.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		12/15/14

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 6 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared 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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include current fall interventions such as non skid floor mats and the use of anti-lock wheelchair brakes for 1 of 3 residents (R9) who was reviewed for accidents. Findings include: R9's care plan last revised 10/23/14, indicated R9 was at risk for falls and identified the following fall interventions: R9 was to ambulate to the noon meal 5 times a week, utilized a wander guard,	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	11/07/2014

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F 280	Continued From page 7 wore non-slip socks at night and rubber soled shoes during the day, utilized a low bed, propelled self in the wheelchair and was to walk with a four wheeled walker three times per week. The care plan also indicated R9 required extensive staff assistance for bed mobility, toileting and transfers and directed staff to monitor R9 every 30 minutes from 2:00 p.m. until 6:00 a.m. daily. On 11/5/14, at 12:49 p.m. R9 was observed seated in the wheelchair, self propelling over to the water cooler. R9's wheelchair had bilateral legs rests in place. R9 was observed to independently stand up while holding the arm of a chair next to the water cooler. When R9 stood her feet were observed between the leg rests. There was no staff present in the area. The surveyor intervened and asked R9 if she would sit down in the wheelchair. R9 stated she was looking for her son. When R9 sat back down into the wheelchair the wheelchair was observed to move backwards, away from R9. Anti-lock brakes were observed on the wheelchair. The director of nursing (DON) was informed of R9's observation. On 11/6/14, at 7:11 a.m. R9 was observed in bed sleeping. The call light was clipped to the blanket. The bilateral grab bars were up and a non-skid floor mat was in place next to the bed. The wheelchair was positioned at the bedside with the brakes engaged. On 11/6/14, at 3:14 p.m. the DON stated she had never seen leg rests on R9's wheelchair before and since R9 could self-propel her wheelchair with her feet, the leg rests should not be used as they posed a safety hazard.	F 280		

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	245550	A. BUILDING _____ B. WING _____	11/07/2014

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F 280	Continued From page 8 On 11/7/14, at 1:35 p.m. the DON verified R9's care plan required revisions to include the use of the non-skid floor mat and the anti-lock wheelchair brakes. In addition, the DON stated the use of leg rests to be used for transporting should also be addressed on the care plan. The facilities Care Plan policy dated 1/09, indicated the plan would be modified to reflect the care currently required/provided for the resident. The facilities Falls Committee Guidelines policy dated 1/11, indicated review of individual resident care plans who had fallen or who were at risk for falls would be completed to add, modify or evaluate interventions aimed at fall prevention.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the written care plan for 1 of 1 resident (R27) who had range of motion (ROM) deficits and required ROM services and for 1 of 1 resident (R44) who required non-pharmacological interventions prior to administration of an anti-anxiety as needed medication. Findings include:	F 282		12/19/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	11/07/2014

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F 282	Continued From page 9 R27's care plan dated 10/15/14, indicated R27 had limited physical mobility and on 7/30/14, directed staff to provider R27 ROM exercises twice a day during the provision of cares. On 11/5/14, at 12:45 p.m. nursing assistant (NA)-E was observed to transfer R27 from the wheel chair to an easy chair with the use of a mechanical lift. NA-E stated R27 could not raise her right arm. ON 11/6/14, at 1:05 p.m. NA-A stated staff had to lift R27's arms up in order to get her shirt on as she was very tight in her arms. NA-A stated the NA's did not provide ROM services to R27. On 10/7/14, at 8:40 a.m. NA-G (Rehab aide) stated she had not provided R27 ROM services as R27 was not on her resident list of who required ROM services. NA-G also stated she had not been told to provide ROM services to R27. ON 10/7/14, at 8:50 a.m. NA-F verified she had assisted R27 this morning and stated she had not provided R27 ROM services. NA-F stated the NA's did not do ROM on R27 and nobody had ever told them to do so. On 10/7/14, at 9:30 a.m. the director of nursing (DON) verified R27's care plan directed the NAs to provide ROM services.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 10	F 282		

R44 had a prn anti-anxiety medication ordered and the facility failed to implement the non-pharmacological interventions as directed by R44's individualized care plan.

R44's Admission Record dated 3/1/13, identified R44's diagnoses as adult failure to thrive, depression, insomnia, mild cognitive impairment and anxiety.

R44's Medication Review Report indicated she had a current order for alprazolam (anti-anxiety medication) 0.5 milligrams (mg) to be given at bedtime as needed. Prior to this, R44 had an additional order that alprazolam 0.25 mg could be given every eight hours as needed for anxiety. This order was discontinued on 8/23/14.

R44's medication administration records (MARs) were reviewed and revealed R44 had been given:
- alprazolam 0.5 mg on 6/27/14 at 7:12 p.m.
- alprazolam 0.25 mg on 7/2/2014, at 1:56 p.m.
- alprazolam 0.25 mg on 8/7/2014, at 10:18 a.m.
- alprazolam 0.5 mg on 10/14/2014, at 7:26 p.m.

R44's care plan dated 10/3/2014, indicated R44 had a potential for a mood problem and directed staff to provide and offer frequent one to one's if R44 was going through a period of increased anxiety. In addition, R44's care plan also indicated on 3/26/2014, R44 to have little or no activity involvement related to her anxiety. Non-pharmacological interventions included: encourage resident to come out of her room for

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

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F 282	Continued From page 11 activities, R44 enjoyed visiting with family, her faith, gardening and for staff to utilize extra gentleness verbally and physically as R44 was easily hurt or offended. R44's Consultant Pharmacist Medication Review dated 4/3/14, included a reminder to nursing staff for them to document non-drug interventions tried/failed prior to giving the alprazolam as needed dose. On 11/6/14, at 1:04 p.m. registered nurse (RN)-A verified R44 had received her prn alprazolam on 6/27/14, 7/2/2014, 8/7/2014, and 10/14/2014. RN-A stated she was not able to show the documentation of the non-pharmacological interventions attempted prior to the administration of the prn alprazolam. RN-A confirmed R44's care plan directed the staff to attempt non-pharmacological interventions. On 11/7/14, at 8:15 a.m. the pharmacist confirmed R44's non-pharmacological interventions should have been attempted and documented prior to the administration of her prn anti-anxiety medication. The pharmacist stated in the past he had reminded the staff that they needed to attempt and document non-pharmacological interventions. The Psychopharmacological Medications And Sedative / Hypnotics policy dated 6/2014, directed staff to initiate other care plan interventions prior to the use of a prn psychopharmacological medication and sedative/hypnotics. In addition, non-pharmacological interventions were recommended before medication interventions and all attempts should be documented in the residents' record.	F 282		

