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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H8YY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00956

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245488**
2.STATE VENDOR OR MEDICAID NO.
(L2) **502043300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WOODLAND**
(L4) **100 BUFFALO HILLS LANE**
(L5) **BRAINERD, MN** (L6) **56401**

4. TYPE OF ACTION: 7 78)
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 7/30/13 (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)
06/30

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

12.Total Facility Beds **41** (L18)

13.Total Certified Beds **41** (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
	41			
(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):
Post Certification Revisit to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective July 22, 2013, the facility is certified for 41 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Sharron Williams HFE NE II 8/14/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen Leach Prgogram Rep 12/20/2013 (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
07/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/25/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5488 December 20, 2013

Ms. Jennifer Grams, Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, Minnesota 56401

Dear Ms. Grams:

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 July 22, 2013, the above facility is certified for:

41 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 41 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

August 14, 2013

Ms. Jennifer Bergstrom, Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, Minnesota 56401

RE: Project Number S5488023

Dear Ms. Bergstrom:

On June 20, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 6, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On July 30, 2013, the 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 June 6, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 22, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 6, 2013, effective July 22, 2013 and therefore remedies outlined in our letter to you dated June 20, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245488	A. Building B. Wing	7/30/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **07/22/2013**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **07/22/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **07/22/2013**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **07/22/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **07/22/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **07/22/2013**
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 State Agency	**Reviewed By** PK/cbl	**Date:** 08/14/2013	**Signature of Surveyor:** 19697	**Date:** 07/30/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/6/2013

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H8YY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00956

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(L1) **245488**

2.STATE VENDOR OR MEDICAID NO.
(L2) **502043300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WOODLAND**
(L4) **100 BUFFALO HILLS LANE**
(L5) **BRAINERD, MN** (L6) **56401**

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 **06/06/2013** (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)
06/30

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (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
	42			
(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 :
Sharron Williams, HFE-NEII 07/08/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 07/23/2013 (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
07/01/1987
(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 7/25/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed on June 6, 2013, the facility was not in substantial compliance and the most serious deficiencies were a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed.

See attached CMS-2567 for survey results. Post Certification Revisit after July 22, 2013.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0000 4830 8090

June 20, 2013

Ms. Jennifer Bergstrom, Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, Minnesota 56401

RE: Project Number S5488023

Dear Ms. Bergstrom:

On June 6, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Telephone: (651) 201-3792

Fax: (651) 201-3790

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 6, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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

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

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

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare

and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 6, 2013 (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 December 6, 2013 (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

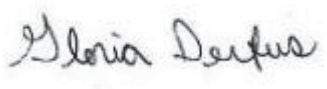
This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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.

Feel free to contact me if you have questions.

Sincerely,



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

Enclosure

cc: Licensing and Certification File

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
	245488	A. BUILDING ______ B. WING ______	06/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY 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 ONSITE 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	Disclaimer attached. RECEIVED JUL - 5 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in accordance with the resident's written plan of care for 1 of 1 resident (R18) who required assistance with ambulation to meals, repositioning and utilization of a chair alarm and for 1 of 1 resident (R66) who did not receive servcies for removal of facial hair. Findings include: R18's plan of care was not followed regarding	F 282	Please see attached.	7-22-13

accepted 7-8-13 [handwritten initials]

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Bergstrom
TITLE: administrator
(X6) DATE: 7/1/13

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
	245488	A. BUILDING _____ B. WING _____	06/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 repositioning, ambulation, and utilization of chair alarm. The current care plan reviewed on 5/8/13, directed staff to reposition R18 every three hours, ambulate with the assistance of one staff to and from every meal and apply chair alarm when sitting in recliner chair. On 6/4/13, from 1:15 p.m. until 5:03 p.m. R18 was observed sleeping in his recliner chair for three hours and 48 minutes without being repositioned and did not have a chair alarm in place. At 5:15 p.m. the resident was then observed to be wheeled by staff to the dining room for the evening meal. On 6/6/13, at 8:30 a.m. registered nurse (RN)-A verified the care plan was correct. RN-A verified the care plan was not followed related to R18's repositioning, ambulation and chair alarm needs. R66's plan of care was not followed regarding hygiene. R66's diagnoses include generalized muscle weakness and depressive disorder. The Social Service Assessment note dated 5/30/13, revealed R66 was alert, orientated and R66's short term and long term memory was intact. On 6/3/13, at 5:17 p.m. R66 was seated in a wheelchair in his room. He was noted to have approximately a quarter inch of uneven facial hair. R66 stated he had been asking for a razor to shave himself since he came in (admit date of 5/30/13), however, he still had not received a	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING _____ B. WING _____	06/06/2013

