DEPARTMENT OF HEALTH	AND HUMAN	SERVICES			CENTERS FOR M	EDICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: HFW0
1. MEDICARE/MEDICAID PROVIDER		- TO BE COMP 3. NAME AND AI			TE SURVEY AGENCY	Facility ID: 00322           4. TYPE OF ACTION: <u>7 (</u> L8)
(L1) <b>245318</b>				CIETY - INT	FERNATIONAL FALLS	1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO. (L2) 004015100		(L4) 2201 KEENA (L5) INTERNAT		S, MN	(L6) <b>56649</b>	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEGO 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY <b>10/23/2</b>	<b>2013</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED A	AS:		
From (a):		X A. In Complia			And/Or Approved Waivers Of T	
To (b):			Requirements ace Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds	<b>54</b> (L18)	1.	Acceptable POC		4. 7-Day RN (Rural SNI 5. Life Safety Code	
13.Total Certified Beds	<b>54</b> (L17)		mpliance with Pro ents and/or Applie		* Code: <b>A</b> *	(L12)
14. LTC CERTIFIED BED BREAKDOW	Ň	I			15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
54						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABL	E SHOW LTC CANC	ELLATION DAT	E):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
<u>Rebecca Haberle, HFI</u>	E NE II		11/13/2013	(L19)	Shellae Dietrich, P	rogram Specialist 02/11/2014
PA	RT II - TO BH	COMPLETED	BY HCFA R	EGIONA	L OFFICE OR SINGLE ST	ATE AGENCY
19. DETERMINATION OF ELIGIBILITY			MPLIANCE WITH GHTS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
X1. Facility is Eligible to Par	ticipate	KI	onits Act.		3. Both of the Above	
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREE	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	TE	<u>VOLUNTARY</u> 0	INVOLUNTARY
06/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursem	5
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER
	A. Suspension	of Admissions:	(L44)			07-Provider Status Change 00-Active
(L27)	B. Rescind Sus	pension Date:	(L44)			
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00140				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL I	DATE		
		10/28/2013				

(L33)

DETERMINATION APPROVAL

(L32)

DEPARTMENT OF HEALTH AND HUMAN SERVICES	CENTERS FOR MEDIC	ARE & MEDICAID SERVICES
MEDICARE/MEDICAID CERTIFICATION AND	) TRANSMITTAL	ID: HFW0

#### PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00322

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

CCN: 24-5318

At the time of the standard survey completed August 15, 2014, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On October 22, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 23, 2013 the Minnesota Department of Public Safety completed a PCR and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on August 15, 2014 effective October 1, 2013, therefore the remedies outlined in our letter to you dated September 3, 2013, will not be imposed.

See attached CMS-2567B form for the results of the October 22, 2013 and October 23, 2013 revisit.

Effective October 1, 2013, Good Samaritan Society - International Falls relocated to a new building. The facility was previously located at 1402 Highway 71, International Falls, Minnesota 56649.



Protecting, Maintaining and Improving the Health of Minnesotans

CCN 24-5318

February 11, 2014

Mr. Adam Coe, Administrator Good Samaritan Society - International Falls 2201 Keenan Drive International Falls, Minnesota 56649

Dear Mr. Coe:

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 October 1, 2013 the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

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



Protecting, Maintaining and Improving the Health of Minnesotans

November 13, 2013

Mr. Adam Coe, Administrator Good Samaritan Society - International Falls 1402 Highway 71 International Falls, Minnesota 56649

RE: Project Number S5318022

Dear Mr. Coe:

On September 3, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 15, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 22, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 23, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 15, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 1, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 15, 2013, effective October 1, 2013 and therefore remedies outlined in our letter to you dated September 3, 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,

Proston

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

Form Approved

OMB NO. 0938-0390

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245318	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/22/2013
Name	of Facility		Street Address, City, State, Zip Code	
GC	OOD SAMARITAN SOCIETY - INTERNAT	IONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56645	9

**Post-Certification Revisit Report** 

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)	ltem		(Y5)	Date	(Y4)	ltem		(Y5)	Date
			Correction					Correction					Correction
ID Prefix	F0164		Completed 09/24/2013		ID Prefix	F0241		Completed 09/24/2013		ID Prefix	F0242		Completed 09/24/2013
	483.10(e), 483.75(l)(4)					483.15(a)					483.15(b)		
LSC					LSC					LSC			_
			Correction					Correction					Correction
ID Prefix	F0248		Completed 09/24/2013		ID Prefix	F0282		Completed 09/24/2013		ID Prefix	F0314		Completed 09/24/2013
Reg. #	483.15(f)(1)		-		Reg. #	483.20(k)(3)(ii)		-		Reg. #	483.25(c)		
LSC					LSC					LSC			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0323		09/24/2013		ID Prefix	F0325		09/24/2013		ID Prefix	F0371		09/24/2013
	483.25(h)					483.25(i)					483.35(i)		
LSC					LSC					LSC			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0431		09/24/2013		ID Prefix					ID Prefix			
-	483.60(b), (d), (e)				Reg. #					Reg. #			
LSC					LSC					LSC			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix			-		ID Prefix			
Reg. # LSC					Reg. # LSC					Reg. #			
					100					200			
Reviewed By	/ Review	ed I	Зу	Da	ite:	Signature o	of Surve	yor:				Date:	
State Agenc	GA	'as		1	1/13/1	3	186	518				10	)/22/13
Reviewed By	r Review	ed I	Зу	Da	ite:	Signature o						Date:	
CMS RO													
Followup to	Survey Completed on:						-				a Summary of		
	8/15/2013					Unc	orrecte	d Deficiencies	s (CM	S-2567) Sent	to the Facility?	YES	NO

#### **Post-Certification Revisit Report**

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

(Y1) Provider / Supplier / CLIA / Identification Number 245318	(Y2) Multiple Constru A. Building B. Wing	I BUILDING 01	(Y3) Date of Revisit 10/23/2013
Name of Facility		Street Address, City, State, Zip Code	
GOOD SAMARITAN SOCIETY - INTERNA	TIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 5664	9

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
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		_10/01/2013	ID Prefix		10/01/2013	ID Prefix			10/01/2013
•	NFPA 101	_	u u	NFPA 101			NFPA 101		
LSC	K0056		LSC	K0067		LSC	K0144		_
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #		_	Reg. #		-	Reg. #			
LSC		_	LSC						
		-							
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		_	ID Prefix		-	ID Prefix			
Reg. #		_	Reg. #			Reg. #			
LSC		-	LSC			LSC			_
		<b>0</b> //			<b>o</b> "				0
		Correction Completed			Correction Completed				Correction Completed
ID Prefix			ID Prefix		Completed	ID Prefix			
Reg. #			Reg. #						
LSC		-				LSC			
						<u> </u>			
		Correction			Correction				Correction
ID Prefix		Completed	ID Brofiv		Completed	ID Brofiv			Completed
		_			-				
Reg. # LSC		_	Reg. # LSC			Reg. #			
		-							
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:	1		Date:	
State Agency	PS/sd		11/13/2	0300	6			1	0/23/13
Reviewed By		Ву	Date:	Signature of Surve				Date:	
CMS RO									
Followup to	Survey Completed on:			Check for any	Uncorrected De	eficiencies. Was	a Summary of	•	
	8/14/2013			Uncorrecte	d Deficiencies (	CMS-2567) Sent	to the Facility?	YES	NO

#### **Post-Certification Revisit Report**

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

(Y1) Provider / Supplier / CLIA Identification Number 245318	.1	(Y2) Multiple Const A. Building B. Wing	ADDITION 02	(Y3) Date of Revisit 10/23/2013
Name of Facility			Street Address, City, State, Zip Code	
GOOD SAMARITAN SO	CIETY - INTERNATI	ONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56	649

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	(Y	5) Date	(Y4) Item	(Y5)	Date ()	r4) Item	(Y5) I	Date
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		10/01/2013			10/01/2013	ID Prefix		_
•	NFPA 101	_		NFPA 101		Reg. #		_
LSC	K0033	_	LSC	K0144				_
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix			ID Prefix			ID Prefix		_
Reg. #			Reg. #			Reg. #		
LSC		_	LSC			LSC		-
		Correction			Correction			Correction
		Correction Completed			Correction Completed			Correction Completed
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #			Reg. #		-			_
					-			_
		Correction			Correction			Correction
ID Prefix		Completed	ID Drofiv		Completed	ID Drofiv		Completed
		_			-	ID Prefix		_
Reg. # LSC		_	Reg. #		-	Reg. #		-
		_						_
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		_	ID Prefix		-	ID Prefix		_
Reg. #		_	Reg. #		-	Reg. #		_
LSC		_	LSC			LSC		_
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:		Date:	
State Agency	v PS/sc	1	11/13/1	03	006		10/2	23/13
Reviewed By	Reviewed	Ву	Date:	Signature of Surve			Date:	
CMS RO								
Followup to	Survey Completed on:			-		ficiencies. Was a Summ	•	
	8/14/2013			Uncorrecte	d Deficiencies (C	CMS-2567) Sent to the Fa	cility? YES	NO

#### State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00322	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/22/2013
Name	of Facility		Street Address, City, State, Zip Code	
GC	OD SAMARITAN SOCIETY - INTERNAT	IONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649	)

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) Ite	m	()	(5)	Date	(Y4	) Item		(Y5)		Date	(Y4)	ltem		(Y5) C	ate
				Correction					C	Correction					Correction
				Completed						Completed					Completed
ID Pr	efix	20565		09/24/2013		ID Prefix	205	90	_0	9/24/2013		ID Prefix	20830		09/24/2013
	•	MN Rule 4658.0405 Sub	p.	3		•	MN F	Rule 4658.0435 Subp.	1			•	MN Rule 4658.0	520 Subp.	1
L	SC					LSC			-			LSC			
				Correction					<i>с</i>	Correction					Correction
				Completed						Completed					Completed
ID Pr	efix	20905		09/24/2013		ID Prefix	209	65		9/24/2013		ID Prefix	21015		09/24/2013
Re	g. #	MN Rule 4658.0525 Sub	р.	4		Reg. #	MN F	Rule 4658.0600 Subp.	2			Reg. #	MN Rule 4658.0	610 Subp.	7
L	SC					LSC			_			LSC			-
				Correction					C	Correction					Correction
ID Pr	efix	21435		Completed 09/24/2013		ID Prefix	216	30		Completed 9/24/2013		ID Prefix	21805		Completed 09/24/2013
				-					_						_
	•	MN Rule 4658.0900 Sub	р.	1		0		Rule 4658.1350 Subp.	2	A.I		•	MN St. Statute		bd. t
					$\neg$				_		+-				-
				Correction					C	Correction					Correction
				Completed					C	Completed					Completed
ID Pr	efix	21830		09/24/2013		ID Prefix			_			ID Prefix			-
Re	g. #	MN St. Statute 144.651	Sul	bd. 1		Reg. #			_			Reg. #			_
L	.SC					LSC			-			LSC			-
				<b>o</b> "											
				Correction						Correction					Correction
ID Pr	efix			Completed		ID Prefix				Completed		ID Prefix			Completed
Re	g. #			-		Reg. #						Reg. #			_
	SC.					LSC			-			LSC			-
											+-				·
Reviewe	d By	Reviewe	dI	Зу	D	ate:		Signature of Surve	eye	or:				Date:	
State Ag	ency	GA/	sc	1		11/13/1	13	1	8	618				10/2	3/13
Reviewe	d By	Reviewe	d I	Зу	D	ate:		Signature of Surve	eye	or:				Date:	
CMS RO															
Followu	p to	Survey Completed on:			_			Check for any	<i>י</i> U	ncorrected D	)efic	iencies. Was	a Summary of		
		8/15/2013						Uncorrecte	ed	Deficiencies	(CM	S-2567) Sent	to the Facility?	YES	NO
STATE F	ORM	1: REVISIT REPORT	(5	i/99)				Page 1 of 1					Event ID: I	HFW012	



Protecting, Maintaining and Improving the Health of Minnesotans

November 13, 2013

Mr. Adam Coe, Administrator Good Samaritan Society - International Falls 1402 Highway 71 International Falls, Minnesota 56649

Re: Enclosed Reinspection Results - Project Number S5318022

Dear Mr. Coe:

On October 22, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 22, 2013, with orders received by you on September 6, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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.

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s)

cc: Licensing and Certification File

DEPARTMENT OF HEALTH A		SERVICES CARE/MEDICAI	D CERTIFIC	CATION A			EDICARE & ME	DICAID SERVICES
	PART I	- TO BE COMPI	LETED BY T	THE STAT	FE SURVE	EY AGENCY	1	Facility ID: 00322
1. MEDICARE/MEDICAID PROVIDER N (L1) 245318 2.STATE VENDOR OR MEDICAID NO. (L2) 004015100	Э.	<ol> <li>NAME AND ADI</li> <li>(L3) GOOD SAMA</li> <li>(L4) 1402 HIGHW</li> <li>(L5) INTERNATION</li> </ol>	ARITAN SOCI 7AY 71	ETY - INI		NAL FALLS (L6) 56649	<ol> <li>TYPE OF AC</li> <li>Initial</li> <li>Termination</li> <li>Validation</li> </ol>	TION: <u>2</u> (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	ERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGO	RY 09 ESRD	<u>02</u> 13 PTIP	(L7) 22 CLIA	7. On-Site Visit 8. Full Survey A	9. Other fter Complaint
<ol> <li>DATE OF SURVEY</li> <li>08/15/20</li> <li>ACCREDITATION STATUS: 0 Unaccredited</li> <li>1 TJC</li> </ol>	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF		FISCAL YEAR EN	DING DATE: (L35)
2 AOA 3 Other				-		-		
<ul> <li>11LTC PERIOD OF CERTIFICATION</li> <li>From (a): To (b):</li> <li>12.Total Facility Beds</li> <li>13.Total Certified Beds</li> </ul>	<b>54</b> (L18) <b>54</b> (L17)	Complianc 1. A X B. Not in Com		ram	2. 3. 4.	Approved Waivers Of Th Technical Personnel 24 Hour RN 7-Day RN (Rural SNF Life Safety Code <b>B</b> *	6. Scope of7. Medical	f Services Limit Director Room Size
14. LTC CERTIFIED BED BREAKDOWN					15. FACILI	ITY MEETS		
18 SNF 18/19 SNF 54	19 SNF	ICF	IID		1861 (e) (	(1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARKS	S (IF APPLICABL	E SHOW LTC CANCE	LLATION DATE	):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STAT	E SURVEY AGENCY A	APPROVAL	Date:
Jane Aandal. HFE NEII		0	9/16/2013	(L19)	Kate	JohnsTon, Sr. I	Program Speci	ialist 10/28/2013 (L20)
PAI	RT II - TO BE	COMPLETED	BY HCFA RI	EGIONAI	L OFFICE	OR SINGLE ST.	ATE AGENCY	
<ol> <li>DETERMINATION OF ELIGIBILITY</li> <li>1. Facility is Eligible to Participation</li> <li>2. Facility is not Eligible</li> </ol>	cipate (L21)		PLIANCE WITH HTS ACT:	CIVIL	21.	<ol> <li>Statement of Finar</li> <li>Ownership/Contro</li> <li>Both of the Above</li> </ol>	l Interest Disclosure Str	
22. ORIGINAL DATE	23. LTC AGREEM	ENT 24	. LTC AGREEM	IENT	26. TERM	MINATION ACTION:		(L30)
OF PARTICIPATION 06/01/1986	BEGINNING	DATE	ENDING DAT	Έ	<u>VOLUNTA</u> 01-Merger, 02-Dissatist		05-Fai	LUNTARY l to Meet Health/Safety l to Meet Agreement
(L24) 25. LTC EXTENSION DATE: 22	(L41) 7. ALTERNATI	/E SANCTIONS	(L25)		03-Risk of I	Involuntary Termination		-
(L27)		of Admissions:	(L44)		04-Other Ro	eason for Withdrawal		wider Status Change
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMAI	RKS		
	(L28)	00140		(L31)	Pos	ted 10/28/20	)13 CO.	
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION O	F APPROVAL D	ATE	H	FW0		