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	245550	A. BUILDING _____ B. WING _____	11/07/2014

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F 282	Continued From page 12 The Care Plan policy, revised date 1/2009, indicated each resident would have an individualized care plan which would assure that the resident received the appropriate care and services.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a repositioning and turning program had been developed and effectively implemented for 1 of 1 resident (R20) identified at risk for developing a pressure ulcer. Findings include: R20's Diagnosis Report dated 11/7/14, identified R20's diagnoses as anxiety, diabetes, dementia, anemia, osteoporosis and malnutrition. R20's quarterly Minimum Data Set (MDS) dated 10/6/14, indicated R20 had severe cognitive impairment and required extensive assist with bed mobility, transferring, walking and personal	F 314		12/19/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 13 hygiene. In addition, the MDS identified R20 to be at risk for the development of a pressure ulcer and suggested a turning and repositioning program to be in place. R20's Braden Scale Assessment dated 10/22/14, identified R20 to be at risk for the development of a pressure ulcer and the intervention guide suggested R20 should be frequently turned and have a planned turning schedule. R20's care plan dated 8/13/14, directed staff to assist her with bed mobility, toileting, ambulation and transfers. However, R20's care plan did not identify the identified risk for pressure ulcer development nor had in place interventions to help minimize her risk for development of a pressure ulcer. On 11/5/2014, at 1:10 p.m. R20 was observed lying in bed, positioned on her back with the covers up to her chest. R20 was continuously observed from 1:10 p.m. until 4:20 p.m. (3 hours and 10 minutes). During this time, R20 remained in her room, positioned on her back, lying in her bed. At no time, was R20 repositioned or offered to be repositioned. On 11/5/14, at 4:31 p.m. registered nurse (RN)-A verified R20 was at risk for the development of a pressure ulcer. RN-A stated R20 should be repositioned every two hours and as needed. The director of nursing (DON) stated the facility's standard of practice would be to reposition someone every two hours if they were identified to be at risk for the development of a pressure ulcer. The DON and RN-A both confirmed three hours and ten minutes was too long for R20 to go without being repositioned. In addition, RN-A	F 314		

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	245550	A. BUILDING _____ B. WING _____	11/07/2014

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

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F 314	Continued From page 14 confirmed R20's care plan lacked a focus area for her risk for development of a pressure ulcer, nor did her care plan provide the staff direction on when R20 should be turned or repositioned. R20's POC Response History report for 11/5/14, and 11/6/14, indicated the intervention for turning and repositioning R20 every two hours had been initiated on 11/5/14. In addition, this report indicated that on 11/6/14, R20 had gone without being repositioned from 3:21 a.m. until 7:56 a.m. (approximately 4 hours and 30 minutes). The Pressure Ulcer Management policy revision date 1/2011, specified a comprehensive pressure ulcer management program should consist of skin assessments and interventions identified on the care plan.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services in order to prevent further limitation or to maintain or improve range of motion (ROM) ability for 1 of 3 residents (R27) in the sample who had limitations in range of	F 318		12/19/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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F 318	Continued From page 15 motion. Findings include: R27's quarterly Minimum Data Set (MDS) dated 10/15/14, indicated R27 was diagnosed with Parkinson's disease and osteoarthritis. The MDS also indicated R27 had cognitive impairment and upper and lower extremity limitations in ROM. R27's Activity of Daily Living (ADL) Care Area Assessment (CAA) dated 2/5/14, indicated underlying problems consisted of change in cognitive status, pain, communication problems, mood decline and recent hospitalization. The CAA also indicated R27 was at risk for functional decline due to complications of immobility such as contractures, incontinence and depression. R27's care plan dated 10/15/14, indicated R27 was to receive ROM exercises which was to be performed by direct staff during the provision of ADL cares. On 11/5/14, at 12:45 p.m. nursing assistant (NA)-E was observed to transfer R27 from her wheel chair to her easy chair with the use of a mechanical lift. NA-E stated R27 could not raise her right arm. ON 11/6/14, at 1:05 p.m. NA-A stated the NA's did not provide ROM exercises to R27. NA-A stated R27's arms were tight and staff had to lift R27's arms up in order to get her shirt on. On 10/7/14, at 8:40 a.m. NA-G (rehab aid) stated she had not provided ROM exercises for R27 as	F 318		

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	245550	A. BUILDING _____ B. WING _____	11/07/2014

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

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F 318	Continued From page 16 R27 was not on her list of residents who required ROM services by the rehab department. NA-G also stated she had not been instructed to provide R27 ROM services. On 10/7/14, at 8:50 a.m. NA-F verified this morning she had assisted R27 with morning cares and stated she had not performed ROM exercises for R27. NA-F stated the NA's did not provide R27 ROM exercises and nobody had ever told them to do so. On 10/7/14, at 9:30 a.m. the DON was observed to do R27's ROM exercises to upper and lower extremities. A ROM deficit was noted in R27's bilateral upper and lower extremities. The DON verified the ROM deficits. The DON verified R27's care plan indicated the NA's were to directed to complete R27's ROM program and stated they should have provided R27 the services. The facility policy, Range of Motion (ROM) dated 2/2005, indicated the facility would ensure that a resident with a limited ROM received appropriate treatment and services to increase ROM as much as possible and to prevent further decrease in ROM.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		12/19/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	11/07/2014

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

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F 323	Continued From page 17	F 323		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to comprehensively assess the root cause of falls and implement appropriate interventions and ensure anit-lock wheelchair brakes were functioning appropriatly in order to minimize the risk of further falls for 1 of 3 residents (R9) reviewed.