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F 282	Continued From page 2 razor or assistance with shaving. R66 stated it bothered him to be unshaven. On 6/4/13, at 4:41 p.m. R66 was observed seated in a wheelchair in his room, still with visible facial hair. R66's plan of care (POC) dated 6/4/13, indicated R66 required one staff participation with personal hygiene. On 6/4/13, at 12:43 p.m. licensed practical nurse (LPN)-A stated residents are usually shaved during morning or evening cares. "Each resident should have their own razor and if they don't have one the staff contact social services." On 6/4/13, at 1:15 p.m. nursing assistant (NA)-A was aware R66 did not have a razor and that social services was aware of his need. On 6/4/13, at 4:48 p.m. social worker (SW)-A stated staff do make her aware of when residents need personal items. SW-A was aware R66 did not have a razor or the ability for him to obtain his from home. On 6/5/13, at 12:16 p.m. the director of nursing (DON) stated her expectations for shaving residents are dependent on the resident's preferences, however, if there was visible facial hair the resident should be offered to be shaved. The facility's Procedure for Shaving dated 11/19, outlines the purpose of the policy to promote a good appearance and a positive self-image. A policy focusing on frequency of shaving residents was not provided.	F 282		

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F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide planned ambulation services to improve and maintain the resident's ability to ambulate for 1 of 1 resident (R18) in the sample who received ambulation services. Findings include: R18 did not receive ambulation services according to the assessed needs. R18's diagnoses included congestive heart failure, chronic kidney disease and depression. The quarterly Minimum Data Set (MDS) dated 4/22/13, identified R18 with a mild cognitive impairment and as requiring assistance of one staff with ambulation. The Care Area Assessment (CAA) regarding falls dated 1/30/13, indicated R18 had impaired balance requiring assistance of one staff for transfers and ambulation with a front wheeled walker. The physical therapist discharge summary dated, 2/11/13 identified R18's long term goal as being able to ambulate with four-wheeled walker (4WW) up to 200 feet with stand by assist and independent for 30 feet with in room with 4WW safely with improved balance and reduced fall risk.	F 311	Please see attached.	

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F 311	Continued From page 4 The current plan of care (POC) reviewed 5/8/13, indicated R18 was to ambulate with assist of one staff and a front wheeled walker to and from every meal. However, on 6/3/13, at 7:00 p.m. R18 was observed to wheel his own wheelchair back to his room. On 6/4/13, at 9:30 a.m. he was observed to be wheeled back to his room by a male visitor. On 6/4/13, at 5:15 p.m. R18 was observed to be wheeled to the dining room by nursing assistant (NA)-B. On 6/5/13, at approximately 9:15 a.m. registered nurse (RN)-A was observed to assist R18 with ambulation back to his room from the dining room. On 6/6/13, at 11:30 a.m. nursing assistant (NA)-C stated they try to complete the ambulation programs back and forth to meals but it is just a busy time. Review of the nursing ambulation sheets indicated: March 2013, the day shift had ambulated R18 20 of 62 opportunities on the day shift for 20-500 total feet. The evening shift had ambulated R18 three of 31 opportunities on the evening shift and no distance was documented on the form. April 2013, the day shift ambulated R18, 22 of 60 opportunities for 50-500 total feet. The evening shift did not ambulate R18 during the month of April the record indicated R18 had refused ambulation eight times. May 2013, the day shift ambulated R18, 26 of 60	F 311		