(L33)

DETERMINATION APPROVAL

(L32)

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 245318

At the time of the August 15, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

Facility ID: 00322



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5032

September 3, 2013

Mr. Adam Coe, Administrator Good Samaritan Society - International Falls 1402 Highway 71 International Falls, Minnesota 56649

RE: Project Number S5318022

Dear Mr. Coe:

On August 15, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

# DEPARTMENT CONTACT

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

Lyla Burkman Minnesota Department of Health 705 5th Street NW, Suite A Bemidji, Minnesota 56601 Telephone: (218)308-2104 Fax: (218)308-2122

#### **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 24, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 24, 2013 the following remedy will be imposed:

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

# PLAN OF CORRECTION (PoC)

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

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

Good Samaritan Society - International Falls September 3, 2013 Page 3

by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

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

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

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

# VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

Good Samaritan Society - International Falls September 3, 2013 Page 4

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 November 15, 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 February 15, 2014 (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

Good Samaritan Society - International Falls September 3, 2013 Page 5 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Good Samaritan Society - International Falls September 3, 2013 Page 6 Sincerely,

Colleen Feach

Colleen Leach, Program Specialist Licensing and Certification Program Division of Compliance Monitoring PO Box 64900 Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

STATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
				GSEP 1-6-2013	00/45/0040
		245318	D. WING N	STREET ADDRESS, CITY, STATE, ZIP CODE	08/15/2013
	PROVIDER OR SUPPLIER	- INTERNATIONAL FALLS	1	1402 HIGHWAY 71 INTERNATIONAL FALLS, MN 56649	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 000		S	F 00	response and plan of correction d constitute an admission or agreen	oes not nent by
	WILL SERVE AS YO COMPLIANCE UPO ACCEPTANCE. YO	OUR ALLEGATION OF ON THE DEPARTMENT'S UR SIGNATURE AT THE FIRST PAGE OF THE VILL BE USED AS		the provider of the truth of the fac alleged or conclusions set forth in statement of deficiencies. The pla correction is prepared and/or exe- solely because it is required by the provisions of federal and state law	cts 1 the an of cuted ie w. For
F 164	AN ONSITE REVIS BE CONDUCTED T SUBSTANTIAL CO REGULATIONS HA ACCORDANCE WI 483.10(e), 483.75(I)	MPLIANCE WITH THE S BEEN ATTAINED IN TH YOUR VERIFICATION. (4) PERSONAL	F 164	the purposes of any allegation that center is not in substantial complexity with federal requirements of participation, this response and p correction constitutes the center's allegation of compliance in accord with section 7305 of the State	iance Ian of
SS=E	The resident has the	ENTIALITY OF RECORDS e right to personal privacy and or her personal and clinical		Operations Manual.	9-21/-13
, , , , , , , , ,	Personal privacy inc medical treatment, v communications, pe meetings of family a	ludes accommodations, vritten and telephone rsonal care, visits, and nd resident groups, but this facility to provide a private ent.		<ul><li>F164</li><li>All resident nutritional information removed from the public dining removed from the public dining removed solution and solution and the solution of the</li></ul>	00ms /13 on
	section, the resident	n paragraph (e)(3) of this may approve or refuse the and clinical records to any e facility.		information in the public. The Director of Dietary Services/designee will complete r	YUC DK
t. R	and clinical records or resident is transferred	o refuse release of personal does not apply when the d to another health care release is required by law.		audits to monitor that resident nutritional information is not post publically and results to QA com- for further recommendation.	mittee 3D
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	Administrator G	(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 oblowing 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 lays 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.

		AND HUMAN SERV					INTED: 09/03/2013 FORM APPROVED 1B NO. 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIEF	web.		CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		245318	B. W	VING	······································		08/15/2013
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE,	ZIP CODE	
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F 164	Continued From pa	ge 1		F 164			, , ,
	contained in the res the form or storage release is required	ep confidential all info ident's records, regar methods, except whe by transfer to another n; law; third party pay dent.	dless of en				
,	by: Based on observat review, the facility fa nutritional information in the main dining ro- residents (R1, R9, F	IT is not met as evid ion, interview and doc ailed to ensure reside on was not visible to t oom. This affected 9 of R10, R20, R32, R41, I in the main dining roo	cument ent he public of 34 R42,				
	Findings include:			5 			
	at 5:20 p.m. a color observed posted on doors of the main di sides of the steam t 8/12/13, and were o	meal observations on coded seating chart v the wall next to the e ning room and also o able. The charts wen bserved to be visible visitors of the facility.	vas ntrance n both e dated				- - - - - -
	The chart mapped c assignments and als information:	out the table seating so identified the follow	ving				4
	R1 was to use an ac R9 was to use an ac to have straws. R10 was to use an a R20 was to use an a R32 was to use an a R41 was to use an a	laptive lip plate and w adaptive lip plate. adaptive lip plate. adaptive lip plate.	as not				
ORM CMS-256	7(02-99) Previous Versions (	Obsolete Eve	nt ID: HFW011	Facility	ID: 00322	If continuatio	n sheet Page 2 of 42

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		I AND HUMAN SERVICES				FORM	09/03/2013 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1000 No.		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245318	B. WING	i <u></u>		08/	15/2013
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F 164	Continued From page	ge 2	F 1	64			
	R42 was to have level			1			
	R46 was to have cu						
	R57 was to use an a	adaptive lip plate.		ļ			
		p.m. the certified dietary ted the color codes on the		•			
		ied the dietary needs of each					
		ditional notations such as "lip"					
r		uipment needed for the					
	resident such as a li	p plate.					
	During all days of th	e survey conducted on		10 		1	
		o.m. to 8:00 p.m. on 8/13/13,				8	
		30 p.m. on 8/14/13, from 7:00				1	
		d on 8/15/13, from 8:00 a.m.				1	
1		ating chart was observed to		1			
Ì		ed in the main dining room sidents and visitors to read.					
÷	visible to all stall, rea	sidents and visitors to read.		:		1	
-	The dietary services	policy entitled Confidentiality				İ	
		irected staff to maintain in		4			
		information as it related to		ł		i.	
		let number six indicated:		1		Ì	
	or other unauthorize	areas viewable to the public		÷		1	
	resident- specific info			3		i t	[
		sing adaptive feeding devices					
	- Lists of residents o	n thickened liquids and/or				1	
		ng resident on special diets				1) 1)	
	or protocols	nent annroaches used with					
	- any care and treath resident"	nent approaches used with					
1				23		÷	
		p.m. the CDM confirmed the		e P		1	
		led confidential, personal				1	
		g individual resident needs		1		1	
	auring meals. She s should be revised.	tated the seating charts		Ì			
B.	7(02-99) Previous Versions O	hsolete Event ID: HEW011		Eacilit	/ID: 00322	on aboat (	Page 3 of 42

		I AND HUMAN SERVICES			FORM	: 09/03/2013 APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		245318	B. WING	<u></u>	08	/15/2013
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GOODS	SAMARITAN SOCIETY	- INTERNATIONAL FALLS		1402 HIGHWAY 71 INTERNATIONAL FALLS, MN 5	6649	
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SS=D	REGULATORY OR LSC IDENTIFYING INFORMATION) 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve all residents seated at the same table their meal in succession for 1 of 5 meals observed. This affected 3 residents (R32, R9, R45) in the main dining room. Findings include: R32 did not receive his evening meal in succession with his table mate R9. During the supper meal on 8/12/13, at 5:40 p.m. homemaker (HM)-C was observed to begin serving the meal. The first plate was served to R9		F 2	<ul> <li>F241 By 9/24/2013, R32, R9, an with all other residents sea same table will be served in succession in a timely man provided the required assis their dining experience to r dignity. By 9/24/2013, education w provided to all staff regardimeals in succession, in a timely man and providing assistance nemaintain dignity. Random meals will be audi Director of Admissions &amp; F</li></ul>	ted at the neals in ner and be tance with naintain ill be ing serving nely manner ecessary to ted by the	1-24-13
	who was seated at a was observed to eat the other residents v and HM-B then bega in the dining room. A continued, HM-C an- serve the other table served within 5 minu homemakers served sitting with R9. At 5:55 p.m. R32 sto angrily. He began was The administrator en	a table with R32 and R45. R9 his meal independently while vaited for their meal. HM-C an serving the other residents As the meal service d HM-B were observed to as in succession (entire table ites.) Neither of the the two other residents od up from the table very alking away from the table. Icouraged R32 to sit down I. R32 yelled "no" and was ining room by the		Life/designee. Results will to the QA committee for fur recommendation.	be forwarded	

		AND HUMAN SERVICES				FOR	D: 09/03/2013 M APPROVED D. 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	the anticipation of the			(X3) DATE SURVEY COMPLETED	
		245318	B. WING			0	3/15/2013
	PROVIDER OR SUPPLIER	- INTERNATIONAL FALLS		14	REET ADDRESS, CITY, STATE, ZIP CODE 02 HIGHWAY 71 TERNATIONAL FALLS, MN 56649		
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F 241	Continued From pa administrator.	ge 4	F 2	41			
;	had received their n	dents in the main dining room neal. A room tray was not ed for R32 who had left the					
	At 6:50 p.m. all of th dining room had cor	e residents eating in the main npleted their meals.					
13 14 12	At 6:50 p.m. R32 was observed to be resting in his bed. R32 stated he had refused his meal because it took too long to be served so he left.						
5 3 4	11/2012, identified the providing a dignified directed staff to serve	Dignity policy revised on ne dietary staffs role in dining experience and re all residents at the table at esidents can eat together.		and the second second			
20	manager (CDM) stal	p.m. the certified dietary ted the dietary staff were to ents at the same time to dining experience.		ж К Ц			
		ed to receive dignified se with their meal service on					
	dated 5/10/13, indica	rly Minimum Data Set (MDS) ited R43 had a memory limited assistance of one					
(	6:07 p.m. Nursing as	ening meal on 8/12/13 at ssistant (NA)-K sat down sted the resident to eat the	2	· · ·			

Facility ID: 00322

If continuation sheet Page 5 of 42

	TMENT OF HEALTH							RINTED: 09 FORM AP	PROVED
STATEMEN	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S		1.12			01	MB NO. 09 (X3) DATE SU COMPLE	JRVEY
		24	5318	B. WING				08/15/	2013
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	nandersen anderen in der einen eine seinen anderen anderen anderen einen ein				*544.5.5*******	HIGHWAY 71			
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(X4) ID	SUMMARY STA	TEMENT OF DEFIC	CIENCIES	ID		PROVIDER'S PLAN	OF CORRECTION	. I	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECE	DED BY FULL	PREFI		(EACH CORRECTIVE A	ACTION SHOULD	BE CC	MPLETION
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				į					
F 241	Continued From pa	ge 5		F 2	241		•	1	
	meal starting at 6:23	3 p.m. (15 min	utes after the	1					
	meal was served) It	was noted that	at NA-K then		1			1	
	stopped feeding R4								
(94 (94	middle of assisting l								
	p.m. NA-K did not re				1				
	finish with eating the				1				
	NA-K returned to as				1				
	she did ask the resident if the food was still warm							1	
	and did not offer to				i			1	
	interviewed upon re			5					
	room and assisting								
	evening meal on 8/1							8 2	
,	which she stated that								
	R43 and leave the ta			ŝ	2			i !	
	who was requesting	immediate as	sistance to go	9	i			l r	
	to bed.				i				
								:	
	R43 was again obse			ſ	l L				
	meal on 8/14/13, fro				1			1	
	was brought to the c							1	
7	was not provided for							L	
	8:25 a.m. At 8:12 a.		and the second		1			İ	
	assistance to eat me							ι.	
	wait in excess of an				i			2 9	
	watching other resid							;	
	available to assist th				8			1	
	stated that she did n								
	these residents had				5				
	assistance with eatir							-	
	enough staff availab		s to provide						
	timely assistance wit	in eaung.	4 1		8				
i.	Povinu of the Distan	v convisos Dia	nity policy		1				
	Review of the Dietar				1				
	revised in 11/2012, c								
	quiet dining room, bu				1				
	the staff to try to stay				1			5	
	completion of the me	zai.						:	
	On 8/15/13, at 10:28	a.m. the direc	tor of nursing		e 5				
ORM CMS-256	7(02-99) Previous Versions C	bsolete	Event ID: HFW011	1	Facility ID	: 00322	If continuation	on sheet Pag	e 6 of 42

CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES		(	<u>DMB NO. 0938-03</u>
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.5 54	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245318	B. WING		08/15/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S.	AMARITAN SOCIETY	- INTERNATIONAL FALLS		1402 HIGHWAY 71 NTERNATIONAL FALLS, MN 56649	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETI
F 242	residents with their of interruptions as p dining experience.	age 6 staff were to assist the meals with the least amount possible to enhance a dignified ETERMINATION - RIGHT TO	F 241 F 242		
a 10	schedules, and hea her interests, asses interact with membrinside and outside to about aspects of his are significant to the This REQUIREMEN by: Based on interview facility failed to prov	e right to choose activities, alth care consistent with his or assments, and plans of care; ers of the community both the facility; and make choices s or her life in the facility that e resident. NT is not met as evidenced v and document review, the vide 1 of 3 residents (R56) the e choices about bathing		F242 On 8-15-13 R56 was interviewed on whether if she wanted a secon shower a week, it is documented resident denies making this reque states she gets washed up real go day. RN asked if she would like a second shower and she stated she if the staff have time. Second sho was added to R56's schedule each No records or interviews from stat indicate and support that the resid had requested a second shower.	d 9-29^ that est and od each would wer h week.
	Findings included: R56's diagnoses ind kidney disease. The dated 7/10/13, indic	cluded blindness and chronic e quarterly Minimum Data Set ated R56 had intact cognition sive staff assistance for		By 9-24-13 DNS/designee will id all residents able to make choices their bathing schedule. By 9/24/13 all staff will be educa the importance of providing choic about bathing frequency.	about ted on
	indicated R56 requi bathe. The POC als weekly bath on Satu Review of the past r	POC) dated 7/23/13, red assistance of one staff to to indicated R56 received a urday mornings. month's Bathing Report received weekly showers.		DNS/designee will perform rando audits to ensure residents have the opportunity to make choices abou bathing schedule. Results will be forwarded to QA committee for fu- recommendation.	t their