Findings include:

R9's significant change Minimum Data Set (MDS) dated 5/30/14, indicated R9's diagnoses were dementia and arthritis. The MDS also identified R9 had moderate cognitive impairment and required extensive assistance with bed mobility, transferring and ambulation in the room. R9's Fall Care Area Assessment (CAA) dated 5/30/14, identified R9 was at risk for falls due to decreased cognition.

R9's quarterly MDS dated 8/20/14, indicated R9 required extensive assistance with bed mobility and transferring.

R9's care plan revised 10/23/14 , indicated R9 was at risk for falls. R9 was to ambulate to the noon meal 5 times a week, use a wander guard, wear non-slip socks at night and rubber soled shoes during the day. The care plan indicated R9 was to have a low bed, was able to self-propel in the wheelchair (w/c) and required extensive assistance with bed mobility, toilet use and transfers. The plan indicated R9 was to walk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	11/07/2014

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

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F 323	Continued From page 18 using a 4-wheeled walker 3 times per week and to be monitored by staff every 30 minutes from 2:00 p.m. to 6:00 a.m. daily. On 11/5/14, at 12:49 p.m. R9 was observed seated in the wheelchair, self propelling over to the water cooler. R9's wheelchair had bilateral legs rests in place. R9 was observed to stand up while holding the arm of a chair next to the water cooler. When R9 stood her feet were observed between the leg rests. There was no staff present in the area. The surveyor intervened and asked R9 if she would sit down in the wheelchair. R9 stated she was looking for her son. When R9 sat back down into the wheelchair the wheelchair was observed to move backwards, away from R9. Anti-lock brakes were observed on the wheelchair, however did not appear to be functioning properly. The DON was informed of the R9's self transfer. At 12:58 p.m. R9 was observed seated in her wheelchair and independently stand up and attempt to take her coat off. Nursing assistant (NA)-B immediately provided R9 assistance to remove her coat and safely sit back down on the wheelchair. Bilateral leg rests were on the wheelchair. On 11/6/14, at 7:00 a.m. R9 was observed in the TV area, asleep in the recliner with her feet elevated. -at 7:08 a.m. NA-A stated she had assisted R9 into bed. -at 7:11 a.m. R9 was observed in bed, sleeping. The call light was clipped to the blanket. Bilateral grab bars were up on the bed and a non-skid floor mat was in place. The wheelchair was positioned at R9's bedside with he brakes	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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F 323	Continued From page 19 engaged. On 11/6/14, during continuous observation from 7:19 a.m. until 9:39 a.m. R9 remained in bed, asleep. -at 9:39 a.m. R9 was observed to remove her pants and socks and her bed comforter was on the floor. R9 independently ambulated to the bathroom with an observable unsteady gait. When R9 entered the bathroom she grabbed onto the wall support bar, pulled down her underwear and voided on the toilet. The surveyor notified licensed practical nurse (LPN)-A, while another surveyor stayed with R9 for safety. When the surveyor told LPN-A that R9 was up and had ambulated unassisted in her room, LPN-A stated, "Oh my God" and went directly to R9's room. On 11/16/14, at 10:29 a.m. NA-A stated R9 had sustained many falls and was at high risk for falls. NA-A stated R9's wheelchair leg rests were to be used when transporting R9 in the wheelchair and were a safety hazard if they were used otherwise. -at 11:57 a.m. NA-A stated R9 had an erratic sleep pattern and altered from quiet and calm days to very "busy" days in which R9 would attempt self transfers 10-50 times per shift. -at 12:08 p.m. NA-C stated at 3:30 a.m. LPN-F had found R9 standing in her room. NA-C stated LPN-F brought R9 out in the w/c and staff just constantly watched her. NA-C stated at night both the NA and the nurse do visual checks on R9. NA-C also stated R9 was getting stronger and staff checked on her all the time and then documented each visual check they made. At 12:42 p.m. NA-C was observed to check R9's auto lock wheelchair brakes. NA-C verified the	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	11/07/2014

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F 323	Continued From page 20 anti lock mechanism was not functioning properly as R9's wheelchair did move backwards when R9 stood up and should not have. At 12:50 p.m. the DON also looked at R9's wheelchair and found the right anti-lock brake was not effectively locking. The DON took the wheelchair to maintenance. At 1:05 p.m. NA-C stated maintenance tightened some screws and the anti-lock brakes were now fixed. At 3:14 p.m. the DON stated since R9 could now self-propel her wheelchair with her feet, the leg rests should not be used as they posed a safety hazard. The DON stated she had never seen leg rests on R9's wheelchair before. Review of R9's incident reports revealed the following: · On 5/14/14, at 12:30 a.m. R9 was in her w/c wheeling up and down the hallway. R9 stood up and fell against the door bumping the right side of her head. R9 was moved closer to the nurse's station for the evening. · On 5/29/14, at 9:45 p.m. R9's bed alarm sounded. R9 was found seated on the floor by the bed. No injury was noted. The report indicated the bed alarm sounded, however R9 was too quick for staff to respond. The report also indicated staff needed to be more aware of her alarm and respond more quickly. · On 6/29/14, at 10:00 p.m. R9's w/c alarm sounded and R9 was found seated on the floor in	F 323		

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F 323	Continued From page 21 the doorway of her room. There was bowel movement (BM) on R9's shoes, the floor and R9's pants were around her knees. No injury was noted. Staff continued to monitor. · On 8/23/14, at 4:00 p.m. R9 was found lying on the floor in her room next to her bed. No injury noted. Staff were to monitor frequently for safety. · On 9/3/14, at 11:45 p.m. R9 was seated at the East end and had slipped out of the recliner. No injury noted. The staff were told not to put R9 in the leather recliner chair anymore. · On 9/22/14, at 7:45 p.m. R9 self-transferred from her w/c to another resident's w/c that did not have anti-lock brakes. R9 stated she hit her head. No injury noted. The staff were to monitor R9 more frequently. · On 10/2/14, at 10:00 p.m. R9 was found on the floor by the magazine table and chairs. R9 complained of back pain and went to the emergency room (ER). Family refused an X-ray and R9 was sent back to the facility. Staff implemented 15 minutes checks on the night shift from 10:00 p.m. to 6:00 a.m. · On 10/4/14, at 4:00 p.m. R9 was found seated on the floor in another residents room. No injury noted. 15 minutes checks were implemented on the p.m. shift. · 10/21/14, at 8:23 p.m. R9 was found on the floor in the commons area. R9 stated she hit her head. Fall was unwitnessed and R9 complained of back and neck pain. Interventions were to continue to monitor resident frequently on the evening and night shift and to make sure there	F 323		