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F 311	Continued From page 5 opportunities for 50-500 total feet. The evening shift ambulated R18 one of 30 times. June 2013, the day shift ambulated R18 four days out of five day shift. However, R18 was not ambulated at all during the evening shift in June. On 6/5/13, at 2:00 p.m. RN-A stated R18 was to ambulated two and from every meal. RN-A reviewed the documentation and verified staff were not ambulating the resident according to the POC. On 6/5/13, at 3:10 p.m. the director of nurses also reviewed the documentation and confirmed that R18 was not being ambulated to and from every meal.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with personal hygiene cares for 1 of 3 residents (R66) in the sample who were dependent on staff to provide assistance and supplies for shaving. R66's diagnoses include generalized muscle weakness and depressive disorder. The Social Service Assessment note dated 5/30/13, revealed	F 312	Please see attached.	

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F 312	Continued From page 6 R66 was alert, orientated and R66's short term and long term memory was intact. On 6/3/13, at 5:17 p.m. R66 was seated in a wheelchair in his room. He was noted to have approximately a quarter inch of uneven facial hair. R66 stated he had been asking for a razor to shave himself since he came in (admit date of 5/30/13), however, he still had not received a razor or assistance with shaving. R66 stated it bothered him to be unshaven. On 6/4/13, at 4:41 p.m. R66 was observed seated in a wheelchair in his room, still with visible facial hair. R66's plan of care (POC) dated 6/4/13, indicated R66 required one staff participation with personal hygiene. On 6/4/13, at 12:43 p.m. licensed practical nurse (LPN)-A stated residents are usually shaved during morning or evening cares. "Each resident should have their own razor and if they don't have one the staff contact social services." On 6/4/13, at 1:15 p.m. nursing assistant (NA)-A was aware R66 did not have a razor and that social services was aware of his need. On 6/4/13, at 4:48 p.m. social worker (SW)-A stated staff do make her aware of when residents need personal items. SW-A was aware R66 did not have a razor or the ability for him to obtain his from home. On 6/5/13, at 12:16 p.m. the director of nursing (DON) stated her expectations for shaving	F 312		

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F 312	Continued From page 7 residents are dependent on the resident's preferences, however, if there was visible facial hair the resident should be offered to be shaved. The facility's Procedure for Shaving dated 11/19, outlines the purpose of the policy to promote a good appearance and a positive self-image. A policy focusing on frequency of shaving residents was not provided.	F 312		
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 resident identified at risk for pressure ulcers received the necessary care and treatment to prevent the development of pressure ulcers for 1 of 1 resident (R18) in the sample identified at risk for pressure ulcers. Findings include: R18 was identified at risk for the development of pressure ulcer to his coccyx area and had a stage II pressure ulcer (partial thickness skin loss	F 314	Please see attached.	

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F 314	Continued From page 8 involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater) to his heel. R18 was observed to be sleeping in his recliner chair from 1:15 p.m. until 5:03 p.m. for approximately three hours and 48 minutes and was not provided timely assistance with repositioning on the afternoon of 6/4/13. R18's diagnoses included congestive heart failure, diabetes, chronic kidney disease and depression. The admission Minimum Data Set (MDS) dated 1/24/13, identified R18 with a cognitive impairment, requiring assistance of one staff with transfers, and at risk for developing a pressure ulcer. The Care Area Assessment (CAA) regarding pressure ulcers dated 1/30/13, indicated R18's coccyx area was noted to be red and needed to have special seat cushions. The CAA noted R18 had a pressure ulcer cushion in the wheel chair and a pressure reduction mattress on the bed. The quarterly MDS dated 4/22/13, indicated R18 had one Stage I pressure ulcer (nonblanchable erythema of intact skin, the heralding lesion of skin ulceration). A progress note from the registered nurse (RN) dated 6/4/13, indicated R18 had been seen by a wound nurse to treat the left heel and required no further visits. The note stated the heel wound was almost closed with red granular tissue. The current plan of care (POC) dated 4/17/13, indicated R18 had an actual impairment to skin integrity with a deep tissue injury to left heel. The current POC directed staff to turn and reposition R18 in bed every two and a half hours and reposition in chair every three hours.	F 314		