Facility ID: 00322

				RINTED: 09/03/2013 FORM APPROVED MB NO. 0938-0391	
T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<ul> <li>Proceeding of the second of the</li></ul>		(X3) DATE SURVEY COMPLETED	
	245318	B. WING		08/15/2013	
PROVIDER OR SUPPLIER	- INTERNATIONAL FALLS	1	402 HIGHWAY 71		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION	
Continued From pa	ge 7	F 242			
received a shower of have two showers w had recently express aide and was told th baths a week as the baths to give alread On 8/14/13, at 11:20	once a week and preferred to veekly. R56 also stated she sed this desire to the bath he staff could not provide two ere were already too many y. 6 a.m. registered nurse (RN)				
and confirmed R56 On 8/15/13, at 8:32 confirmed at the tim asked if they prefer however the freque Additionally, HL-A c quarterly assessme preference for frequ 483.15(f)(1) ACTIVI	received a weekly shower. a.m. household lead (HL)-A e of admission residents were ed a shower or a tub bath, ncy of bathing was not asked. onfirmed the resident nt did not address a resident's ency of bathing. TIES MEET	F 248	F248		
of activities designed the comprehensive the physical, mental of each resident. This REQUIREMEN by: Based on observati review, the facility fa individualized activity the needs for 2 of 3	d to meet, in accordance with assessment, the interests and , and psychosocial well-being T is not met as evidenced on, interview and document iled to provide an y program in order to meet residents (R41, R58)		On 6/14/13 R58's comprehensive activity assessment was completed based on a prior SNF's information care plan was written as the residen became agitated when interviewed assessment couldn't be completed attempts to reach the family were unsuccessful. On 8-19-13 data coll tool and social history was able to competed in conjunction with the resident's son. By 9/24/13 R41 wil receiving an individualized activity	n and nt and and ection be I be	
	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER AMARITAN SOCIETY SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From part On 8/13/13, at 3:47 received a shower of have two showers w had recently express aide and was told th baths a week as the baths to give alread On 8/14/13, at 11:20 -B provided a copy of and confirmed R56 On 8/15/13, at 8:32 confirmed at the tim asked if they preferr however the frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally, HL-A co quarterly assessment preference for frequent Additionally (HL-A co quarterly assessment preference for frequent Additionally (HL-A co quarterly assessment preference for frequent Additionally (HL-A co quarterly assessment preference for frequen	DF CORRECTION       IDENTIFICATION NUMBER:         245318         PROVIDER OR SUPPLIER         AMARITAN SOCIETY - INTERNATIONAL FALLS         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 7         On 8/13/13, at 3:47 p.m. R56 stated she currently received a shower once a week and preferred to have two showers weekly. R56 also stated she had recently expressed this desire to the bath aide and was told the staff could not provide two baths a week as there were already too many baths to give already.         On 8/14/13, at 11:26 a.m. registered nurse (RN) -B provided a copy of the unit's bath schedule and confirmed R56 received a weekly shower.         On 8/15/13, at 8:32 a.m. household lead (HL)-A confirmed at the time of admission residents were asked if they preferred a shower or a tub bath, however the frequency of bathing was not asked. Additionally, HL-A confirmed the resident quarterly assessment did not address a resident's preference for frequency of bathing. 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES         The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	RS FOR MEDICARE & MEDICAID SERVICES         TOF DEFICIENCIES         TOF DEFICIENCIES         OF CORRECTION         (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:         245318         B. WING         PROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES         (EACH DEFICIENCY WIDS BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX         Continued From page 7         FOR 8/13/13, at 3:47 p.m. R56 stated she currently received a shower once a week and preferred to have two showers weekly. R56 also stated she had recently expressed this desire to the bath aide and was told the staff could not provide two baths a week as there were already too many baths to give already.         On 8/14/13, at 11:26 a.m. registered nurse (RN) -B provided a copy of the unit's bath schedule and confirmed R56 received a weekly shower.         On 8/15/13, at 8:32 a.m. household lead (HL)-A confirmed at the time of admission residents were asked if they preferred a shower or a tub bath, however the frequency of bathing was not asked. Additionally, HL-A confirmed the resident quarterly assessment did not address a resident's preference for frequency of bathing.         483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES         The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.         This REQUIREMENT is not met as evidenced by: Based on observation, interview a	TMENT OF HEALTH AND HUMAN SERVICES       O         RS FOR MEDICARE & MEDICAID SERVICES       O         STORECTION       (x) PROVIDER SUPPLEXCUA         DECISIONCES       245318         DERUFFICATION NUMBER:       STREET ADDRESS, CITY, STATE, ZIP CODE         MARRITAN SOCIETY - INTERNATIONAL FALLS       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES       ID         REQULATORY OR LSC IDENTIFYING INFORMATION       PREVIDER'S FLAV OF CORRECTIVE ACTION SHOLD CROSS-REFERENCED TO THE APPROPH DEFICIENCY WING INFORMATION         Continued From page 7       F 242         On 8/13/13, at 3:47 p.m. R56 stated she currently received a shower once a weekk and preferred to have two showers weekly. R56 also stated she had recently expressed this desire to the bath aide and was told the staff could not provide two baths a week as there were already too many baths to give already.       F 242         On 8/15/13, at 8:32 a.m. household lead (HL)-A confirmed at the time of admission residents were asked if they preferred a shower or a tub bath, however the frequency of bathing was not asked. Additionally, HL-A confirmed the resident's preference for frequency of bathing.       F 248         The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.       F 248         This REQUIREMENT is not met as evidenced by:       This net met as evidenced by:       This net previde for a nongoing	

Facility ID: 00322

If continuation sheet Page 8 of 42

		AND HUMAN SERVICES				FORM	09/03/2013 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY PLETED
		245318	B. WING	<del></del>		08/15/2013	
	PROVIDER OR SUPPLIER	- INTERNATIONAL FALLS		14	REET ADDRESS, CITY, STATE, ZIP CODE 02 HIGHWAY 71 TERNATIONAL FALLS MN 56649		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFID TAG	-	TERNATIONAL FALLS, MN 56649 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	dementia. The ann dated 4/9/13, indica cognitive impairmer assistance for locor The MDS also indic preferences such as activities, going outs services were very i also indicated R41 I newspapers were su R41's quarterly MD had moderate cogni total staff assistance the facility and exter activities of daily livin identification of indiv The Activity Interest 4/29/11, indicated R included activities su worship services, go talking/conversing w educational televisio The quarterly Care ( 7/17/13, indicated R visits four times a we members visited and and cards. The plan of care (PC staff to invite R41 to	cluded depression and ual Minimum Data Set (MDS) ted R41 had moderate in and required total staff notion throughout the facility. ated R41's activity is music, news, group side and attending church important to her. The MDS had stated reading books and omewhat important to her. S dated 7/5/13, indicated R41 tive impairment and required with locomotion throughout hsive staff assistance with all ing (ADLs). The MDS lacked ridual activity preferences. Data Collection Tool dated 41's current interests uch as Bingo, Twins baseball, ing outside, animal visits, ith others and enjoying	F 2	48	<ul> <li>By 9/24/13 the Director of Admiss &amp; Household Life/designee will re all residents to ensure they have an receiving individualized activity program to meet their needs.</li> <li>Education will be provided to all s responsible for writing and implementing resident individualiz activity programs to meet their need the importance of completing and following each residents individual plan.</li> <li>Director of Admissions &amp; Househ Life/designee will perform random audits to ensure residents have an individualized activity plan writter followed. Results will be forwarde the QA committee for further recommendation.</li> </ul>	eview nd are staff zed eds on lized old n	

Facility ID: 00322

		HAND HUMAN SERVICES				PRINTED: 09/03/2013 FORM APPROVED OMB NO: 0938-0391	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCT		(X3) DATE SURVEY COMPLETED	
		245318	B. WING	Э		08/15/2013	
	PROVIDER OR SUPPLIER	- INTERNATIONAL FALLS		1402 HIGHWAY			
	····				NAL FALLS, MN 56649		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX (EACH	VIDER'S PLAN OF CORRECTI CORRECTIVE ACTION SHOUL REFERENCED TO THE APPRO DEFICIENCY	D BE COMPLETION	
F 248	Continued From pa	age 9	F	248			
	activity of Cash Bin	tivity calendar indicated an go would be held. R41 was eping in bed during this activ	ity.				
	a.m. there would be	tivity calendar indicated at 9: e morning coffee, at 2:30 p.n d be held followed by Keno a	n.				
	asleep in bed. The than 15 residents d snacks. The staff n assist R41 to the co members were obs from the main dinin room for Keno. R4 sleeping. At 3:30 p.	p.m. R41 was observed to la main dining room had less lrinking coffee and eating nembers were not observed offee party. At 3:00 p.m. state reved to assist the residents of room to the North dining t continued to be in bed m. seventeen residents were or dining room as R41 slept in	to ff				
	indicated at 9:30 a. would be held, at 1 conducted, at 2:30	a.m. the activity calendar m. a morning coffee time 30 p.m. nail salon would be p.m. there would be a coffee p.m. Catholic Mass would be					
	from the dining room observed to particip main dining room w residents (less than and 1-2 residents d	as observed to be wheeled m to her room. R41 was not bate in the coffee social. The vas observed to have a few n 10) finishing their breakfast rinking coffee. No formal am was observed in the dinit					
	(LPN)-C stated R41	5 a.m. licensed practical nur I usually did not participate in	<mark>۱</mark>		lé applique	ition sheet Page 10 of 42	
<b>URM CMS-25</b>	67(02-99) Previous Versions	Obsolete Event ID: HF	44011	Facility ID: 00322	II CONUNUS	aion aneer Faye TU UI 42	

	TMENT OF HEALTH							RINTED: 09/03/201 FORM APPROVE MB NO. 0938-039		
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S				ONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		24	5318	B. WING	3			08/15/2013		
NAME OF	PROVIDER OR SUPPLIER				STRE	ET ADDRESS, CITY, STAT	E, ZIP CODE	40.3 A AB		
GOOD S	AMARITAN SOCIETY	- INTERNATIO	NAL FALLS		1	HIGHWAY 71 RNATIONAL FALLS,	MN 56649			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED T DEFICIE	ACTION SHOULD	BE COMPLETION		
E 049		40		; ; ; ; ; ;	240					
F 248	Continued From pa	-		) F2	248					
	the morning coffee to go back to bed d				1			i i		
					)			1		
	On 8/14/13, at 1:40			1				3		
	leader (HL)-B stated			i ,						
	included providing a She stated the hom									
	included serving th				1					
	the dishes and prov									
	in addition to activiti		, ,		1					
	nell se eltre l'in 16 best 1				1					
	Review of R41's acl									
	8/15/13, revealed th				2					
	From 5/14/13 - 6/14 activities.	713, R41 partic	cipated in six		ł			E B I I		
	From 6/15/13 - 7/14	/13 R41 nartic	inated in seven		i					
	activities.	710, 1041 para	spared in oeven		1 1			1 2		
	From 7/15/13 - 8/14	/13, R41 partic	pipated in 12		32 19					
	activities.									
;	The documentation							<i>K</i> .		
(	participation identifie									
1	asleep, responding documentation did r				50 50					
	when a small group									
2	the topic of discussi				E .					
	responded to the dis				ŗ					
	documentation relat				ļ					
	and what type of act				10 20			1		
	during the one to on				ż					
ŝ	clinical record did no				:					
1	related to the types of	or activities col	npietea.		2					
	On 8/14/13, at 1:50	nm HI-R stat	ed she							
İ	reviewed the docum									
:	quarterly and could r									
1	needed. HL-B confir	med R41 was	not being		28 53			:		
	engaged in the activ	ities of interest	as directed by		а			1		
	the plan of care.				4		2			
ORM CMS-256	37(02-99) Previous Versions (	Obsolete	Event ID: HFW011		Facility II	D: 00322	If continuatio	n sheet Page 11 of 42		

								FORM	09/03/201 APPROVEI
STATEMEN	RS FOR MEDICARI	(X1) PROVIDER			TIPLE CONST		1	(X3) DATI	0938-039 E SURVEY PLETED
		2	45318	B. WING			08/15/2013		
NAME OF	PROVIDER OR SUPPLIER				STREET A	DDRESS, CITY, STATE, ZIP	CODE		
					1402 HIGI	HWAY 71			
GOOD S	AMARITAN SOCIET	- INTERNATIO	JNAL FALLS		INTERNA	ATIONAL FALLS, MN	56649		
(X4) ID PREFIX TAG			EDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CO EACH CORRECTIVE ACTIO OSS-REFERENCED TO TH DEFICIENCY)	n Should E appropr	BE	(X5) COMPLETION DATE
F 248	Continued From pa	ade 11		E 2	248				
		<b>T</b>	in a small droup	. 14				-	
	She added R41 had participated in a small group activity on 8/13/14, at 10:30 a.m. with homemaker (HM)-D.								
	·		;		I.				
	On 8/14/13, at 2:10 breakfast on 8/13/1	) p.m. HM-D s	tated after		Ê				
	the dining room an								
1	could not recall how				1				
i.	stated R41 was alert during the activity. HM-D								
:	stated it was difficu with activities beca								
	universal workers.							4	
	the day were used				4			1	
	noon meal, wash th				.,			3	
8	rooms and bathroo residents. She stat							i	
1	activities were com							1	
			!		4			ŗ	
	On 8/14/13, at 2:10 be providing nail ca				1			1	
1	Four residents were				ŕ				
	R41 was observed								
	0 0/11/0 10/5								
	On 8/14/13, at 2:15 life stated the activi							i.	
	completed by the h							i	
8) (1)	household leaders	were to assist	with the					3	
	activities. She state								
	a transition phase a participating in activ							5 22	
	the staff were not de							13	
0	stated R41's family	members visit	ed regularly but					-	
	the visits were not r	eflective in R4	1's record.		:				
•	The Non-Traditiona	Setting and A	sctivities noticy					9	
	dated 1/2010, identi				13 13 1911			5	
	homemaker role as	the staff mem	bers						
	responsible for prov							1	
	activities. The blend								
RM CMS-256	7(02-99) Previous Versions	Obsolete	Event ID: HFW011		Facility ID: 003	22 If (	continuation	sheet Pa	age 12 of 42

	TMENT OF HEALTH							INTED: 09/03/2 FORM APPROV 1B NO: 0938-03	/ED
STATEMEN		(X1) PROVIDER					r	(X3) DATE SURVEY COMPLETED	
		24	45318	B. WING				08/15/2013	
NAME OF I	PROVIDER OR SUPPLIER					SS, CITY, STATE, ZIP	CODE		
GOOD S	AMARITAN SOCIETY	- INTERNATIO	NAL FALLS		1402 HIGHWAY	NAL FALLS, MN	56649		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	(EACH	VIDER'S PLAN OF CO CORRECTIVE ACTIC REFERENCED TO TH DEFICIENCY)	N SHOULD E		
	Continued From paractivities to each reinterest. The activities were then to monitor ensure all residents activities. The facility's Compression (POC) Conference indicated the POC weresident issues/compresenting the bedirecting care. The dated 1/2009, indicated the POC were activity interests and program. R58 was not compression of the resident were the resident of the resident within the resident were activity interests and program. R58 was observed of 7:30 p.m.; 8/13/13 frand 8/14/13 from 7:11 which the resident were activity endered from the resident were and so the resident were activity endered from the resident were and so the resident were activity endered from the resident were allowed for the resident were activity endered from the resident were and participating in favor outside to get fresh a and participating in favor outside to get favor outside to get favor outside to g	sident' abilitie by director/hou or the activity p were receivir rehensive Car policy revised was driven by ditions and it is st approach to facility's Care ated the POC red/provided f ehensively as d provided an on 8/12/13 fro rom 2:16 p.m. 03 a.m. to 4:1 vas not observ ganized activi ged in leisure ided dementia try disease an OS dated 6/10 nitive impairn llowing activit aving books a c; listening to r pets; keeping vith groups of ite leisure act air when the v	sehold leaders orograms to ng individualized e Plan and Care 1/2011, identified s a tool o providing and Plan policy reflected the or the resident. sessed for ongoing activity m 5:00 p.m. to to 3:31 p.m.; 0 p.m. during ved to ties or activities. a, chronic d osteoporosis. /13, indicated nent. The MDS ies were "very and magazines music; being up with the people; ivities; going veather is good;	F 2	48				
<u> </u>	7(02-99) Previous Versions (		Event ID: HFW01	1	Facility ID: 00322	If	continuation	sheet Page 13 of	