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F 323	Continued From page 22 are no other disoriented residents by R9 prior to going into another residents room. On 11/7/14, at 8:21 a.m. the DON verified R9 required assistance of one with ambulation and transfers. The DON stated they had determined R9 was falling more in the evening so they had implemented every 30 minute visual checks from 2:00 p.m. to 6:00 a.m. which was effective 10/23/14. The DON stated the day shift NAs had not documented any visual checks of R9. At 8:50 a.m. the DON and registered nurse (RN)-A concurred R9 self-transferred when she was looking for her small children and also when she needed the toilet. However, the DON verified there had not been a root cause analysis completed for all of R9's falls. On 11/7/14 at 9:25 a.m. NA-F stated this morning when she first checked on R9, the bathroom light was off and R9 was in bed, covered up with blankets. NA-F stated when she checked on R9 later the bathroom light was on and there was urine in the toilet. NA-F stated staff try to frequently check on R9 and verified R9 self transferred and had walked around in her rooms. At 9:32 a.m. the DON verified visual checks were initiated on 10/3/14, however, stated they were not being consistently documented. R9's visual check documentation was reviewed from 10/23/14, through 11/5/14. The visual check documentation identified multiple entries on the same date with the same time. Documentation recorded was outside the time frame of accurate visual checks according to R9's care plan.	F 323		

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F 323	Continued From page 23 At 10:07 a.m. the DON verified the above documentation findings and stated there were 4-6 entries on the same date with the same time listed for the visual checks. At 1:35 p.m. the DON stated the day shift had more staff available to check on R9 and formal monitoring on the day shift would be warranted. The DON verified R9's care plan required revisions to include the non-skid floor mat, use of leg rests for wheelchair transportation and the use of the anti-lock brakes. The facilities Fallen Or Injured Resident policy dated 6/14, directed staff to complete the falls data collection tool, compare the results with previous data collected and to look for differences that may indicate a change in the risk for falls. The policy also stated to use the tool for identifying fall risk or performing a post-fall evaluation to further explore risk factors and to assist in planning for resident safety. The policy also directed staff to update the comprehensive care plan and documentation record with any changes/new interventions and monitor the resident's condition for effectiveness of the interventions to prevent further falls. The facilities Falls Committee Guidelines policy dated 1/11, indicated the purpose of this committee was to review trends, evaluate the program and to identify hazards and risks. The purpose statements also indicated audits were to ensure procedures were followed for quality of care and review of individual resident care plans who have fallen or are at risk for falls and add, modify and evaluate interventions aimed at fall prevention.	F 323		

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement non-pharmacological interventions for 1 of 2 residents (R44) who was receiving an as needed (prn) anti-anxiety medication. Findings include: R44's Admission Record dated 3/1/13, identified	F 329		12/19/14

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F 329	Continued From page 25 R44's diagnoses as adult failure to thrive, depression, insomnia and anxiety. R44's quarterly Minimum Data Set (MDS) dated 9/8/14, indicated R44 had moderate cognitive impairment. R44's Medication Review Report indicated she had a current order for alprazolam (anti-anxiety medication) 0.5 milligrams (mg) to be given at bedtime as needed. Prior to this, R44 had an additional order that alprazolam 0.25 mg could be given every eight hours as needed for anxiety. This order was discontinued on 8/23/14. R44's medication administration records (MARs) were reviewed and revealed R44 had been given: · alprazolam 0.5 mg on 6/27/14 at 7:12 p.m. · alprazolam 0.25 mg on 7/2/2014, at 1:56 p.m. · alprazolam 0.25 mg on 8/7/2014, at 10:18 a.m. · alprazolam 0.5 mg on 10/14/2014, at 7:26 p.m. R44's care plan dated 10/3/2014, indicated R44 had a potential for a mood problem and directed staff to provide and offer frequent one to one's if R44 was going through a period of increased anxiety. In addition, R44's care plan also indicated on 3/26/2014, R44 to have little or no activity involvement related to her anxiety. Non-pharmacological interventions included: encourage resident to come out of her room for activities, R44 enjoyed visiting with family, her faith, gardening and for staff to utilize extra gentleness verbally and physically as R44 was easily hurt or offended. R44's Consultant Pharmacist Medication Review	F 329		

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F 329	Continued From page 26 dated 4/3/14, included a reminder to nursing staff for them to document non-drug interventions tried/failed prior to giving the alprazolam as needed dose. On 11/6/14, at 12:46 p.m. a sign was observed to be posted in the east nursing station area that read "ATTENTION NURSING: Any PRN (as needed) medication that is administered must have documentation to support it. All interventions prior to administration need to be included in the documentation." On 11/7/14, at 8:51 a.m. R44 was observed seated at the dining room table eating her breakfast and interacting appropriately with the other residents and staff. At 10:13 a.m. R44 was observed walking back from the beauty shop with her walker; she appeared calm and relaxed. On 11/6/14, at 1:04 p.m. registered nurse (RN)-A verified R44 had received her prn alprazolam on 6/27/14, 7/2/2014, 8/7/2014, and 10/14/2014. RN-A stated she was not able to show the documentation of the non-pharmacological interventions attempted prior to the administration of the prn alprazolam. RN-A stated it had been the facility's practice that if someone can ask for a prn anti-anxiety medication; the staff did not need to attempt non-pharmacological interventions. RN-A confirmed R44's care plan directed the staff to attempt non-pharmacological interventions. On 11/7/14, at 8:15 a.m. the pharmacist confirmed R44's non-pharmacological interventions should have been attempted and documented prior to the administration of her prn anti-anxiety medication. The pharmacist stated in the past he had reminded the staff that they	F 329		

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F 329	Continued From page 27 needed to attempt and document non-pharmacological interventions. The Psychopharmacological Medications And Sedative / Hypnotics policy dated 6/2014, directed staff to initiate other care plan interventions prior to the use of a prn psychopharmacological medication and sedative/hypnotics. In addition, non-pharmacological interventions were recommended before medication interventions and all attempts should be documented in the residents' record. The Care Plan policy, revised date 1/2009, indicated each resident would have an individualized care plan which would assure that the resident received the appropriate care and services.	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431		12/19/14