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F 314	Continued From page 9 However, on 6/4/13, at 1:15 p.m. R18 was observed to be sleeping in his recliner chair. He remained in the chair until 5:03 p.m., a total of three hours and 48 minutes, when nursing assistant (NA)-B transferred him to the wheelchair and then wheeled him in to the bathroom. R18 refused to have the surveyor go into the bathroom to observe his skin condition. At 5:15 p.m. NA-B stated R18 was incontinent of bowel and bladder with a red bottom. The NA stated there was no open area it was just red. NA-B was not sure how long R18 had been sitting in the recliner and stated she started the shift at 4:00 p.m. and R18 was in the recliner at that time. NA-D was interviewed and stated her shift started at 2:00 p.m. and she had seen him sleeping in the recliner but had not repositioned him. NA-D stated at that time R18 had a history of having a reddened bottom but had no open areas. On 6/4/13, at 5:10 p.m. the RN-A stated there would have been two NA's working the hall, one covers the entire hall from 2:00 p.m. to 4:00 p.m., then at 4:00 p.m. another NA would cover that end of the hall. RN-A verified NA-B and NA-D would have been the two NA's to reposition R18. On 6/5/13, at 3:10 p.m. RN-A stated R18's POC directed staff to reposition him from the wheel chair every three hours and that staff did not follow the POC.	F 314		
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	F 323	Please see attached.	

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F 323	Continued From page 10 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate interventions had been implemented to minimize the risk of further injuries related to falls for 1 of 3 residents (R18) reviewed who were identified at risk for falls. Findings include: R18 was identified at risk for falls and the plan of care (POC) directed staff to utilize a tabs alarm while in reclining chair; however, R18 was observed to be sleeping in his recliner chair from 1:15 p.m. until 5:03 p.m. without a tabs alarm in place for three hours and 48 minutes. On 6/4/13, at 1:15 p.m. R18 was observed in his room sleeping in his recliner chair until 5:03 p.m. without the personal alarm (used for monitoring individuals at risk of falls, whether in bed, or wheelchair) in place. The resident had a personal alarm attached to his empty wheelchair but there was not a tabs alarm in the recliner chair. The wheelchair had a pressure relieving cushion. The resident was observed to have the call light in place and have the proper footwear donned. At 5:03 p.m. a nursing assistant (NA)-B was observed to transfer R18 to the wheelchair. R18 had difficulty getting up but was able to pivot transfer with the assist of NA-B. R18 was then wheeled in to the bathroom to use the toilet and	F 323		

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F 323	Continued From page 11	F 323		

then was wheeled to the dining room with the chair alarm attached. At that time, NA-B verified the tabs alarm had been attached to the wheelchair and but not the recliner. On 6/6/13, at 7:00 a.m. R18 was observed to be sleeping in the recliner with the tabs alarm in place.

R18's diagnoses included congestive heart failure, anemia, and depression. The admission Minimum Data Set (MDS) dated 1/24/13, identified R18 with a cognitive impairment, requiring assistance of one staff with transfers, had a history of falling before admission, and had a fall after his admission. The quarterly MDS dated 4/22/13, indicated a Brief Interview of Mental Status (BIMS) score 9 out of 15 (moderate cognitive impairment). The quarterly MDS dated 4/22/13, indicated R18 had one fall since the previous assessment with no injury and one fall since the prior assessment with a minor injury.

The Care Area Assessment (CAA) regarding falls dated 1/30/13, indicated R18 was at risk for fall due to medical conditions and that resident expressed concerns of falling and had been cooperative about waiting for assistance before transferring.