		HAND HUMAN SERVICES				RINTED: 09/03/2 FORM APPRO MB NO. 0938-0	VED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245318	B. WING			08/15/2013	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS				STREET ADDRESS, CITY, STATE, 1402 HIGHWAY 71 INTERNATIONAL FALLS, M			10.0
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE COMPLET	TION
	completed. Ř58's in (e.g., favorite color, religious practices, assessed; the resid own choices, ambut wheelchair mobility, independent with th experience had not R58's POC dated 6/ "Alteration in sociality with behavioral distu- history of inappropri females." Intervention interests: resident fill family. He likes outdor (sports), bingo. Esco special events, outdor Review of the facility Involvement in the A 6/10, indicated the for assessment: 7. The participates in the Review of the Review of the Review of the facility involvement in the Review of the Re	esment was blank, not idividual activity preferences favorite activity, family, hobbies) had not been ents strengths (e.g., makes lates, independent with has own computer, e use of one hand); and work been assessed. 20/13, for activities indicated: zation related to dementia irbances manifested by a ate sexual behaviors towards ons included : "Independent kes to spend time with his oor activities, watching TV, ort to groups such as Bingo, oor activities." policy Activity Services dmission Process revised ollowing related to activity activity services department esident Assessment	F 248				
	sections of the Initial Collection Tool prior The Activity Interest initiated upon admiss the resident's initial of Develop an individua assessment informat or prior to the initial of						2 2
.     (		vho was responsible for the activity assessment stated		iliby ID: 00322			

Facility ID: 00322

If continuation sheet Page 14 of 42

		AND HUMAN SERVICES			RINTED: 09/03/2013 FORM APPROVED MB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second second second second second	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245318	B. WING		08/15/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS				STREET ADDRESS, CITY, STATE, ZIP CODE 1402 HIGHWAY 71 INTERNATIONAL FALLS, MN 56649	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
SS=E	she had not complete activity assessment agitated when appre- interests. She state and had asked him assessment but he non-clinical househ not attempted to ca provide input on the 483.20(k)(3)(ii) SEF PERSONS/PER CA The services provide must be provided by accordance with ea care. This REQUIREMEN by: Based on observation review, the facility fa interventions (alarm R36) according to the to provide timely rep (R26) as directed by individualized activities (R41) as directed by provide dietary inter- resident as directed by individualized activities (R41) as directed by individualized activities (R48's diagnoses inco- Alzheimer's disease The current POC data was at risk for falls a	<ul> <li>Ated R58's comprehensive because R58 had became bached about activity</li> <li>A she had called R58's son to assist with completing the had not done so. The old leader confirmed she had II R58's two daughters to residents activity interests.</li> <li>AVICES BY QUALIFIED INE PLAN</li> <li>A or arranged by the facility y qualified persons in ch resident's written plan of</li> <li>IT is not met as evidenced</li> <li>An, interview and document illed to implement fall</li> <li>S) for 2 of 3 residents (R48, he plan of care (POC); failed hositioning for 1 of 2 residents y the POC, failed to provide an y program for 1 of 3 (R58) by the POC.</li> </ul>	F 24		R26 is are eiving n per R58 is

Facility ID: 00322

If continuation sheet Page 15 of 42

TATEMEN	IT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
		245318	B. WING		0.01	46/2042
	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	08/	15/2013
		- INTERNATIONAL FALLS	1	402 HIGHWAY 71 NTERNATIONAL FALLS, MN 56649		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 282		ge 15 eep bed locked and in the low ne call light within reach.	F 282	As of 9/24/13 all current and n admitted residents care planned		
	* • • * *	3 a.m. R48 was observed to		personal alarm for a fall interve will be identified. As of 9/24/1 current and newly admitted res	3 all	
	attempt to sit up on clip fall alarm was o	the edge of the bed. The tabs bserved attached to R48's he alarm box was lying to the		having a pressure sore and who care planned for an individuality repositioning plan will be ident	om are zed	-
	right of R48's pillow sound when R48 sa the intervention to b	The bed clip alarm did not t on the edge which caused e ineffective. At this time the		By 9/24/13 the Director of Adr & Household Life/designee will all residents to ensure they are	nissions Il review	
		rsing assistant (NA)-A.		activities per their plan of care. 9/24/13 the Dietary Director/de	By signee	
0	6:57 a.m. until 8:53 seated in his wheeld	continuous observations from a.m. R48 was observed hair at the table in the main d not have his wheelchair clip		will review all residents with w loss below ideal body weight to nutritional interventions have b implemented. Education will be	ensure een	
:	observed to attempt nursing staff presen	ir. At 8:53 a.m. R48 was to stand up. There was no t in the dining room. At 8:54	E	provided to all staff responsible implementing resident individu activity programs to meet their	for alized	
94 19	again. At this time, H observed to approact	ved to attempt to stand up lomemaker (HM)-D was h R48 and asked him what		and the importance of completing following each residents individe plan of care. Staff responsible f	ng and lualized	
1	table. At 8:55 a.m. H	IND assisted R48 from the M-D as observed to assist I room and down the East In still off.		assessing and implementing nut needs per care plan will be educ 9-24-13 on the importance of do	ritional ated by	
	she had seen R48's	p.m. NA-C stated earlier bed clip alarm unhooked had attached the clip alarm		to attempt to minimize further v loss.	veight	
:	to R48's sock and we	ent to notify a nurse. NA-C n should be attached to the	ŝ			
	he had placed R48's	p.m. NA-A stated yesterday alarm box next to the pillow older box was not on the				

		AND HUMAN SERVICES				FORM	: 09/03/2013 APPROVED . 0938-0391	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245318	B. WING	;		08	/15/2013	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	SAMARITAN SOCIETY	- INTERNATIONAL FALLS			1402 HIGHWAY 71 NTERNATIONAL FALLS, MN 56649			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	clip alarm applied the At 12:53 p.m. regist alarm box should be RN-A also stated la clip alarm on R48's placed on the foot of stated she was not an alarm on the whe was a fall risk and the followed. On 8/15/13, at 9:06 R48 no longer used The facility failed to alarm in order to mine POC. R36's diagnoses inco- fractured ankle whice R36's POC dated 8/ personal clip alarm ( the resident stands) wheelchair. On 8/14/13, at 7:08 a in bed sleeping. The located on her table the clip alarm was not to a stable surface w On 8/14/13, at 7:39 a clip alarm had not be was lying in bed. NA alarm had been sittir On 8/15/13, at 8:25 a POC directed staff to on when in bed or th	erified R48 did not have his	F2	282	On 8/13/13 and 8/14/13 staff inv incidents were educated on the importance of placement of perso alarms for those persons care pla for fall interventions. As of 9/24/ staff will be educated on the impo of placement of personal alarms those persons care planned for fa interventions. On 8/13/13 & 8/14 nursing staff providing care to R2 educated on the importance of tim repositioning and following the individualized plan of care. By 9/ all nursing staff will be educated importance of timely repositionin accordance with the plan of care those persons with a pressure ulc Audits will be completed to insu those residents having a personal as a fall intervention are having t place in accordance with the plan care. Audits will be completed 22 weekly for four weeks. DNS/des will complete audits to insure that residents with a pressure ulcer are repositioned in accordance with t individualized plan of care. Audit be completed 2x weekly for four Director of Admissions & House. Life/designee will perform randon audits to ensure residents have an individualized activity plan written	onal nned 13 all ortance for II /13 26 were hely 24/13 on the ng in for er. re that alarm hem of c gnee t those e heir ts will weeks. hold m		

Facility ID: 00322

		AND HUMAN SERVICES				FORM	09/03/2013 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	the second second second		ONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245318	B. WING	3		08/	15/2013
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP COD		
GOOD S	AMARITAN SOCIETY	- INTERNATIONAL FALLS			HIGHWAY 71 ERNATIONAL FALLS, MN 5664	19	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	as directed by the F R26's POC dated 7, repositioning every wheelchair and eve On 8/13/13, during 6 2:30 p.m. until 4:20 remain seated in he repositioning assists stated R26 was last total of two hours ar time NA-I was obse On 8/14/13, at 1:30 POC directed staff t every 1.5 hours whil stated R26 should h POC directed. R41 did not receive program as directed R41's POC dated 7/ R41 to activities and activities program 2- During the survey co 4:00 p.m. to 8:00 p.r to 4:00 p.m. on 8/14 p.m. and on 8/15/13 R41 was not observ- organized activities pro-	assistance with repositioning POC. /3/13, directed staff to assist 1.5 hours while in the ry 2 hours while in bed. continuous observations from p.m. R26 was observed to er wheelchair without ance. At 4:15 p.m. NA-I repositioned at 1:40 p.m. a nd 40 minutes earlier. At this rved to assist R26 to stand. p.m. RN-C verified R26's to assist with repositioning le in the wheelchair. RN-C have bee repositioned as the an individualized activity I by the plan of care. (17/13, directed staff to invite I to have R41 participate in -3 times per week. onducted on 8/12/13, from m. on 8/13/13, from 8:00 a.m. /13, from 7:00 a.m. to 3:30 , from 8:00 a.m. to 12:00 p.m ed to participate in any of the provided by the facility.			followed. Dietary Director/d complete weekly random aud beginning Sept.1 <sup>st</sup> on residen weight loss below ideal body ensure their nutritional needs assessed and interventions an implemented per plan of care results will be forwarded to t committee for further recomm	dits tts with weight to have been e being a. Audit he QA	
8	8/15/13, revealed the	ivity log from 5/14/13 - e following information: /13, R41 participated in six		;			
ORM CMS-256	7(02-99) Previous Versions (	Obsotete Event ID: HFW0	011	Facility II	D: 00322 If contin	nuation sheet P	age 18 of 42

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CONTRACTOR STOCKS		AND HUMAN SERVICES			FORM	): 09/03/2013 1 APPROVED ). 0938-0391		
INTERVISE COOPERTION			Contraction of the second second			(X3) DATE SURVEY COMPLETED		
		245318	B. WING		- 08	/15/2013		
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS				STREET ADDRESS, CITY, STA 1402 HIGHWAY 71 INTERNATIONAL FALLS	TE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED	NOF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE		
	activities. From 7/15/13 - 8/14 activities. On 8/14/13, at 1:50 leader HL-B confirm engaged in the activithe plan of care. R58 was below idea weight loss since ac consistently provide according to the PO R58 had diagnoses limited to: dementia pulmonary disease The POC dated 6/19 interventions related Enlive juice (a high p times a day; Fortifie times a day; Diet reg be fed by feeding as chocolate; tootsie ro gastritis. During continuous o 7:03 a.m. to 12:51 p breakfast meal nor o p.m. in which R58 w On 8/14/13, at 9:06 usually not offered th R58 generally slept	<ul> <li>I/13, R41 participated in seven</li> <li>I/13, R41 participated in 12</li> <li>p.m. household non clinical hed R41 was not being vities of interest as directed by</li> <li>al body weight; had ongoing dmission and was not d weight loss interventions of that included, but were not chart included, but were not chart included, but were not chart included, but were not chart included the following to weight loss that included: brotein supplement) three d foods; Supplements three gular level 4 thin liquids; May sistant; enjoys candy vills; medication as needed for</li> <li>bservations on 8/14/13, from .m. R58 was not offered the offered any food until 12:22 as offered the noon meal.</li> <li>a.m. NA-J stated R58 was he breakfast meal because in until after 10:00 a.m.</li> </ul>	F 2					
		only offered the noon meal	1	Facility ID: 00322	If continuation sheet	Page 19 of 42		

	TMENT OF HEALTH							RINTED: 09 FORM AP /IB NO. 09	PROVED
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO	PPLIER/CLIA		TIPLE CONSTRU			(X3) DATE SU COMPLE	
- - - -		2453	318	B. WING				08/15/	2013
NAME OF I	PROVIDER OR SUPPLIER					RESS, CITY, STATE, ZIP	CODE		
GOOD S	AMARITAN SOCIETY	- INTERNATION	AL FALLS		1402 HIGHW	AY 71 ONAL FALLS, MN	56649		
(X4) ID PREFIX TAG		TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INF	ED BY FULL	ID PREFI) TAG	(EA0	ROVIDER'S PLAN OF CC CH CORRECTIVE ACTIO S-REFERENCED TO THE DEFICIENCY)	n Should i E appropr	BE CC	(X5) DMPLETION DATE
F 282	Continued From pa	ge 19		F 2	82				
	which was served a	t 11:30 a.m.		:	4 : : ;				
	On 8/14/13, at 12:2: be served squash, a and sweet potatoes squash to increase did not receive the f Further review of the revealed that there interventions that ac the breakfast meal of The residents suppl reviewed from 8/1/1 noted the resident h calorie nutritional sup any of the days. The supplements three t care plan on 2 of the one nutritional supp and there are no hig recorded as offered On 8/15/13, at 10:37 manager (CDM) cor interventions related the breakfast meal of verified R58 was no and supplements as	a pork chop, dic Butter was add caloric intake, h ortified mashed e care plan date is no care plan ddressed the res daily. ement intake re 3-8/14/13, durin ad not been offe pplements 3 tim e resident had b imes a day acco e 14 days; had b lement on 5 of th h caloric supple on 7 of the 14 c firmed R58's Pi to R58 repeate daily. Additionally t provided with f	ed potatoes led to the owever, R58 potatoes. ed 6/19/13, ed sident missing cords were g which it was ered high nes a day on een offered ording to the peen offered he 14 days; ments lays. ed dietary OC lacked dly missing y, The CDM ortified foods			·			
	Conference policy re the POC created by issues/conditions an directed the best ap directing care. The facility's Care P	identified reside d it was used as proach to provid	nt s a tool which ing and						
DRM CMS-256	7(02-99) Previous Versions (	)bsolete	Event ID: HFW01	1	Facility ID: 00322	lf r	continuation	n sheet Page	20 of 42

			(VO) MULT	PLE CONSTRUCTION		E SURVEY
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<ul> <li>A 107 march 1000</li> </ul>	G		PLETED
		245318	B. WING	and the second second second second second second second second second second second second second second second	08/	15/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INTERNATIONAL FALLS		1402 HIGHWAY 71 INTERNATIONAL FALLS, MN 56649		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 282	Continued From pa	ge 20	F 28	2:		
		eflected the care currently		45 45 55		ic N
F 314 SS=D	483.25(c) TREATM PREVENT/HEAL P	ENT/SVCS TO	F 314	<b>4</b> .		
	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.			<ul><li>F314</li><li>As of 8/14/13 R26 is being reported according to care plan.</li><li>As of 9/24/13 all current and new admitted residents having a pression sore and whom are care planned individualized repositioning plantidentified.</li></ul>	wly sure for an	7-24-1
	by: Based on observat review, the facility fa assistance for two h	IT is not met as evidenced ion, interview and document ailed to provide repositioning iours and forty minutes for 1 reviewed with a pressure		On 8/13/13 & 8/14/13 nursing st providing care to R26 were educ the importance of timely repositi and following the individualized care. By 9/24/13 all nursing staff educated on the importance of tin repositioning in accordance with plan of care for those persons with pressure ulcer.	ated on oning plan of will be nely the	
	muscle mass), failur status post amputat tips, status post colo decline in health cor Minimum Data Set ( indicated R26 had n impairments and red with all activities of c indicated R26 had a	luded cachexia (loss of re to thrive, malnutrition, ion/gangrene of the finger on cancer, diabetes and a ndition. R26's quarterly MDS) dated 6/23/13, noderate cognitive quired extensive assistance laily living. The MDS also n unstageable pressure ulcer. Care Area Assessment		DNS/designee will complete aud insure that those residents with a pressure ulcer are repositioned in accordance with their individuali plan of care. Audits will be comp 2x weekly for four weeks with re reported to QA for further recommendations.	zed leted	