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F 431	Continued From page 28 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly label 2 of 4 insulin vials with a "when opened" date. This had the potential to affect 1 of 3 residents (R24) who was receiving insulin. In addition, the facility failed to ensure 8 of 10 catheter supplies were not expired. This had the potential to affect all residents who would require catheterization. Findings include: R24's Lantus and NovoLog insulin vials were not labeled with a "when opened" date. On 11/6/14, at 3:30 p.m. the large west medication cart was reviewed with licensed practical nurse (LPN)-A. R24's Lantus insulin 10 milliliter (ml) vial and NovoLog insulin 10 ml vial were observed opened and lacking a label or marking which indicated when the vials had been	F 431		

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F 431	Continued From page 29 opened. LPN-A verified both vials had been used for R24 and both the vials and/or their boxes were not labeled with a "when opened" date. LPN-A confirmed the facility policy was to put the date when the insulin was opened on the insulin vials. On 11/6/14, at 4:00 p.m. the director of nursing (DON) confirmed the facility policy was to date insulin vials with the date they are opened to assure they remain within their recommended expiration time. On 11/6/14, at 4:12 p.m. LPN-A verified she was unaware of when R24's insulin vials had been opened. On 11/7/14, at 8:15 a.m. the pharmacist confirmed his expectation was that insulin vials would be labeled with a "when opened" dated. The Insulin Administration policy dated 11/2013, directed staff to write the "open date" on multi-dose vials of insulin. Catheter and catheter supplies were observed to be expired. On 11/7/14, at 10:18 a.m. the west medication storage room was toured with LPN-C. The following expired items were observed to be located in a bottom supply cupboard in the west medication storage room: · Two catheter extension tubes - use by date of 3/2014. · Two 18 Fr (French) (system used to commonly measure the size of a catheter) - use	F 431		

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F 431	Continued From page 30 by date of 5/2013. · Two 18 Fr catheters - use by date of 5/2014. · One 18 Fr catheter - use by date of 7/2011. · One 18 Fr catheter - use by date of 1/2014. On 11/7/14, at 10:39 a.m. LPN-C confirmed the facility did use catheters. On 11/7/14, at 1:46 p.m. registered nurse (RN)-A verified outdated supplies should not be readily available for staff to use. The Nursing Care Equipment And Supplies policy dated 2/2005, indicated outdated supplies would be disposed of properly.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441		12/19/14

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F 441	Continued From page 31 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the glucometers (devices utilized for monitoring blood sugars) were appropriately disinfected after each use. This had the potential to affect all 5 residents (R11, R14, R24, R31, and R48) who used a community glucometer. Findings include: On 11/4/14, at 5:10 p.m. licensed practical nurse (LPN)-B was observed to conduct a blood glucose check on R31. Immediately following R31's blood glucose check, LPN-B was observed to place the glucometer in her front uniform pocket, transport R31 in her wheelchair out to the dining room area and return to the large east medication cart. LPN-B proceeded to record R31's glucose reading on a piece of paper which	F 441		

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F 441	Continued From page 32	F 441		

was placed on the top of the medication cart, removed the glucometer from her pocket and placed it in the top drawer of the medication cart. LPN-B proceeded to conduct medication passes and then assist residents with eating.

On 11/4/14, at 7:10 p.m. LPN-B verified the glucometer she utilized on R31 was a community glucometer and that the facility did not have individual glucometers designated for each resident who required glucose checks. LPN-B stated the glucometers were cleaned with an alcohol wipe once a day by the night staff. LPN-B provided a sample of the alcohol prep wipe, which contained 70% isopropyl alcohol.

On 11/4/14, at 7:27 p.m. registered nurse (RN)-B confirmed her practice was to clean the glucometers after each use by wiping them down with an alcohol prep wipe. RN-B verified the following residents had the potential to utilize the community glucometers at the facility: R11, R14, R24, R31 and R48.

On 11/7/14, at 10:18 a.m. LPN-C confirmed she utilized an alcohol prep wipe to clean the glucometers after each resident use.

On 11/6/14, at 11:37 a.m. the director of nursing (DON) verified the glucometers should be cleaned according to the facility policy which directed staff to clean the glucometers after each resident use and staff should be using the germicidal disposable wipes. The DON confirmed the alcohol prep wipe was not the appropriate disinfectant to be used for cleaning the glucometers.

The Cleaning And Disinfecting Blood Glucose

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	11/07/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 33 Meters policy dated 11/2011, directed staff to properly disinfect the glucometer with 1:10 bleach to water solution or to use an acceptable germicidal disposable wipe. The Assure Pro glucometer manufacture instructions directed staff to disinfect the glucometer with a 1:10 bleach solution between patients.	F 441		

Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.

Approved
w/ revisions
12/12/14
SB

F 279

SS: D

1. New care plans have been developed for residents R33 and R20 based upon comprehensive assessments. These included comprehensive assessments for falls for R33 and comprehensive assessments for skin and pain for R20. Appropriate interventions have been care planned.
2. All residents Care Plans have been updated and revised to ensure proper goals and interventions are current and appropriate. Interventions reviewed and updated.
3. All staff caring for residents will be educated on GSS policy and procedure on Care Planning including development and implementation and access of care Plans.
4. Audits will be done with each new admission and significant change to ensure that care plans were developed and effective interventions are in place. Auditing for random residents care plans to ensure interventions are appropriate. Will be done weekly x 3, and then monthly x 3.
5. Completion Date: 12-19-14

F280

SS: D

1. R9's antilock wheelchair brakes were repaired and are in working order. R9's Care Plan has been reviewed and updated to reflect appropriate interventions for fall prevention.

2. All residents Care Plans have been updated and reviewed with appropriate fall prevention interventions.

3. DNS reviewed education on the GSS policy and procedure related to falls. All nursing staff will receive education on proper assessments procedures to insure Care Plans are reviewed and updated appropriately to reflect resident's needs.