The current POC updated 5/24/13, indicated R18 was at risk for falls related to weakness and had a history of falls. The POC directed staff to ensure resident had shoes on while napping to prevent slipping in socks. "Monitor for changes in gait, mobility, positioning device, standing/sitting balance and lower extremity joint function. Escort resident to activity or assist into bed right after meals to prevent self-transfers and have tabs

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F 323	Continued From page 12 alarm in bed, wheelchair, and recliner used to alert staff to resident's movement and to assist staff in monitoring movement." The facility's Risk Management/Incident reports indicated R18 had the following falls: - On 1/19/13, at 7:00 a.m. "Resident was lying on floor by bed wearing his clothing and gripper socks, blanket was under patient and call light was attached. Resident stated he was reaching over to grab blanket and slid right off the edge of bed. No injuries were noted. No documented interventions." The investigation indicated no injuries, oriented to person, place, and situation. There was no unsafe condition. The predisposing factor was weakness and admitted with in last 72 hours. No changes were made to the plan of care to minimize/prevent potential injury from further falls. - On 2/13/13, at12:39 p.m. A nursing assistant found resident on floor by the bed. The resident stated he slipped when trying to replace telephone receiver. The investigation indicated no injuries, oriented to person, place, and situation. The report indicated was no unsafe condition; however, the predisposing factor was improper footwear. The care planning intervention dated 2/13/13, was to ensure resident was wearing shoes while napping. - On 4/16/13, at 7:05 p.m. resident found on floor, "had on rubber shoes, resident stated he was trying to get into bed and rolled off the edge." The investigation indicated no pain, abrasion to top of scalp, oriented to person, situation, and oriented to time. The predisposing factor was impaired memory and weakness. The care planning intervention dated 4/16/13, was to assist resident to bed right after meals to prevent self-transfers.	F 323		

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F 323	Continued From page 13 - On 5/21/13, at 4:40 a.m. "Resident found on floor by bed on left side of his body with his head resting head on arm. Stated he was reaching for the urinal." R18 had fallen from the bed. R18 had a skin alteration of a red bruise and a skin tear to the left wrist. Resident was assisted to the bathroom and then requested to sit in recliner. The investigation indicated no pain, injury to left hand; R18 was oriented to person, place, time and situation. There were no predisposing factors listed. The POC for bladder incontinence was updated on 5/21/13, to provide the resident with a urinal at bedside each night to aid with independence with toileting. - On 5/23/13, at 4:09 p.m. "Resident found on the floor by his doorway, on left side with head against his dresser", "resident denied pain", and "there was a pool of blood on the floor. "R18 was noted to have an approximate three centimeter (cm) laceration in length to the back of his head. "Resident stated he was wobbly and trying to get to the bed." The investigation indicated no pain, and the resident was oriented to person and situation. There was no unsafe condition. The predisposing factor was gait imbalance. The investigation indicated resident was provided education on using call light and resident verbalized understanding and stated he did need to get better at that. The POC was updated on 5/24/13, to have tab alarm in bed, wheelchair, and recliner used to alert staff to resident's movement and to assist staff in monitoring movement. The report indicated the call light was within reach and the resident had proper shoes on while napping. The report lacked evidence of where the resident was before he had fallen such as if in the bed or the recliner.	F 323		

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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 323	Continued From page 14 On 6/6/13, at 8:30 a.m. RN-A stated the resident had been injured from a fall from the recliner and the POC directed staff to apply the tabs alarm when he is in both the wheelchair and the recliner. The RN confirmed if the tabs alarm was not in the wheelchair then staff did not follow the POC. When RN-A was questioned where the resident had fallen from, RN-A assumed the resident had fallen from the recliner.	F 323		
F 431 SS=E	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 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	F 431	Please see attached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING _____ B. WING _____	06/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