		I AND HUMAN SERVICES					FORM	: 09/03/2013 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION			E SURVEY IPLETED
		245318	B. WING				08/	15/2013
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CC	)DE	10 - FOILMA	
GOOD S	AMARITAN SOCIETY	- INTERNATIONAL FALLS			402 HIGHWAY 71 NTERNATIONAL FALLS, MN 56	649		0. 100
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
	the facility with an u coccyx/buttocks. The was educated on the refusals to get out of Cognitive Loss / De- indicated R26 was a debilitated state with hand fingers related autoamputations. R26's plan of care ( R26 had moderate of alteration in health se weight, failure to the to gangrene and a co- diabetes. The POC impaired skin integre muscle weakness, re- malnutrition. The POC been educated on the repositioning. Additi- refused any vascular arterial ulcers. The F R26 with repositioning the wheelchair and of The Positioning Ass dated 4/3/13, indicated facility with a coccyx also indicated R26 w related ulcers due to refusal to get out of R26 was educated of risk versus benefits assessment concluor repositioned every 1	cated R26 was admitted the nstageable ulcer on the ne CAA also indicated R26 e risks versus benefits of of bed and repositioning. The mentia CAA dated 4/1/13, admitted from the hospital in a n open lesions on left and right to gangrene with POC) dated 7/3/13, indicated cognitive impairment, status related to decreased ive, open wounds secondary lecline in condition and indicated R26 was at risk for ity related to weight loss, metabolic alteration and DC also indicated R26 had he need for frequent onally, the POC indicated R26 ir diagnostic work up for POC directed staff to assist ng every 1.5 hours while in every 2 hours while in bed. essment and Evaluation form ted R26 was admitted to the pressure ulcer. The form vas at high risk for pressure o health co-morbidities and bed. The form also indicated on skin integrity as well as the of repositioning. The led R26 was to be .5 hours while in the	F 3	314	DEFICIENCY)			
- 1999 - 1990	wneelchair and ever	y two hours while in bed.						

		AND HUMAN SERVICES			PRINTED: FORM A OMB NO. (	PPROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	15. 2.256	PLE CONSTRUCTION G	(X3) DATE COMP	
		245318	B. WING		08/1	5/2013
	PROVIDER OR SUPPLIER	- INTERNATIONAL FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 HIGHWAY 71 INTERNATIONAL FALLS, MN 56649		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	Continued From pa	ne 22	F 314	1		
	The Initial Interdisci dated 4/7/13, indica	plinary Data Collection Tool ted R26 was admitted to the ntimeter (cm) by 1.5 cm			-	
	dated 7/2/13, indica which increased the of pressure ulcers. continued to have tw improved from four, concluded R26 was	eessment and Evaluation form ted R26 had chronic diarrhea risk for further development The form also indicated R26 vo pressure ulcers which was previously. The assessment to be repositioned with staff irs while in wheelchair and in bed.				
	Risk dated 7/10/13,	or Predicting Pressure Sore indicated R26 was at high nent of pressure sores.				
	7/13/13, indicated th	Progress Notes dated e coccyx wound was healed. ndicated the wound had				
2	coccyx wound indica	neets last entry related to the ated the wound was healed vere no further notes related		×		
	wheel herself into th She remained in the which time R26 was room for an activity ( observed to remain 4:10 p.m. at which ti her room. At no time	p.m. R26 was observed to e dining room for coffee time. dining room unit 3:10 p.m. at assisted to the North dining Keno card game). R26 was in the North dining room until me she was assisted back to e during the activities was assisted or encouraged to				

		I AND HUMAN SERVICES & MEDICAID SERVICES					FORM A	09/03/2013 PPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ALL PRESSOR	TIPLE CONSTRUC		I	(X3) DATE COMPI	SURVEY
		245318	B. WING				08/1	5/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRI	ESS, CITY, STATE, ZIP CO	DDE		
GOOD S	AMARITAN SOCIETY	- INTERNATIONAL FALLS		1402 HIGHWA	NY 71 ONAL FALLS, MN 56	649		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACI	OVIDER'S PLAN OF CORF H CORRECTIVE ACTION S REFERENCED TO THE A DEFICIENCY)	SHOULD I	BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 23	F 3	14				
	stated she had arriv and R26 had been if checked the compu- documentation and assisted with reposi- On 8/13/13, at 4:20 the west shower roo while holding onto th was able to stand for seconds and stood assistance of NA-I. at that time. R26's v equipped with a pre- NA-I confirmed R26 repositioning at 1:40 40 minutes earlier. On 8/14/13, at 8:40 receive morning car area was observed to bandage over the co On 8/14/13, at 1:10 completed wound ca While removing the coccyx wound had b an open area on her However, upon remo- reported R26's cocc RN-C stated she wa wound had reopened	p.m. NA-I assisted R26 into om and cued her to stand he railings on the wall. R26 or 20 seconds, sat for 20 again for 20 seconds with the NA-I did not check R26's skin wheelchair was observed ssure redistribution cushion. had last been assisted with p.m. a total of 2 hours and a.m. R26 was observed to es by NA-C. R26's coccyx to have a large intact occyx area. p.m. registered nurse (RN)-C are on R26's coccyx region. dressing, RN-C reported the een healed but R26 still had left ischial tuberosity. oving the old dressing RN-C yx wound had reopened. s unaware of when the d. The wound measured 2.5 mall amount of yellow slough						
×.,	0-04440 -1400	DN 0		1			-	
	On 8/14/13, at 1:30 p 7(02-99) Previous Versions C	D.m. RN-C verified R26 was Event ID: HFW011		Facility ID: 00322	16		1	ne 24 of 42

		AND HUMAN SERVICES			PRINTED: 09/03/2013 FORM APPROVED OMB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245318	B. WING		08/15/2013
	PROVIDER OR SUPPLIER	- INTERNATIONAL FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 HIGHWAY 71 INTERNATIONAL FALLS, MN 56649	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 323	when in the wheelc The Pressure Ulcer Prevention policy at 1/2012, stated : "Re reposition themselv repositioned as ofte approaches." 483.25(h) FREE OF HAZARDS/SUPER' The facility must en environment remain as is possible; and	repositioning every 1.5 hours hair as the POC directed. Skin Assessment and nd procedure updated on esidents who are unable to es independently should be an as directed by the care plan	F 314		vly for a
	by: Based on observat review, the facility fa interventions (alarm R36) as directed by (POC). Findings include: R48's diagnoses ind and Alzheimer's dis The initial Minimum indicated R48 had a admission. The Fall	NT is not met as evidenced ion, interview and document ailed to implement fall is) for 2 of 3 residents (R48, the individual plan of care cluded a fractured right femur ease. Data Set (MDS) dated 3/4/13, history of falls prior to Care Area Assessment dated 48 was at high risk for falls.		On 8/13/13 and 8/14/13 staff invincidents were educated on the importance of placement of personal alarms for those persons care plat for fall interventions. As of 9/24, staff will be educated on the imp of placement of personal alarms those persons care planned for fat interventions. Audits will be completed to insut those residents having a personal as a fall intervention are having to place in accordance with the plate care. Audits will be completed 2 weekly for four weeks with result for further recommendations.	onal nned /13 all ortance for dl re that l alarm hem n of x

		AND HUMAN SERVICES				FORM	: 09/03/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1				re Survey Mpleted
		245318	B. WING	i		08/	/15/2013
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S.	AMARITAN SOCIETY	- INTERNATIONAL FALLS			402 HIGHWAY 71 NTERNATIONAL FALLS, MN 56649		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 25	E:	323			
		dated 5/31/13, indicated R48					
		e impairment, was non d extensive staff assistance					•
		fallen since last assessment			1		
	was at risk for falls implement the follow pillows when in bed	dated 6/12/13, indicated R48 and directed staff to wing fall interventions: 2 body , TABs alarm to bed and sition and locked, and call					
	0	ection Tool dated 6/4/13, at high risk for falls.					
	a.m. indicated R48 on the left side of th	t (IR) dated 5/26/13, at 5:45 was found lying on the floor e bed. The IR also indicated was laying on the bed but was					
: : :	found lying on the fl TAB alarm string ap did not separate to a	3:00 a.m. indicated R48 was oor. The IR also indicated the opeared too long as the string activate the alarm. The alarm IR also indicated two body blace.					
	attempt to sit up on TABs clip alarm was sweater, however, the the bed, to the right a permanent surface sound when R48 sa which caused the in	3 a.m. R48 was observed to the edge of the bed. The s observed attached to R48's he alarm box was lying on of R48's pillow not affixed to e. The bed clip alarm did not t on the edge of the bed tervention to be ineffective. At or notified nursing assistant					

Facility ID: 00322

If continuation sheet Page 26 of 42

		AND HUMAN SERVICES				RINTED: 09/03/2013 FORM APPROVED		
STATEMEN	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		AB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		245318	B. WING			08/15/2013		
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, (	CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- INTERNATIONAL FALLS	1402 HIGHWAY 71 INTERNATIONAL FALLS, MN 56649					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH COF	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD I RENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 323	Continued From pa	ge 26	F 3	23				
	seated in the wheel dining room. R48 d alarm on the chair. this time until 8:55 a At 8:53 a.m. R48 w stand up from the w	a.m. R48 was observed chair at a table in the main id not have his wheelchair clip Continuous observation from a.m. revealed the following: as observed to attempt to wheelchair and then sit back	E : : :					
	dining room. At 8:54 a.m. R48 wastand up again. Hor observed to approa	o nursing staff present in the as observed to attempt to nemaker (HM)-D was ch R48 and asked him what At this time HM-D assisted						
	R48 away from the his wheelchair, with the dining room.	table and R48 self propelled his feet towards the middle of was observed to wheel R48						
	out of the dining roo	m and down the East hallway.						
e		assistant (NA)-B was 148 into the bathroom.						
	back into the wheeld was observed to atta	vas observed to transfer R48 chair and then into bed. NA-B ach the The TAB clip alarm to m box holder was attached to (HOB).		2				
1	should be attached t the bed (FOB). NA-0 had seen R48's bed R48's shirt therefore	p.m. NA-C stated the alarm o either the HOB or foot of C also stated previously she clip alarm unhooked from , she had attached the clip and notified the nurse.						
DRM CMS-256	7(02-99) Previous Versions (	Dbsolete Event ID: HFW01	1	Facility ID: 00322	If continuation	sheet Page 27 of 42		

		I AND HUMAN SERVICES				RINTED: 09/03/2013 FORM APPROVED MB NO. 0938-0391	
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245318	B. WING			08/15/2013	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY	, STATE, ZIP CODE	Line in the second second second second second second second second second second second second second second s	
GOOD S	AMARITAN SOCIETY	- INTERNATIONAL FALLS	1402 HIGHWAY 71 INTERNATIONAL FALLS, MN 56649				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	ID PREFI TAG	K (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION	
	he had to lay the ala because the holder the bed. NA-A state was attached to the had noticed that R4 applied this a.m. N/ a.m. cares for R48. On 8/14/13, at 12:53 -A stated the alarm attached to the HOE had trialed the clip a therefore, the alarm RN-A stated typicall alarm box for the wh did not have to mov the chair. Additional aware R48 did not h wheelchair. RN-A ve the POC had not be On 8/15/13, at 9:06 have a wheelchair a admitted and also us NA-B stated since th used she thought the longer being used si wheelchair. The Facility's policy revised 10/08, indica ensure that staff are alarm system. R36 had a history of	5 p.m. NA-A stated yesterday arm box next to R48's pillow for the alarm box was not on id today the alarm holder box HOB. NA-A also stated he 8 did not have his clip alarm A-A stated NA-B had provided 3 p.m. registered nurse (RN) box should have been 3. RN-A stated last week they alarm on R48's sock, box was placed on the FOB. y they would have a separate neelchair and the bed so staff e the alarm from the bed to ly, RN-A stated she was not lave an alarm on the erified R48 was a fall risk and	F3	23			
	POC. 7(02-99) Previous Versions C	Dosolete Event ID: HFW011	andra ta ta a	Facility ID: 00322	If continuation	n sheet Page 28 of 42	

		AND HUMAN SERVICES				FORM	09/03/2013 APPROVED 0938-0391
STATEMEN'	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2000-000.040200.00000000000		CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245318	B. WING	·		08/	15/2013
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INTERNATIONAL FALLS			02 HIGHWAY 71 TERNATIONAL FALLS, MN 56649		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 28	F3	323			
	(decrease in heart f diabetes, hypertens osteoporosis, catara accident (stroke) ar was surgically repai R36's annual MDS was cognitively inta- walking, toileting an significant change M R36 was moderatel demonstrated a dec increased staff assis R36's current POC place a TABs perso in bed or wheelchaid R36's Fall Data Coll indicated R36 was a R36's Mobilization S dated 8/8/13, indica any weight on her le assist to transfer Review of R36's IR's IR dated 8/4/13 at 6 responded to R36's found on the bathroo The report also indic however no apparer indicated immediate to prevent future fall	dated 4/30/13, indicated R36 ct and independent with d transferring. R36's /DS dated 8/13/13, indicated y cognitively impaired, which cline in cognition and required stance for mobility. dated 8/5/13, directed staff to onal clip alarm on R36 when					

		AND HUMAN SERVICES				NTED: 09/03/2013 FORM APPROVED B NO, 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.2.2	LTIPLE CONSTRUCTION	¢	X3) DATE SURVEY COMPLETED
		245318	B. WING	۱ <u></u>		08/15/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CH	TY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- INTERNATIONAL FALLS		1402 HIGHWAY 71 INTERNATIONAL F	ALLS, MN 56649	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORR	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)	
	responded to R36's on the floor next to I position. The report Ted support hose of Additionally, the rep- incontinent of urine increased confusion immediate interventi educate R36 not to support hose on fee footwear and directe offer help when goin IR dated 7/30/13, at found sitting on the f indicated R36 stated her and no apparent indicted immediate in consisted of : ask R sugar (BS) was low i However, R36's BS y the staff provided R3 crackers which incre IR dated 6/13/13, at observed walking up step R36's leg/knee on the first and secon injury. Immediate inte- included to educate F versus using the step IR dated 2/20/13, at 4 found sitting on the fl complained of her ha ndicated R36 sustair and left hands and a	t 3:20 a.m. indicated staff call for help and found R36 her closet in the prone also indicated R36 had only n her feet. No apparent injury. ort indicated R36 was at the time of the fall with noted. The report indicated ions put into place was to get up or walk with only t without proper gripper type ed staff to check R36 and ig to bed. 4:02 a.m. indicated R36 was loor in own room. The report her legs had buckled under injuries. The report also nterventions put into place 36 if she thought her blood in which R36 denied. was found to be 52 in which 86 with orange juice and ased BS to 119 at 5:45 a.m. 9:40 a.m. indicated R36 was bus steps which on the first buckled and R36 crouching nd steps with no apparent erventions put into place R36 on use of the bus lift	F3	323		
						<u>.</u>