4. Audits will be conducted for R-9 weekly x3 and then monthlyx3 to insure that care Plan is current and accurate. Other random residents will be audited weekly x3 and then monthly x3 for accuracy with Care Plan. Audit results will be brought to the facility QAPI meeting for further recommendation.

5. Completion Date: 12-15-14

F282

SS: D

1. Care plans for resident R27 and R44 have been reviewed. Assessments for ROM and the use of anxiolytics have been updated to reflect current needs. Care plan interventions have been implemented.
2. All residents current Care Plans have been reviewed to ensure assessments are up to date for ROM and the use of anti-anxiety meds. Current and future residents will have nursing assessments completed upon admission, quarterly, annually and with significant change and PRN to address ROM and anti-anxiety meds. All care Plans will be updated to reflect assessment findings.
3. An education webinar was attended by the care plan team on 12-11-14, and all licensed staff also attended education on implementing a Care Plan and follow through. All other staff including CNA's attended education on 12-11-14 on accessing care plans and documenting interventions and communicating changes to the nurse. Each nursing assistant will be trained in small groups on the kiosks to be able to access care plans and kardex's to better understand the individualized care that is required for each resident. Consultant will also work with Case Manager and other licensed staff on non-pharmacological interventions prior to identifying the need for PRN medication.
4. Care Plans and assessments will be audited for accuracy of ROM and the use of PRN medication by observation and record review 3x weekly and then 3 xs monthly. Audit results will be

brought to facility monthly QAPI meeting for further recommendation.

5. Completion Date: 12-19-14

F: 314

SS: D

1. Care Plans and MDS for resident R20 have been reviewed and updated based off the current nursing assessments r/t pressure issues. Nursing assessments reflect current needs of the resident. We are collecting data from the skin assessments, mobilation support data collection tool along with the Braden scale. Care Plan implementations made related to tissue tolerance.
2. All residents current and future will have assessments completed on admission, quarterly, annually, with significant change and PRN to address risk for pressure ulcers, along with Braden scale. All care plans will be updated to reflect assessment findings.
3. All licensed staff will be educated on GSS policies and procedures for assessing and developing a comprehensive care plan for those at risk for pressure ulcers as well as appropriate interventions as well as Implementing Care Plan interventions. All licensed staff will be educated on the Position Data Assessment Tool along with the use of the Braden scale. This took place on 12-10-14 at the staff meeting. All staff including CNA's were trained on 12-11-14 on the definitions of care plan interventions and how to properly implement an intervention, along with reporting changes and concerns to the nurses.
4. Auditing will be conducted for R20 and other random residents that are at risk for pressure ulcers via observation and record review that interventions are effective. Weekly x3 and monthly

x4. Audit results will be brought to faculty QAPI meeting for further recommendation.

5. Completion Date: 12-19-14

F: 318

SS: D

1. Assessment for ROM on R27 has been completed and Plan of Care Updated. ROM is being provided by qualified trained staff.
2. All residents current care plans have been updated to ensure that assessments are up to date and results for ROM are addressed on the Plan of Care. Current and future residents will have nursing assessments completed upon admission, quarterly, annual and with significant change and PRN to address the need for ROM.
3. Nursing staff education was held on November 19th 2014 to address ROM. Training was provided by Physical Therapy. Licensed staff is receiving education on the importance of completing the nursing assessments, and how to update Care Plans to reflect current state of resident.Training was also done with staff on providing care plan interventionsand documentation of ROM.
4. Care Plans and assessments along with ROM observations and record review will be completed 3x weekly x3 and then monthly x4. Audit results will be brought to QAPI meeting for further recommendation.
5. Completions Date: 12-19-14

F: 323

SS: D

1. R'9s wheelchair brakes were repaired and are in working order. Care plan reviewed and interventions were implemented for R9 related to falls interventions. Assessments completed to reflect appropriate care for this resident. Incident reports have been looked at to reflect the root cause analysis.
2. All current and future residents who are at risk for falls will have fall risk assessment completed on admission, quarterly, annually and with significant change. Root cause analysis will be conducted after every fall.
3. Staff will be educated on the importance of the incident report accuracy, and how to implement a root cause analysis, and also how to utilize maintenance requests to notify the maintenance department, pull the equipment off the floor and notify the nurse. Care Plans developed to address fall prevention, and conduct fall scene investigation. Nursing staff educated in implementation of care plan interventions, this training was conducted on 12-11, and 12-12 to nursing staff.
4. Care plans and incident reports will be audited to determine root cause analysis after each fall. Auditing will be conducted for R9 and random other residents weekly 3 and monthly x 4 to insure a fall scene investigation, root cause analysis and updating of care plan have been completed as appropriate. Audit results will be brought to the facility QAPI meeting for further recommendation.
5. Completion Date: 12-19-14

F: 431

SS: D

1. R24's unlabeled insulin was destroyed. A new one was opened and properly labeled with dates. All vials and bottles are labeled with current dates. All catheters that were outdated have also been disposed of.
2. A new workflow process has been put into place. An easy to see sticky neon green dots have been put on vials and bottles after opening that is marked with open date and date of expiration. The sticky neon green dots are kept in the medication cart, upon opening of the drops, and vials nurses will be putting the sticky neon green dots on the of the vials, and bottles, and putting the date of opening and the expiration date on them.
3. Audits of insulin's and other drops will be weekly x4 and monthly x3. Calendar put in place to show audits have been done. A monthly cart audit is also in place to check for opened and expired meds. Audit results will be brought to facility monthly QAPI meeting for further recommendation.
4. Completion Date: 12-19-14

F441

SS: E

1. Each resident will have their own glucometer. We will have 1 community glucometer that will be cleaned and disinfected according to manufacturer's recommendations. The glucometers are being cleaned with Sani-Cloth Plus, Germicidal Disposable Cloth.
2. All current and future residents will have their own glucometers.
3. DNS will educate all licensed staff including non-licensed TMA's using manufacturer's recommendations as to the cleaning of the glucometers, using Sani-Cloth Plus, Germicidal Disposable Cloth. The education was given on 12-10-14 Process put in place for test out and returns demonstration.
4. Random audits of staff will be weekly x 3 and then monthly x4 for proper disinfection. Audit results will be brought to monthly QAPI meeting for further recommendation. Completion Date: 12-19-14