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F 431	Continued From page 15 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 interview and document review, the facility failed to establish a system that was consistent with current standards of practice for the disposal of controlled substances within the facility, for 5 of 5 residents (R43, R14, R37, R22, R33) with prescribed Fentanyl transdermal patches. Findings include: During medication storage review on 6/5/13, at 7:30 a.m. licensed practical nurse (LPN)-A stated when a Fentanyl patch was removed from a resident's skin, the Fentanyl patch was placed in the sharps container. LPN-A stated currently five resident were on prescribed Fentanyl transdermal patches, R43, R14, R37, R22, and R33. On 6/5/13, at 9:45 a.m. registered nurse (RN)-A was interviewed on the facility's process for disposal of controlled substances, including Fentanyl patches stated when staff removed a resident's Fentanyl patch, and the patch was placed in a sharps container. On 6/5/13, at 10:05 a.m. the director of nursing (DON) verified staff disposed of Fentanyl patches in a sharp container.	F 431		

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GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

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F 431	Continued From page 16 The DON stated the pharmacist had recommended for the facility to develop a policy on destruction of Fentanyl patches however; had not instructed them on how to dispose of Fentanyl patches. On 6/5/13, at 10:15 a.m. the DON gave the surveyor the facility's undated policy for Appropriate Disposal of Fentanyl Patches, which indicated old Fentanyl patches were to be placed in a sharps container and to only be touched with a gloved hand. On 6/5/13, at 10:45 a.m. the consulting pharmacist stated he would expect the facility staff to be flushing the Fentanyl patches down the toilet. He stated the Fentanyl patches should not be placed in a sharps container. Adding, he had advised the facility to develop a policy on the destruction of Fentanyl patch. On 6/5/13, at 12:04 p.m. the DON stated she had a conversation with pharmacy consultant regarding the proper destruction of Fentanyl patches and had revised the facility's policy on 6/4/13, during the survey. The updated policy for Appropriate Disposal of Fentanyl Patches dated 6/4/13, indicated a Fentanyl patch that was removed from a resident was to be flushed down the sewer. Disposal of the patch was to be completed as soon as it was removed from the resident.	F 431		

Disclaimer

Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it.

F 282 services provided by qualified persons.

1. Resident #18 is receiving ambulation assistance to meals. Immediate education occurred on 6/07/2013 with the staff involved in not implementing the care plan. Resident #18 is currently being repositioned according to the plan of care. Staff involved in care was educated on 06/05/2013. Alarm is placed according to plan of care for resident #18 on 6/4/2013. Staff involved in failure to place alarm was educated on alarm placement on 6/5/2013. Resident #66 was provided with a razor on 6/5/2013 he was then able to shave per his desire.
2. All residents requiring assistance with ambulation to and from meals have the potential to be affected by the deficient practice. Review of all resident's ambulation plans occurred to determine appropriate plan in place. All residents are being assisted according to their individualized care plan. All residents who need assistance with repositioning are at risk for this deficient practice. The residents who need assistance with repositioning are being repositioned according to their individualized plan of care. All residents with alarms are at risk for this deficient practice. Residents who are care planned for alarms have alarms in place according to their individualized plan of care. All residents with facial hair have potential to be affected by this deficient practice. Residents who need assistance with shaving are being provided with that assistance and those who need assistance with access to a razor have been provided with a razor.
3. Mandatory nursing staff education took place on 6/25/2013 and included education on need to follow resident's individualized plan of care for: ambulation, repositioning residents in a timely manner, alarm placement, and for staff to notify nursing staff if alarm is not in place. Topics also included monitoring for facial hair, providing items to residents to perform shaving, review of process of notification to Social Services when a resident does not have a razor, and completion of shaving residents.
4. Observation audits will be done weekly by DNS/designee to ensure that ambulation, timely repositioning, alarm placement, and shaving assistance, is being delivered/completed according to the care plan. These audits will be completed 3 times/week for 4 weeks with results to Quality Assurance Committee for further recommendations.
5. Date of Completion 7/22/2013

F 311 Treatment/services to improve/maintain ambulation

1. Resident #18 is receiving ambulation assistance to meals according to plan of care. Immediate education occurred on 6/07/2013 with the staff involved in not implementing the care plan.
2. All residents requiring assistance with ambulation to and from meals have the potential to be affected by the deficient practice. Review of all resident's ambulation plans occurred to determine appropriate plan in place. All residents are being assisted according to their individualized care plan.
3. Mandatory nursing staff education took place on 6/25/2013 and included education on need to follow residents individualized plan of care for ambulation.
4. Observation audits will be done weekly by DNS/designee to ensure that ambulation assistance is being delivered according to the care plan. These audits will be completed 3 times/week for 4 weeks with results to Quality Assurance Committee for further recommendations.
5. Date of Completion 07/22/2013.