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								FORM A	)9/03/2013 PROVED
STATEMEN	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER	USUPPLIER/CLIA	Contract - State and State and State	TIPLE CONSTRUC		01	(X3) DATE S COMPL	
		2	45318	B. WING				08/15	/2013
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRE	SS, CITY, STATE, ZI	P CODE		
GOOD S	AMARITAN SOCIETY	- INTERNATIO	ONAL FALLS	1402 HIGHWAY 71 INTERNATIONAL FALLS, MN 56649					
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFI) TAG	(EACH	DVIDER'S PLAN OF C I CORRECTIVE ACTIV REFERENCED TO TH DEFICIENCY	on Should He Appropr	BE C	(X5) COMPLETION DATE
	Continued From par R36 to wear shoes. IR dated 11/24/12, a had reported she ha bag and had fallen h report indicated R36 herself back up and indicated no appare also indicated imme included to add a ho R36 to hang her line prevent R36 from pl report also indicated and fall interventions however, indicated f maintain independen IR dated 11/22/12, a responded to the so found R36 lying on h stretched under walk sustained a 2.0 inch the back of her head required emergency consisted of placeme of the head. While al was diagnosed with and found to be hypo indicated the immedi place consisted of Ba UTI, add an evening dose of Lantus insul The report also indicated to request	at 7:30 p.m. ir ad tripped over backwards. H 5 stated she h sat on the co ont injuries not ediate interver bok to the close en bag in the r acing it on the trisk versus to s discussed w R36 refused of nce. at 12:05 a.m. i und of a loud her back on the ker. The report (in.) X 1.5 in. I. The report i room treatme ent of two sta t the emerger a urinary trac- polycemic. The iate interventi actrim X seve snack, decre in to prevent ated R36 was staff assistar	er her dirty linen owever, the had gotten buch. The report ted. The report ted. The report ted. The report ted. The report ted. The report ted. The report for more for room in order to e floor. The benefits of falls vith R36 due to desire to indicated staff thump and te floor with legs rt indicated R36 contusion to ndicated R36 ent which ple to the back ney room R36 t infection (UTI) re report ons put into en days for the ase the evening hypoglycemia. e educated and nee and not to	F 3	23				
ļ	mobilize when feeling IR dated 11/16/12, a	it 3:00 a.m. in	dicated when		1				
	staff responded to R3 7(02-99) Previous Versions O		Event ID: HFW011	F	acility ID: 00322	1f	continuation	sheet Page	31 of 42

		AND HUMAN SERVICES				FORM	: 09/03/2013 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.		E CONSTRUCTION		IE SURVEY MPLETED
•		245318	B. WING	. <u></u>		08/	/15/2013
NAME OF I	PROVIDER OR SUPPLIER			1000	REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INTERNATIONAL FALLS			02 HIGHWAY 71 TERNATIONAL FALLS, MN 56649		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 31	F 3	323			
	on the floor next to	the bed. R36 stated she had	6 15				
		ne report indicated R36 elbow scrape. In addition, the		E K			
	report indicated imr	nediate interventions put into	с. 1	1			
		ducate R36 and staff to	1		2		
5 <b>1</b>	to prevent roll onto	r to wall when lying left sided floor.					
				e. C			1
3	Nurse's Note (NN)	dated 7/30/13, indicated R36		I			2.7
	had complained of	left ankle soreness, however,	-				
25 (1	R36 had demonstra	ated ability to bear own weight.		ļ			
1	NN dated 7/31/13, i	ndicated R36 had denied pain		Ì			
	and confusion.			!			
19	NN dated 8/1/13, in	dicated R36 stated the left		11			
		roved and therefore R36		94 94			
	declined to be seen	by the physician.		63			
		dicated R36 had complained					1
9 2	<ul> <li>Alternational Contraction of the state of th</li></ul>	ain with notable swelling. The education of the education					
	and orders for an xi	ay was received. A follow up					
		icated R36 had a bimalleolar were received to send R36 to		ġ.			, ,
		artment. R36 was admitted to		D.			Ì
		ical repair of the fracture.		1			
6	On 8/14/13, at 7:08	a.m. R36 was observed lying		i.			
;	in her bed sleeping.	The personal clip alarm					
2		f when the resident stands) table next to her bed.		1			
		arm was not clipped to R36		4			
1	nor affixed to a stab	le surface rendering it		ļ			
	ineffective. On 8/14/13 at 7:39	a.m. NA-C verified R36's clip					
	alarm box had been	sitting on the table,		2			
	unattached to a per	manent surface. NA-C also					1

ORM CMS-2567(02-99) Previous Versions Obsolete Event ID: HFW011 Facility ID: 00322

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		AND HUMAN SERVICES				FORM	: 09/03/2013 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 Y Y		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245318	B, WING			08/	15/2013
	PROVIDER OR SUPPLIER	- INTERNATIONAL FALLS		14	TREET ADDRESS, CITY, STATE, ZIP CODE 402 HIGHWAY 71 ITERNATIONAL FALLS, MN 56649		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325 SS=D	to her when she was should have been. On 8/15/13, at 8:25 POC directed staff R36 was in bed or v staff were expected The facility's Comp Conference policy r the POC is driven b issues/conditions a best approach to pr The facility's Care F reveals the POC re required/provided for 483.25(i) MAINTAII UNLESS UNAVOID Based on a resident assessment, the far resident - (1) Maintains accept status, such as bod unless the resident' demonstrates that to (2) Receives a ther nutritional problem. This REQUIREMEN by: Based on observat review, the facility far nutritional intervention with weight loss and	p alarm had not been attached is lying in bed and stated it a.m. RN-C confirmed R36's to utilize a TABs alarm when wheelchair. RN-C verified I to follow the POC as written. rehensive Care Plan and Care revised date 1/2011, revealed by identified resident and it is a tool representing the roviding and directing care. Plan policy dated 1/2009, flects the care currently flects the care currently or the resident. N NUTRITION STATUS DABLE t's comprehensive cility must ensure that a stable parameters of nutritional y weight and protein levels,	F3	323	F325 R58 was assessed for nutritional interventions and they were implemented on 9/10/13 in attempt minimize further weight loss. By 9-24-13 the Dietary Director/designee will audit all resi with weight loss below ideal body weight to ensure their nutritional ne are assessed and interventions have implemented. Staff responsible for assessing and implementing nutritional needs per plan will be educated by 9-24-13 on importance of doing so to attempt to minimize further weight loss.	idents eeds been care n the o	7-24-13
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: HFW01	1	Faci	ility ID: 00322 If continuation	on sheet	Page 33 of 42

		AND HUMAN SERVICES				FORM APPROVED 18 NO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	an and the second	PLE CONSTRUCTION G	1	(X3) DATE SURVEY COMPLETED
		245318	B. WING_			08/15/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
GOOD S	AMARITAN SOCIETY	- INTERNATIONAL FALLS		1402 HIGHWAY 71 INTERNATIONAL FALLS, MN	56649	
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	n Should e Appropri	BE COMPLETION
	obstructive pulmonal R58's admission Mi 6/10/13, indicated R impairment, was included up and weighed 138 R58's current POC with Enlive juice (a lithree times a day; F three times a day; C May be fed by feedi chocolate; tootsie ro needed for gastritis. R58's plan for missi On 8/14/13, during of 7:03 a.m. until 12:51 the breakfast meal a until 12:22 p.m. at w the noon meal. During the continuous nursing assistant (N not offered the break generally slept in un NA-J stated R58 wa which was served at R58's Nutritional Ass 6/13/13, indicated R 149-183 pounds. Th	cluded dementia, chronic ary disease and osteoporosis. nimum Data Set (MDS) dated R58 had severe cognitive dependent with eating after set 8 pounds. directed staff to provide R58 high protein supplement) fortified foods; Supplements Diet regular level 4 thin liquids; ng assistant; enjoys candy olls and medications as The POC lacked indication of ng the breakfast meal daily. continuous observation from 1 p.m. R58 was not offered and was not offered any food which time R58 was offered us observations, at 9:06 a.m. A)-J stated R58 was usually kfast meal because R58 til after 10:00 a.m. therefore, s only offered the noon meal : 11:30 a.m. daily. sessment form completed 58's ideal weight range was e form also indicated R58's	F 32	5 Dietary Director/designee weekly random audits beg on residents with weight le ideal body weight to ensur nutritional needs have been interventions are being imp plan of care. Audit results forwarded to QA committee recommendation.	inning Se oss below e their n assesse plemente will be	d and d per
1		8 (below ideal weight).	المتعار			
DRM CMS-256	7(02-99) Previous Versions C	Obsolete Event 1D: HFW011	Fa Fa	cility ID: 00322 If c	ontinuation	sheet Page 34 of 42

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED	DEPARTMENT OF HEALTH				PRINTED: FORM A OMB NO. (	<b>\PPROVED</b>
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS       INTERNATIONAL FALLS, MN 56649         [X4]ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MST BE PRECIDED BY FULL TAG       D PREFIX REGULATORAL FALLS, MN 56649         [X4]ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MST BE PRECIDED BY FULL TAG       D PREFIX REGULATORY OR LSC IDENTIFYING BNOMMATION       THE STATE CORRECTION (EACH DEFICIENCY MST BUDGED AND CORRECTION (EACH DEFICIENCY MST BUDGED AND CORRECTION (EACH DEFICIENCY MST BUDGED AND CORRECTION (EACH DEFICIENCY MST BUDGED AND CORRECTION (EACH DEFICIENCY MST BUDGED AND CORRECTION (EACH DEFICIENCY MST BUDGED AND CORRECTION (EACH DEFICIENCY MST BUDGED AND CORRECTION (EACH DEFICIENCY)       THE COMPECTIVE ADVICE PREFIX (EACH DEFICIENCY MST BUDGED AND CORRECTION (EACH DEFICIENCY MST BUDGED AND CORRECTION (EACH DEFICIENCY)       D PREFIX (EACH DEFICIENCY (EACH DEFICIENCY (EACH DEFICIENCY MST BUDGED AND CORRECTION (EACH DEFICIENCY)       D PREFIX (EACH DEFICIENCY (EACH DEFICIENCY (EACH DEFICIENCY MST BUDGED AND CORRECTIVE ADVICE (EACH DEFICIENCY)       D PREFIX (EACH DEFICIENCY (EACH DEFICIENCY MST BUDGED AND CORRECTIVE ADVICE AND CORRECTIVE ADVICE (EACH DEFICIENCY)       D PREFIX (EACH DEFICIENCY (EACH DEFICIENCY (EACH DEFICIENCY MST BUDGED AND CORRECTIVE ADVICE AND CORRECTIVE ADVICE (EACH DEFICIENCY)       F 325         F 325       Continued From page 34 (F 32.8 mST BUDGED AND CORRECTIVE ADVICE AD	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA				
Image of Provider Control       1402 PIGHWAY 71         GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS       1402 PIGHWAY 71         Image of Providers of the Provider of Deficiences       Providers PLAN of CORRECTION (EACH CORRECTIVE ACTION SHORMATION)       0         Image of Providers of PLAN of CORRECTION PRETIX       PROVIDERS PLAN of CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRE		245318	States and states and a			5/2013
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS     INTERNATIONAL FALLS, MN 55649       [X4] ID PHEND PERCENCE TO STATUENT OF DEFICIENCIES TAG     ID PROVIDENTS PLAN OF CORRECTION RECOULTORY OR LSC IDENTIFYING INFORMATION)     ID PROVIDENTIFYING INFORMATION	NAME OF PROVIDER OR SUPPLIER					
(X4)10 TAS     PATERX REGULATORY OR LSCIDENTIFYING INFORMATION)     PREFIX TAS     CACH CORRECTIVE ACTION SHOULD BE CROSS.REPERSINCE ACTION SHOULD BE CROSS.REPERSINCE ACTION SHOULD BE DEFICIENCY)     COMMENTION DEFICIENCY       F 325     Continued From page 34     F 325       R56 was observed to be weighed on 8/14/13, at 11:39 a.m. R58 weighed 129.8 pounds (a loss of 8.2 pounds show the lowest range of ideal body weight.     F 325       During the noon meal on 8/14/13, at 12:22 p.m. R56 was observed to be served squash, a pork chop, diced potatoes and sweet potatoes. Butter was added to the squash to increase caloric intake, but R56 was not served the fortified mashed potatoes.       R69's supplement intake records from 8/1/13-8/14/13, indicated R56 was never offered high calorie nutritional supplements 3 times a day. The records indicated R56 was offered supplements three times a day as the POC directed on 2 of the 14 days, had been offered one nutritional supplements recorded as offered on 7 of the 14 days.       On 8/15/13, at 10:312 A.M. The certified dietary manager (CDM) stated she was aware that R56 had slept past the time of the breakfast meal. The CDM also stated she had instructed the facility stated R56 was supposed to receive fortified foods during meals to increase the residents caloric intake. She confirmed R56 should have	GOOD SAMARITAN SOCIETY	- INTERNATIONAL FALLS		NTERNATIONAL FALLS, MN 56649		
<ul> <li>R58 was observed to be weighed on 8/14/13, at 11:39 a.m. R58 weighed 129.8 pounds (a loss of 8.2 pounds below the lowest range of ideal body weight.</li> <li>During the noon meal on 8/14/13, at 12:22 p.m. R58 was observed to be served squash, a pork chop, diced potatoes and sweet potatoes. Butter was added to the squash to increase caloric intake, but R58 was not served the fortified mashed potatoes.</li> <li>R58's supplement intake records from 8/1/1/3-8/14/13, indicated R58 was never offered high calorie nutritional supplements 3 times a day. The records indicated R58 was offered supplements three times a day as the POC directed on 2 of the 14 days, had been offered one nutritional supplements records and there are no high caloric supplements records a offered one nutritional supplements records indicated R58 was enter the 2 mashed potatoes are than the R58 had sleep to 1 the 14 days.</li> <li>On 8/15/13, at 10:312 A.M. The certified dietary manager (CDM) stated she was aware that R58 had sleep tast the lime of the breakfast meal. The CDM also stated she had instructed the facility staff to provide R58 with a supplement and toast or whatever R58 chose if he woke up after the breakfast meal serving was over. The CDM stated R58 was supposed to receive fortified foods during meals be increase the residents caloride caloride caloride caloride caloride caloride the facility stated R58 was supposed to receive fortified foods during meals be increase the residents caloride caloride for the source as the residents caloride caloride for the source as the residents caloride for the source as the residents caloride for the source as the residents caloride for the receive fortified foods during meals be increase the residents caloride for the source as the residents caloride for the source as the residents caloride for the source as the residents caloride for the the caloride for the source as the residents caloride for the the caloride for the source as the residents caloride for the the facility staff to provi</li></ul>	PREFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE	ULD BE	COMPLETION
noon meal on 8/14/13. The CDM also confirmed R58 had not been provided nutritional supplements according to R58's assessed need from 8/1/13-8/14/13.	<ul> <li>R58 was observed 11:39 a.m. R58 we 8.2 pounds since a pounds below the I weight.</li> <li>During the noon m R58 was observed chop, diced potatoo was added to the s intake, but R58 wa mashed potatoes.</li> <li>R58's supplement 8/1/13-8/14/13, ind high calorie nutrition day. The records i supplements three directed on 2 of the one nutritional sup and there are no hi recorded as offerent On 8/15/13, at 10:3 manager (CDM) st had slept past the CDM also stated s staff to provide R58 or whatever R58 cl breakfast meal sen stated R58 was su foods during meals caloric intake. She received fortified m noon meal on 8/14 R58 had not been supplements accord</li> </ul>	to be weighed on 8/14/13, at ighed 129.8 pounds (a loss of dmission). R58 was 19.2 owest range of ideal body eal on 8/14/13, at 12:22 p.m. to be served squash, a pork es and sweet potatoes. Butter quash to increase caloric s not served the fortified intake records from icated R58 was never offered nal supplements 3 times a ndicated R58 was offered times a day as the POC e 14 days, had been offered plement on 5 of the 14 days; gh caloric supplements d on 7 of the 14 days. B12 A.M. The certified dietary ated she was aware that R58 time of the breakfast meal. The he had instructed the facility 8 with a supplement and toast nose if he woke up after the ving was over. The CDM pposed to receive fortified is to increase the residents confirmed R58 should have nashed potatoes during the /13. The CDM also confirmed provided nutritional rding to R58's assessed need				