F329

SS: D

1. Care Plans for resident R44 have been reviewed and updated. Assessments for non-pharmacological interventions have been completed. R44's medication has been discontinued. Care plan interventions have been implemented.
2. All residents current care plans have been reviewed to ensure all care plans address non-pharmacological approaches appropriate to the resident. Current and future residents will have nursing assessments completed upon admission, quarterly, annually, and with significant change and PRN to address the need for this type of medication and applying non-pharmacological interventions.
3. Licensed staff was educated on 12-10-14 related to the administration of Psychopharmacological meds, and the use of non-Pharmacological interventions. Each staff member will be furnished with the policy and procedure of using non-pharmacological interventions before prn medications. Each staff member was also educated on how to Care Plan non-pharmacological interventions in the care plan on 12-11, and 12-12-14.
4. Care Plans for R44 and random other residents will be observed and record review to insure non-pharmacological interventions are being used appropriately. Audits will be conducted weekly x3 and then monthly x4. Audit results will be brought to facility monthly QAPI meeting for further recommendation.
5. Completions Date: 12-19-14

Rebecca Sorensen 12-10-14

addendum Approved 12/16/14 gb

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

F 5550024

PRINTED: 11/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/05/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Good Samaritan Society Warren 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	POC ok JB 12-10-14 RECEIVED DEC - 8 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

RAdmon — Administrator — 12-3-14

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 000	Continued From page 1 Marian.Whitney@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Facility was inspected as 2 buildings: Good Samaritan Society Warren (Marshal Manor) was built in 1968 as a 1-story building without a basement and was determined to be Type II (111) construction. In 1973 a 1-story addition was constructed to the east of the original building and was determined to be Type II (000) construction. In 2010 a kitchen addition was constructed to the north of the original building's dining room. It is 1-story, no basement and Type II(000) construction. In 2013 a connecting link was constructed to the east connecting the new hospital with the facility. This addition is i-1story , no basement and Type II(000) construction. The building is divided into 6 smoke zones with 1/2 hour fire rated barriers. An apartment building is attached to the southwest wing that is separated with a 2-hour fire barrier. The facility is completely protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition).	K 000		

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K 000	Continued From page 2 The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code (1999 edition) with automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 52 beds and had a census of 45 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This Standard is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a clear un-obstructed for 2 of several means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2.1 and 7.2.1.5.4, 7.2.1.6.1(d), 7.7.2 (1) and the 2007 MN State Fire Code, Appendix I. The deficient practice could affect 20 of 52 residents. Findings include: On facility tour between 11:30 PM and 3:30 PM	K 038		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 038	Continued From page 3 on 11/05/2014, observation revealed that the 100 and 200 wing exterior entry doors have a 2 inch gap between the building and the sidewalk that also have 2 inch drops at the threshold. This deficient practice was verified by the Director of Maintenance (MR).	K 038		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This Standard is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents. Findings include: On facility tour between 11:30 PM and 3:30 PM on 11/05/2014, during the review of all available maintenance documentation and interview with the Director of Maintenance (MR) it was revealed that the facility failed to conduct 2 of 12 fire drills	K 050		

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K 050	Continued From page 4 for the night shift during the last 12-month period. This deficient practice was verified by the Director of Maintenance (MR).	K 050		
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This Standard is not met as evidenced by: Based on observation and staff interview it was revealed that the facility failed to correctly install 1 of several manually actuated alarm-initiating devices located throughout the facility in accordance with NFPA 101 Life Safety Code (00),	K 051		

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K 051	Continued From page 5 Sections 19.3.4.2 and 9.6.2 as well as NFPA 72 National Fire Alarm Code (99), Sections 2-8.1. This deficient condition could adversely affect the ability to initiate the fire alarm system and delay emergency actions, and emergency forces notification in the event of an emergency, thus negatively affecting residents of the facility. Findings include: On facility tour between 11:30 PM and 3:30 PM on 11/05/2014, observation revealed, that the manual fire alarm pull station located in the boiler room was mounted 70 inches above the floor and not within the 42 to 54 inch range specified by NFPA 72 (99) Section 2-8.1. This deficient practice was verified by the Director of Maintenance (MR).	K 051		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This Standard is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect all residents. Findings include:	K 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 054	Continued From page 6 On facility tour between 11:30 PM and 3:30 PM on 11/05/2014, a review of the facility's available fire alarm maintenance and testing documentation revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. The last smoke detector sensitivity test was 10/17/2011. This deficient practice was verified by the Director of Maintenance (MR).	K 054		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This Standard is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all residents. Findings include: On facility tour between 11:30 PM and 3:30 PM on 11/05/2014, documentation review of the emergency generator testing logs indicated that	K 144		

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

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K 144	Continued From page 7 the facility could not locate or provide documentation for any of the weekly or monthly testing of the emergency power generator. This deficient practice was verified by the Director of Maintenance (MR).	K 144		

K 038, SS=D Bldg 1

1. **Gaps at exit doors of 100 and 200 wings have been eliminated by installing 6 inch metal thresholds at the bottom of the door leading to the sidewalk.**
2. **Monthly audits x 3 months have been put into place to inspect effectiveness of thresholds and audit results will be brought to monthly Safety Committee.**
   Completion date: 12/15/2014

K 050, SS=D Bldg 1 and Bldg 2

1. Fire drills will be conducted monthly rotating quarterly for each shift.
2. The Environmental Services Director was educated as to the policy/procedure for monthly fire drills on 11/7/2014. Fire drills will be signed and dated by the Administrator and Environmental Services Director and then presented monthly to the Safety and QAPI committees.
3. The Environmental Services Director and/or

Designee will be responsible to have fire drills Completed according to code. The first monthly fire drill according to the plan of correction was held on 11/21/14 at 01:10.