F312 ADL Care Provided for Dependent Residents

1. Resident #66 was provided with a razor on 6/5/2013 he was then able to shave per his desire.
2. All residents with facial hair have potential to be affected by this deficient practice. An audit was completed to review residents for visible facial hair, and accessibility to a razor. Care plans updated as needed.
3. All staff was educated on 6/25/2013. Topics included monitoring for facial hair, providing items to residents to perform shaving, process of completing concern form to notify Social Services when a resident does not have items needed to shave and completion of shaving residents.
4. Observation audits will be done by DNS/designee to ensure that shaving is being completed according to the individualized care plan, and razors are provided in a timely manner. These audits will be completed 3 times/week for 4 weeks with results forwarded to the Quality Assurance Committee for further recommendations.
5. Date of Completion 07/22/2013

F 314 Treatment/SVCS to Prevent/Heal Pressure Sores

1. Resident #18 is currently being repositioned in a timely manner according to the plan of care. Staff involved in care were educated on 06/05/2013.
2. All residents who need assistance with repositioning are potentially at risk for this deficient practice. Review of care plans completed and staff are repositioning residents according to their individualized plan of care.
3. Mandatory all staff education held on 06/25/2013 to educate staff on the importance of repositioning residents in a timely manner according to the individualized plan of care.
4. Audits will be completed on the timeliness of repositioning and that the resident individualized plan of care has been followed. These audits will be completed 3 times/week for 4 weeks with results forwarded to the Quality Assurance Committee for further recommendations
5. Date corrective action completed 07/22/2013

F 323 Free of Accident Hazards/Supervision/Devices

1. Alarm was put in place for resident #18 according to plan of care on 6/4/2013. Staff involved in failure to place alarm was educated on alarm placement on 6/5/2013.
2. All residents with alarms care planned are at risk for this deficient practice. All residents with alarms were reviewed and all alarms were placed per individualized plan of care.
3. All staff education occurred on 06/25/2013 to look for proper alarm placement according to the individualized plan of care. All staff also educated to notify nursing staff if alarm is not in place to ensure alarms are in place. Nursing staff educated to place alarms as individualized plan of care states.
4. Visual audits also will be done to ensure that alarms are in place as care planned. These audits will be completed 3 times/week for 4 weeks with results forwarded to Quality Assurance Committee for further recommendations.
5. Date of Completion 07/22/2013.

F431 Disposal of Fentanyl Patches

1. All residents prescribed Fentanyl patches now have them destroyed by sewer per FDA recommendations. All nurses educated on proper process for patch removal and disposal on 6/5/2013.
2. All residents using Fentanyl patches have the potential to be affected by this deficiency. All patches are disposed of in sewer per FDA recommendations.
3. An addendum procedure to the GSS procedure Dispostion of Medication II.M.8r was created for destruction of all transdermal patches. Licensed staff have been educated on this new policy on 6/25/2013.
4. DNS/designee will audit licensed staff 2 times a week for 4 weeks to assure patches are disposed of by sewering and policy is being followed. The summary of these audits will be presented to the Quality Assurance Committee for further recommendation.
5. Completion date: 07/22/2013

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	245488	A. BUILDING **01 - 100 MAIN BUILDING** B. WING _____	**06/04/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	**100 BUFFALO HILLS LANE** **BRAINERD, MN 56401**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society, Woodland was found 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. Good Samaritan Society, Woodland is a 1-story building without a basement. The building was constructed in 1982 and was determined to be of Type V(111) construction. The building is separated from the apartment building with a 2-hour fire barrier and is divided into 3 smoke zones with 1-hour fire barriers. The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. . The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 42 beds and had a census of 41 at the time of the survey.	K 000		

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

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

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K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		