Facility ID: 00322

If continuation sheet Page 35 of 42

2 A 65 A		HAND HUMAN SERVICES				FORM APPROVED MB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		245318	B. WING			08/15/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	
GOODS	AMARITAN SOCIETY	- INTERNATIONAL FALLS		1402 HIGHWAY 71 INTERNATIONAL FA	LLS, MN 56649	
(X4) ID PREFIX TAG	EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROPE EFICIENCY)	BE COMPLETION
F 371	The facility must - (1) Procure food fro considered satisfac authorities; and	ROCURE, /SERVE - SANITARY om sources approved or tory by Federal, State or local distribute and serve food	F 3 F 3	<ul> <li>F371</li> <li>Effective 9/1/13 terminated, replay washing and propaper, as to ensure sanitary condition</li> <li>By 9-24-13 educator</li> <li>By 9-24-13 educator</li> </ul>	, glove use has been aced by proper har per use of parchm re serving food un- ns. ation has been pro- g food on ensuring anitary conditions.	nd <b>7-21-13</b> ent der
1 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	by: Based on observati review, the facility fa served under sanita contaminated glove affect all 51 residen	use. This had the potential to		are served under s	udits to ensure me anitary conditions warded to the OA	•
	observed to dish R9 steam table while we the meal to R9, set i the steam table. At 5:43 p.m. HM-B v	p.m. homemaker (HM)-C was d's evening meal up from the earing gloves. HM-C carried it on the table and returned to was observed to dish up				
	plate to R10's table, had been drinking fr table and returned to not observed to char to the steam table.	earing gloves, carried the moved R10's glass which he om, placed the plate on the o the steam table. HM-B was nge her gloves upon returning vas observed to serve R29				
	37(02-99) Previous Versions (	inter state interesting in the second state of	11 F	acility ID: 00322	If continuation	sheet Page 36 of 42

PRINTED: 09/03/2013

	TMENT OF HEALTH RS FOR MEDICARE							FORM A	09/03/2013 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUI IDENTIFICATIO	PLIER/CLIA			E CONSTRUCTION		(X3) DATE COMP	SURVEY
		2453	18	B. WING	·			08/1	5/2013
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- INTERNATIONA	AL FALLS		14	REET ADDRESS, CITY, STATE, ZIP 02 HIGHWAY 71 TERNATIONAL FALLS, MN			
(X4) ID PREFIX TAG		TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREF TAG	2000 B.	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	n Should E appropr	BE ;	(X5) COMPLETION DATE
	Continued From pa his meal, walked int sharp knife and cut returned to the stea board and pencil. H and asked him wha HM-B documented board and returned was not observed to dishing up the next HM-B and HM-C co meal without remov their hands. At 6:06 served from the Ma On 8/12/13, at 6:00 R20 were observed meals. Nursing ass to be wearing glove meal. At 6:06 p.m. NA-H w from the table and v as she fed R20 3-4 returned to R38 gav then walked to assist table. At 6:07 NA-H continued to assist to observed to change hands in between th At 6:09 p.m. NA-H le cup who was sitting dining rotan red a glas to R38 and fed him At 6:10 p.m. R60 joi table. NA-H attempt	to the kitchen, re R29's meal. Sh m table and pick IM-B then walke t he would like for R54's responses to the steam table o change her glo meal. Intinued to serve ing their gloves of 5 p.m. the last m in kitchen dining p.m. table mater to receive their sistant (NA)-H was a she assister vas observed to valk over to R20 bites of food and re him 1-2 bites of st another reside returned to R38 him to eat. NA-F her gloves or whe residents. eft R38 and filled on the opposite She then went to so of milk for R7 another bite of for ned R38 and R2	e then (ed up a clip d over to R54 or supper. s on the clip ble. HM-B ves prior to the evening eal was room. s R38 and evening as observed d R38 with his stand up . She stood d then of food and nt at another and i was not ash her I R17's coffee side of the o the fluids and returned od. 0 at the	F	371				
	67(02-99) Previous Versions I		Event ID: HEW01	1	Cacil	ity ID: 00322 If	continuatio	n choot P	age 37 of 42

		AND HUMAN SERVICES				RINTED: 09/03/201 FORM APPROVEI MB NO. 0938-039
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		245318	B. WING			08/15/2013
NAME OF I	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	<u> </u>	STREET ADDRESS, CITY	Y, STATE, ZIP CODE	
GOODS	AMARITAN SOCIETY	- INTERNATIONAL FALLS		1402 HIGHWAY 71 INTERNATIONAL F	ALLS, MN 56649	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
: : :	R38 with their meal At 6:12 p.m. NA-H a around the table an R20 with two bites of and returned to R38 At 6:20 p.m. R38 be R38's mouth while of remove the contam At 6:25 p.m. NA-H I a few bites of her m returned to R38. At 6:28 p.m. NA-H s assisted R68 with h out of the dining roo R38. At 6:39 p.m. NA-H a around the table to a food. At 6:42 p.m. NA-H t At no time during the was she observed to her hands. At 6:46 p.m. NA-H o removed her gloves assisting multiple re During the noon me HM-A was observed	s at the same time. again left R38 and R60 walked d stood while she assisted of her meal, cued her to eat 3 and R60. egan to cough. NA-H covered coughing. NA-H did not inated gloves. eft R38 and assisted R20 with eal. At 6:26 p.m. NA-H stood up and left R38 as she er walker and directed R68 om. NA-H then returned to again left R38 and walked assist R20 with a few bites of hen returned to R38. e dining observation of NA-H o change her gloves or wash confirmed she had not or washed her hands while	F 3	71		
(	cart. She was obse 57(02-99) Previous Versions	rved to be wearing gloves as Dbsolete Event ID: HFW01	1	Facility ID: 00322	If continuatio	n sheet Page 38 of 42

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/03/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
		245318	B. WING			08/	15/2013
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INTERNATIONAL FALLS			2 HIGHWAY 71 ERNATIONAL FALLS, MN 56649		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	- I.	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 371	filled them. On sev	of the individual glasses and eral occasions, HM-A walked	F	371			
	to the juice station a and glasses from th room.	and removed additional cups ae cupboard in the dining		e: St			
	her meal. HM-A wa and the back of the as she returned to to opened a bucket of crackers with her g	was observed to serve R28 as observed to touch the table chair with her gloved hands he steam table. She then crackers and removed the oved hand, placed them on a					
	observed to change to the steam table.	em to R28. HM-A was not her gloves prior to returning	행 태 태 월				
	was observed to de R28. She placed th up an item of garba	he same gloved hands, HM-A liver a plate to a tablemate of he plate on the table, picked ge off of the table, carried it to d returned to the steam table.					
	(CDM) began to ob system. She stated any time a staff me surface such as a r the staff touches th	ertified dietary manager serve the meal delivery I the gloves are to be changed mber touches an unclean esident, a piece of furniture or eir clothing. She stated the veral educational classes on the dining room.					
	At 12:00 p.m. the C item onto the floor, kitchen. She stated with a hand washin the dining room. The not have washed he	DM observed HM-A drop an pick it up and walk into the I the kitchen was equipped g station, as HM-A returned to ne CDM stated HM-A could er hands and changed her ht of time she was in the					

Facility ID: 00322

If continuation sheet Page 39 of 42

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED: 09/03/2013 FORM APPROVED DMB NO: 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2003 28		(X3) DATE SURVEY COMPLETED
	245318	B. WING		08/15/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY	- INTERNATIONAL FALLS	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1402 HIGHWAY 71 NTERNATIONAL FALLS, MN 56649	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
<ul> <li>on 5/2009, directed for cross-contaminate by using gloves whet directed the staff to ready to eat foods. Use of gloves does reproper hand washing</li> <li>On 8/14/13, at 12:4 not washed her hand during the meal server F 431 483.60(b), (d), (e) D SS=D LABEL/STORE DRU</li> <li>The facility must emate a licensed pharmacio of records of receipt controlled drugs in structions and biological labeled in accordance professional principle appropriate accesso instructions, and the applicable.</li> <li>In accordance with S facility must store all locked compartment</li> </ul>	policy entitled Gloves revised the staff to limit the potential tion during the food service in appropriate. The policy wear gloves when handling The policy stated: "Note: The not eliminate the need for g or good hygiene." 6 p.m. HM-A stated she had ds or changed her gloves vice and should have. RUG RECORDS, JGS & BIOLOGICALS ploy or obtain the services of st who establishes a system and disposition of all ufficient detail to enable an on; and determines that drug and that an account of all naintained and periodically s used in the facility must be with currently accepted es, and include the ry and cautionary expiration date when State and Federal laws, the drugs and biologicals in s under proper temperature only authorized personnel to	F 371	<ul> <li>F431 As of 8/13/13 R12's Fentanyl patare being appropriately disposed reconciled. </li> <li>By 9/24/13 all current and newly admitted residents prescribed a Fepatch will be identified.</li> <li>By 9/24/13 all nurses will be edue on the appropriate disposal and reconciliation of Fentanyl patches Audits of the facility wide Narcot Record will be completed twice w for four weeks to insure that Fentapatches are correctly disposed of a reconciled. Report to QA for furth recommendations.</li></ul>	of and <b>7-2.4-13</b> entanyl cated s. ic veekly anyl and

	TMENT OF HEALTH RS FOR MEDICARE							FORM	09/03/2013 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUP IDENTIFICATION	PLIER/CLIA	Entendide - Second Property	IPLE CONSTR			(X3) DAT	E SURVEY PLETED
		24531	8	B. WING		<u> </u>		08/	15/2013
NAME OF	PROVIDER OR SUPPLIER				www.com.com.com.com.com.com.com.com.com.com	DRESS, CITY, STAT	E, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INTERNATIONA	L FALLS		1402 HIGH	NAY 71 FIONAL FALLS,	MN 56649		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	(E/	PROVIDER'S PLAN ACH CORRECTIVE A SS-REFERENCED T DEFICIE	ACTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 431	Continued From page	ge 40		F 43	1				
	The facility must propermanently affixed controlled drugs lists Comprehensive Dru Control Act of 1976 abuse, except when package drug distrik quantity stored is mi be readily detected. This REQUIREMEN by: Based interview and failed to ensure apply reconciliation of com- resident (R12) who we (narcotic) patch. Findings include: During medication states 2:00 p.m. licensed p- two staff members we and disposal of a Fe stated the Fentanyl p- disposed of down the members signing the this process was followed.	compartments for ed in Schedule II ig Abuse Prevent and other drugs is the facility uses pution systems in inimal and a miss of document revie to a document revie to priate disposal trolled substance was prescribed a torage review on ractical nurse (LF vere to witness the nancyl patch. LPI batches were ther e sewer with both a narcotic log boo	or storage of of the ion and subject to single unit which the ing dose can evidenced w, the facility and s for 1 of 1 Fentanyl 8/13/13, at PN)-A stated e removal N-A also n to be staff						
	Upon review of the n entry dated 8/5/13, re had been removed o been lost and unable	evealed R12's Fe n 8/5/13, and the to be found agai	ntanyl patch patch had n.						
	On 8/13/13, at 2:10 μ Fentanyl patch was ι	inaccounted for a			k) • • • • • • • • •				
DRM CMS.256	7(02-99) Previous Versions ()	healata	Event ID: HEW011	F	acility ID: 00322		If continuation	aboat Dr	no 11 of 12

		AND HUMAN SERVICES				M APPROVED D. 0938-0391
	de la constante de la constante de la constante de la constante de la constante de la constante de la constante	& MEDICAID SERVICES				ATE SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		DMPLETED
		245318	B. WING		0	8/15/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	TE, ZIP CODE	
GOOD S.	AMARITAN SOCIETY	- INTERNATIONAL FALLS		1402 HIGHWAY 71 INTERNATIONAL FALLS,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE	(X5) COMPLETION DATE
	report should be co and director of nurs stated she was uns been completed. On 8/14/13, at 11:4 -B stated she was u Fentanyl patch and locate an incident re 8/5/13, Fentanyl pa policy was to compl unaccounted for na On 8/14/13, at 11:5 (DON) confirmed s missing Fentanyl pa have an incident re unaccounted for Fe verified it was faciliti incident report whe missing. On 8/14/13, at 2:09 a memo dated 6/18 directed staff to hav the removal and de patch. On 8/15/13, at 8:50	mpleted and the charge nurse ing (DON) notified. LPN-A ure if an incident report had 7 a.m. registered nurse (RN) inaware of the missing confirmed she was unable to eport for the unaccounted tch. RN-B verified the facility's lete an incident report for any rcotic. 0 a.m. the director of nursing the was unaware of the atch and stated she did not	F 43	31		
		itoring and destruction of	*			
				2		
				4 9		

Facility ID: 00322

If continuation sheet Page 42 of 42

PRINTED: 09/03/2013

CENTERS FOR MEDICARE & MEDICAID SERVICES	F5318021 FORM APPROV OMB NO. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SURVEY COMPLETED
245318	B. WING 08/14/2013
Name of Provider or Supplier	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	1402 HIGHWAY 71 INTERNATIONAL FALLS, MN 56649
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFIC/ENCY)
K 000 INITIAL COMMENTS FIRE SAFETY 1963 BUILDING 01 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 International Falls 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 Evistion Health Care	K 000 PRC of R q.16.13 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 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
Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	7305 of the State Operations Manual
<ul> <li>Health Care Fire Inspections</li> <li>State Fire Marshal Division</li> <li>445 Minnesota Street, Suite 145</li> <li>St. Paul, MN 55101</li> </ul>	SEP 1 3 2013
TORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNAT	URE STATE TITLE (X8) DATE

y deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ier safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued igram participation.