Completion Date: 12/15/14

K 051, SS=D Bldg 1

1. Manual fire alarm pull station in boiler room
Relocated on 12/4/14 to be within range of
42-54 inch range as specified by NFPA 72.
2. Any other fire alarm pull stations not in compliance
Have been relocated per NFPA 72 code.
Completion date: 12/15/2014

K 054, SS=F Bldg 1 and Bldg 2

1. Smoke detectors were tested and inspected On 12/3/14 in accordance with the Manufacturer's specifications.
2. The facility will ensure that sensitivity Testing is completed on all smoke detector Systems bi-annually in accordance with NFPA 72.
3. The Environmental Services Director and Administrator will maintain all records and ensure that the facility follows manufacturer's testing specifications.
   Completion date: 12/15/2014

K 144, SS=F Bldg 1 and Bldg 2

1. **Generator inspections are completed weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.**
2. **Environmental Services Director was educated to generator inspection procedure and locations logs on 11/10/14. Completion Date 12/15/2014**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **02 - KITCHEN ADDTION** B. WING _____	**11/05/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 02 Kitchen Addition and Connecting Link THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Good Samaritan Society Warren 02 Kitchen Addition was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	POCok JB 12-10-14 RECEIVED DEC - 8 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 12-3-14
Exit: 11-7-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	12-3-14

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **02 - KITCHEN ADDTION** B. WING _____	**11/05/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was inspected as 2 buildings: Good Samaritan Society Warren (Marshal Manor) was built in 1968 as a 1-story building without a basement and was determined to be Type II (111) construction. In 1973 a 1-story addition was constructed to the east of the original building and was determined to be Type II (000) construction. In 2010 a kitchen addition was constructed to the north of the original building's dining room. It is 1-story, no basement and Type II(000) construction. It is 1-story, no basement and Type II(000) construction. In 2013 a connecting link was constructed to the east connecting the new hospital with the facility. This addition is i-1story , no basement and Type II(000) construction. The building is divided into 6 smoke zones with 1/2 hour fire rated barriers. An apartment building is attached to the southwest wing that is separated with a 2-hour fire barrier. The facility is completely protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **02 - KITCHEN ADDTION** B. WING _____	**11/05/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code (1999 edition) with automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 52 beds and had a census of 45 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This Standard is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 18.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire.	K 050		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **02 - KITCHEN ADDTION** B. WING _____	**11/05/2014**

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

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K 050	Continued From page 3 Improper reaction by staff would affect the safety of all residents. Findings include: On facility tour between 11:30 PM and 3:30 PM on 11/05/2014, during the review of all available maintenance documentation and interview with the Director of Maintenance (MR) it was revealed that the facility failed to conduct 2 of 12 fire drills for the night shift during the last 12-month period. This deficient practice was verified by the Director of Maintenance (MR).	K 050		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This Standard is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect all residents. Findings include: On facility tour between 11:30 PM and 3:30 PM on 11/05/2014, a review of the facility's available fire alarm maintenance and testing documentation revealed that at the time of the inspection the facility could not provide any	K 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **02 - KITCHEN ADDTION** B. WING _____	**11/05/2014**

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

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K 054	Continued From page 4 current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. The last smoke detector sensitivity test was 10/17/2011. This deficient practice was verified by the Director of Maintenance (MR).	K 054		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96 This Standard is not met as evidenced by: Based on observations and staff interview, it was determined that the kitchen hood fire suppression system has not been maintained in accordance with National Fire Protection Association (NFPA) 96 The Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 1998 edition nor the Minnesota State Fire Code 2007 (MSFC). This deficient practice could allow the system to fail allowing a kitchen fire to spread which could negatively impact the all the residents near or in the kitchen area. Findings include: On facility tour between 11:30 PM and 3:30 PM on 11/05/2014. a review of the facility's hood suppression testing records is was revealed that the kitchen hood suppression system has not been serviced every six months as required. The last service was done 02/10/2014. This deficient practice was verified by the Director of Maintenance (MR).	K 069		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **02 - KITCHEN ADDTION** B. WING _____	**11/05/2014**

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

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K 144 SS=F	Continued From page 5 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This Standard is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all residents. Findings include: On facility tour between 11:30 PM and 3:30 PM on 11/05/2014, documentation review of the emergency generator testing logs indicated that the facility could not locate or provide documentation for any of the weekly or monthly testing of the emergency power generator. This deficient practice was verified by the Director of Maintenance (MR).	K 144		

K 050, SS=D Bldg 1 and Bldg 2

1. **Fire drills will be conducted monthly rotating quarterly for each shift.**
2. **The Environmental Services Director was educated as to the policy/procedure for monthly fire drills on 11/7/2014. Fire drills will be signed and dated by the Administrator and Environmental Services Director and then presented monthly to the Safety and QAPI committees.**
3. **The Environmental Services Director and/or Designee will be responsible to have fire drills Completed according to code. The first monthly fire drill according to the plan of correction was held on 11/21/14 at 01:10.**

Completion Date: 12/15/14

K 054, SS=F Bldg 1 and Bldg 2

1. Smoke detectors were tested and inspected On 12/3/14 in accordance with the Manufacturer's specifications.
2. The facility will ensure that sensitivity Testing is completed on all smoke detector Systems bi-annually in accordance with NFPA 72.
3. The Environmental Services Director and Administrator will maintain all records and ensure that the facility follows manufacturer's testing specifications.
   Completion date: 12/15/2014

K 069, SS=D Bldg 2

1. Kitchen hood fire suppression system was inspected on 12/3/14.
2. The facility will ensure that hood suppression Testing will occur every six months in Accordance with NFPA 96.
3. The Environmental Services Director and Administrator will maintain all records and ensure that the hood suppression system is tested every six months.
   Completion date: 12/15/2014

K 144, SS=F Bldg 1 and Bldg 2

1. Generator inspections are completed weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.
2. Environmental Services Director was educated to generator inspection procedure and locations logs on 11/10/14. Completion Date 12/15/2014

Certified Mail # 7013 2250 0001 6356 6559

November 20, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5550024, H5550007

Dear Ms.. Sorenson:

The above facility was surveyed on November 4, 2014 through November 7, 2014 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, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Lyla.burkman@state.mn.us

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

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at the email or phone number listed above.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

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

Enclosure(s)

cc: Licensing and Certification File 5550s15Licltr

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	11/07/2014

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/4/14, 11/5/14, 11/6/14, and 11/7/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca Sorensen — TITLE: Administrator — (X6) DATE: 12-3-14