RM CMS-2567(02-99) Previous Versions Obsolete

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STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DA	D. 0938-0 TE SURVE MPLETED
		245318	B. WING			
	PROVIDER OR SUPPLIER	- INTERNATIONAL FALLS	1	STREET ADDRESS, CITY, STATE, ZIP C 402 HIGHWAY 71 NTERNATIONAL FALLS, MN 56	ODE	/14/2013
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION	(X5) COMPLET DATE
F F I I I I I I I I I I I I I I I I I I	DEFICIENCY MUST COLLOWING INFOR A description of who correct the deficient The actual, or prop The name and/or the sponsible for correct event a reoccurrent the Good Samaritan as constructed at two ginal building (Build -story building, with software a reoccurrent to constructed at two ginal building (Build -story building, with software a reoccurrent software a reoccurrent to a struction. The main sprinkler protected a tion of the basement '9 an addition (Build ne north of building ement, was determ struction, is fully spi ordance with NFPA allation of Sprinkler separated from the fire barrier. matic smoke detection	ate.mn.us and 2state.mn.us 5-0525 RECTION FOR EACH INCLUDE ALL OF THE RMATION: that has been, or will be, done ncy. bosed, completion date. We of the person stion and monitoring to se of the deficiency Society International Falls o different times. The ing 01) was built in 1963, is a partial basement, and of a Type II (111) n level of the 1963 building ind all but a 2000 sq ft at is sprinkler protected. In ling 02), was constructed 01, which is 1-story with a inerd to be Type II (000)	К 000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		E CONSTRUCTION	OMB NO. (X3) DATE	SURVEY
		A. BUILDING	01 - MAIN BUILDING 01	COMP	LETED
NAME OF PROVIDER OR SUPPLIER	245318	B. WING		08/1/	4/2013
GOOD SAMARITAN SOCIETY		14	REET ADDRESS, CITY, STATE, ZIP CODE 02 HIGHWAY 71 TERNATIONAL FALLS, MN 56649		
PREPIA I (CAURI DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID   PREFIX   TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	Lhee 🦓 🖉	(X5) COMPLETI DATE
with extended spacial accordance with NF Alarm Code" (1999 a smoke detection is in and single station sm sleeping rooms of the automatic fire detection required by the Minne edition and the fire all automatic fire departs The bullding is divided the main floor and 2 of The facility has a capa census of 52 at the time Because the original 1 sprinkler protected and 1979 building which is facility was surveyed a The requirement at 42 NOT MET in Building 00 056 NFPA 101 LIFE SAFET If there is an automatic installed in accordance for the Installation of Sp provide complete covern building. The system is accordance with NFPA 1 inspection, Testing, and Water-Based Fire Prote- supervised. There is a r	es and down the corridors ng in the building in PA 72 "The National Fire adition). Additional automatic o all common use spaces toke detectors are in the a 1963 building. Additional on is provided in all rooms assota State Fire Code 2007 arm system is monitored for ment notification. d Into 5 smoke zones, 3 on in the basement level. acity of 64 beds and had a ne of the survey. 963 building is only partially d is separated form the sprinkler protected the s two separate buildings. CFR, Subpart 483.70(a) is 1 as evidenced by: TY CODE STANDARD sprinkler system, it is with NFPA 13, Standard rinkler Systems, to age for all portions of the properly maintained in 25, Standard for the Maintenance of ction Systems. It is fully eliable, adequate water	K 000			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	OMB N	ED: 09/0 RM APPR 10. 0938 DATE SURV
		A. BUILDI	NG 01 - MAIN BUILDING 01	C	OMPLETE
NAME OF PROVIDER OR SUPPLIE	245318 R	B. WING			
	Y - INTERNATIONAL FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 HIGHWAY 71	12-51-57	8/14/201
(X4) ID SUMMARY ST PREFIX (EACH DEFIDIENC	ATEMENT OF DEFICIENCIES		INTERNATIONAL FALLS, MN 56649	)	
TAG REGULATORY OR	A TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	TION	(X5) COMPLE DATE
K 056 Continued From pa switches, which are building fire alarm s	aloctrically and	K 056			
completely protected sprinkler system as n Medicaid Medicare S S&C-09-04. This def fire to start in a non-s grow to a point that m fire sprinkler system			K 056 This deficiency will be resolved when we move out of this buil We will be moving to the new facility at 2201 Keenan Drive October 1 <sup>st</sup> 2013. Gary Hooker Facilities Director		10-1-12
Findings include: Based on observations August 14, 2013 betwe pm, by surveyor 03006, the following areas do n sprinkler protection: 1. The basement laundr 2. The basement offices 3. The basement locker 4 The west basement locker The Director of Maintena these findings during the during the exit conference NFPA 101 LIFE SAFETY Heating, ventilating, and a with the provisions of sect in accordance with the maintena	It was determined that not have automatic fire y room, room, and orage room, nce and his staff verified tour of the facility and coDE STANDARD ir conditioning comply	< 067	ħ		

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	NT OF DEFICIENCIES		(X2) MULTI	FLE CONSTRUCTION		O. 0938-03 ATE SURVEY
and flan	OF CORRECTION	IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01		MPLETED
		245318	B. WING		01	3/14/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		11112010
GOODS		- INTERNATIONAL FALLS		1402 HIGHWAY 71 INTERNATIONAL FALLS, MN 56649		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETI( DATE
K 067		ge 4 5.2.1, 9.2, NFPA 90A,	K 067			
FEDAP FEDAP CAP SI SI SI SI SI SI SI SI SI SI SI SI SI	Observations and ar that the 1963 building conditioning (HVAC) as part of the air distr practice of using the oblenum could allow the move from the room of corridor complicating esidents, any visitors findings include: lased on observation Director of Maintenand ugust 14, 2013 between m, by surveyor 03000 the facility's HVAC sys upply make-up air for eeping room bathroo nd does not meet the 299 edition, Section 2 at allows air transfer fferentials through co the Administrator, the d his staff verified thill a facility and during the nual Waiver Previous	rridors. Director of Maintenance s finding during the tour of le exit conference. sly approved. Y CODE STANDARD	K 144	K 067 Request for waiver- "Unsprint Buildings" was previously approved. We will be moving this building by October 1 <sup>st</sup> . 20 We will be moving to the new facility at 2201 Keenan Drive. Gary Hooker Facilities Director	out of 013.	10-1-1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVE COMPLETED		
	245318		B. WING			
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS				STREET ADDRESS, CITY, STATE, ZIP CODE 1402 HIGHWAY 71 NTERNATIONAL FALLS, MN 56649	08/14/2013	
(X4) ID PREFIX TAG	: (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IE COMPLETI ATE DATE	
·	Continued From pa under load for 30 m accordance with NF	linutes per month in	K 144			
F d h a re F B in to apware its wa	A review of facility m nterview with staff re generator is not tested 10 The Standard for ower Systems 1999 efficient practice cou- ave a problem that w nd which could nega- esidents, any visitors indings include: ased on a review of ternational Falls, gen- terview with the Dire the facility tour on A proximately 9:45 am as determined that the onthly under load, bu- nameplate rating as s the exhaust gas te cumentation of an an ailable for review.	ctor of Maintenance, prior ugust 14, 2013 at n, by surveyor 03006, it ne generator was run at is was not 30 percent of required by NFPA 110 not emperature taken. No nnual load bank test was		K 144 The generator will be moved to th new location, 2201 Keenan Drive, after October 3, 2013. An annual load bank test will be preformed. The generator will be load tested to 30% of its nameplate rating and the exhaust gas temperature will be taken before October 15. This will become an annual inspection. To be completed by: October 15, 2013. The facility at 2201 Keenan Drive has temporary generators in place until then. We will be moved out of this building (1402 Hwy 71) on October 1 <sup>st</sup> 2013. Gary Hooker Facilities Director		

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PRINTED: 09/03/2013 FORM APPROVED

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

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:		TPLE CONSTRUCTION NG 02 - 1978 ADDITION 02	(X3) DATE SURVEY COMPLETED
		245318	B. WING_		08/14/2013
	PROVIDER OR SUPPLIER	- INTERNATIONAL FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 HIGHWAY 71 INTERNATIONAL FALLS, MN 56649	
(X4) 10 PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO
K 000	INITIAL COMMENT	S	K 000	PUCUK 9-16-13	
	FIRE SAFETY	-		A grie	1
	1979 Building 02			Preparation and execution this response and pla	
	THE FACILITY'S PO ALLEGATION OF C	C WILL SERVE AS YOUR		correction does	not
	DEPARTMENT'S AC SIGNATURE AT THI PAGE OF THE CMS VERIFICATION OF (	CEPTANCE. YOUR E BOTTOM OF THE FIRST -2567 WILL BE USED AS		constitute an admissio agreement by the provid the truth of facts allege	er of ed or
1	JPON RECEIPT OF	AN ACCEPTABLE POC.		conclusions set forth in statement of deficiencies	
E	BE CONDUCTED TO SUBSTANTIAL COM	PLIANCE WITH THE		The plan of correctio prepared and/or exec	
F A	REGULATIONS HAS	BEEN ATTAINED IN YOUR VERIFICATION.		solely because it is required by the provisions of features	uired
N	linnesota Departmen	rvey was conducted by the it of Public Safety. At the		and state law. For purposes of any allege	the
Ir	ternational Falls 02	od Samaritan Society Building was found not in e with the requirements for		that the center is no substantial compliance	t in
pi   S	articipation in Medica ubpart 483.70(a), Life	re/Medicaid at 42 CFR, a Safety from Fire, and the		federal requirements participation, this resp	of
As Co PL CO	000 edition of Nation ssociation (NFPA) St ode (LSC), Chapter 1	al Fire Protection andard 101, Life Safety 9 Existing Health Care.			ter's
	EASE RETURN TH DRRECTION FOR T EFICIENCIES (K-TAI	HE FIRE SAFETY		7305 of the State Operat	tion
Sta	alth Care Fire Inspe ate Fire Marshal Divi	sion		Manual.	
St.	5 Minnesota Street, I Paul, MN 55101	0			
TORY DIR	ECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVES SIGNAT	URE	Be Himmedute	9-13-12

Any deficiency statement ending with an esterisk (\*) 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

STATEMEN	IT OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	). 0938-03 TE SURVEY
and Plan	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	02 - 1979 ADDITION 02	CO	MPLETED
		245318	B. WING	1110-11-110-11-11-11-11-11-11-11-11-11-1	08	/14/2013
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- INTERNATIONAL FALLS		402 HIGHWAY 71 NTERNATIONAL FALLS, MN 56649		
(X4) ID		TEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECTIO		(25)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETIC
K 000	Continued From pa	ge 1	K 000			
	Or by email to: Marian.Whitney@st Barbara.Lundberg@	ate.mn.us and Ostate.mn.us				
	Fax Number 651-21	5-0525				
		RECTION FOR EACH I INCLUDE ALL OF THE RMATION:				
	1. A description of w to correct the deficie	hat has been, or will be, done ncy.			l.	
	2. The actual, or pro	posed, completion date.				
(I	3. The name and/or responsible for corre prevent a reoccurren	ction and monitoring to				
v c is p t t c a	was constructed at two original building (Buil a 1-story building, with was determined to be construction. The mail is sprinkler protected portion of the baseme original of the baseme 979 an addition (Buildin asement, was detern onstruction, is fully s ccordance with NFP	in level of the 1963 building and all but a 2000 sq ft ent is sprinkler protected. In Iding 02), was constructed g 01, which is 1-story with a mined to be Type II(000)				
ai he	nd separated from th our fire barrier.	e 1963 building with a 2				
		r doors that are held open			1	

	NAMES OF TAXABLE PROPERTY AND A DESCRIPTION OF TAXABLE PROPERTY AND A	AND HUMAN SERVICES			FOR	D: 09/03/2 MAPPRON O. 0938-0
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION NG 02 - 1979 ADDITION 02		ATE SURVEY
		245318	B. WING		0	8/14/2013
	PROVIDER OR SUPPLIER	- INTERNATIONAL FALLS		STREET ADDRESS, CITY, STAT 1402 HIGHWAY 71 INTERNATIONAL FALLS,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED 1 DEFICII	ACTION SHOULD BE	(X5) COMPLET DATE
K 033 SS=F Ee maaa	with extended spaci- accordance with NF Alarm Code" (1999 of smoke detection is in and single station sn sleeping rooms of th automatic fire detect required by the Minn edition and the fire a automatic fire depart The building is divide the main floor and 2 The facility has a cap census of 52 at the ti Because the original sprinkler protected ar 1979 building which is acility was surveyed The requirement at 42 NOT MET in Building NFPA 101 LIFE SAFE exit components (suc inclosed with constru- asistance rating of at rranged to provide a	es and down the corridors ng in the bullding in PA 72 "The National Fire edition). Additional automatic in all common use spaces noke detectors are in the e 1953 building. Additional ion is provided in all rooms esota State Fire Code 2007 larm system is monitored for ment notification. ed into 5 smoke zones, 3 on on the basement level. eacity of 64 beds and had a me of the survey. 1963 building is only partially id is separated form the s sprinkler protected the as two separate buildings. 2 CFR, Subpart 483.70(a) is 02 as evidenced by: ETY CODE STANDARD h as stairways) are ction having a fire least one hour, are continuous path of escape, a against fire or smoke from	K 00			
CMS-2567(		colate Event 1D: HFW021	Fac	liky ID: 00322	If continuation shee	t Page 3 g

	ENT OF DEFICIENCIES N OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION IG 02 - 1979 ADDITION 02		TE SURVEY
		245318	B. WING	and the state of t	08	14/2013
	OF PROVIDER OR SUPPLIER	- INTERNATIONAL FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 HIGHWAY 71 INTERNATIONAL FALLS, MN 55649		
(X4) (C PREFI TAG	( EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CRO5S-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(XS) COMPLETI DATE
K 144 SS=C	Observations and to revealed that one of not in accordance w Safety Code" 2000 of This deficient practic any visitors and the facility and the stairw up through the stairw pup through the stairw Findings include: Based on observatio doors during the facil between 10:00 am at 03006, it was determ on the main level has that allows the door to the door is not positiv released. The Director of Maint during the facility tour conference. NFPA 101 LIFE SAFE	a not met as evidenced by: esting of stairway doors two stairway doors tested is ith NFPA 101 "The Life edition (LSC) section 19.3.1.1. ce could affect 22 residents, staff in the north wing of this vay allowed smoke to travel vay. Ins and testing of stairway lifty tour on August 14, 2013 nd 12:00 pm, by surveyor ined the north stairway door is an electronic strike plate o become free swinging, so re latching when the latch is enance verified this finding and during the exit ETY CODE STANDARD cted weekly and exercised utes per month in A 99. 3.4.4.1.	K 033	K 033 This deficiency will be resolve we move out of this building. We will be moving to the new location at 2201 Keenan Drive October 1 <sup>st</sup> 2013. Gary Hooker Facilities Director		(0-7-13

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY
ANU PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDH	NG 02 - 1979 ADDITION 02	co	MPLETED
		245318	B. WING_		80	/14/2013
	PROVIDER OR SUPPLIER	- INTERNATIONAL FALLS		STREET ADDRESS, CITY, STATE, 21P 1402 HIGHWAY 71 INTERNATIONAL FALLS, MN	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
	interview with staff r generator is not test 110 The Standard for Power Systems 199 deficient practice co have a problem that and which could neg residents, any visitor Findings include: Based on a review o International Falls, gen interview with the Dir to the facility tour on approximately 9:45 a was determined that monthly under load, I ts nameplate rating a vas the exhaust gas locumentation of an available for review.	maintenance records and an revealed that the emergency ted in accordance with NFPA or Emergency and Standby 99 edition section 6-4.2. This uld allow the generator to would go unnoticed by staff jatively impact the all 67 rs and the staff in the facility. If the Good Samaritan Soclety enerator logs and an rector of Maintenance, prior August 14, 2013 at im, by surveyor 03006, it the generator was run but is was not 30 percent of as required by NFPA 110 not temperature taken. No annual load bank test was enance and his staff verified the tour of the facility and ence.	I () A ft ti b an T T T te W () Ga	K 144 The generator will be move location, 2201 Keenan Driv October 3, 2013. An annual load bank test wi preformed. The generator w ested to 30% of its namepla he exhaust gas temperature before October 15. This will nnual inspection. To be completed by: October the facility at 2201 Keenan Emporary generators in place will be moved out of this 402 Hwy 71) on October 1 <sup>th</sup> ary Hooker incilities Director	e, after Il be ill be load te rating and will be taken become an 15, 2013. Drive has e until then. building	10-7-13

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