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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: HFW0
Facility ID: 00322

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245318**

2. STATE VENDOR OR MEDICAID NO. (L2) **004015100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS**
(L4) **2201 KEENAN DRIVE**
(L5) **INTERNATIONAL FALLS, MN** (L6) **56649**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **10/23/2013** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **54** (L18)

13. Total Certified Beds **54** (L17)

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE NE II 11/13/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 02/11/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **06/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **10/28/2013** (L33)

DETERMINATION APPROVAL

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,

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 and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245318	A. Building B. Wing	10/22/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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

(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	**09/24/2013**
ID Prefix **F0241** Reg. # **483.15(a)** LSC	**09/24/2013**
ID Prefix **F0242** Reg. # **483.15(b)** LSC	**09/24/2013**
ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	**09/24/2013**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**09/24/2013**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	**09/24/2013**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	**09/24/2013**
ID Prefix **F0325** Reg. # **483.25(i)** LSC	**09/24/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	**09/24/2013**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**09/24/2013**
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	GA/as	11/13/13	18618	10/22/13
Reviewed By CMS RO				

Followup to Survey Completed on: 8/15/2013

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

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

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245318	01 - MAIN BUILDING 01	10/23/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0056	10/01/2013	ID Prefix Reg. # NFPA 101 LSC K0067	10/01/2013	ID Prefix Reg. # NFPA 101 LSC K0144	10/01/2013
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/sd	11/13/13	03006	10/23/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/14/2013

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

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

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245318	A. Building B. Wing 02 - 1979 ADDITION 02	10/23/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0033	10/01/2013	ID Prefix Reg. # NFPA 101 LSC K0144	10/01/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/sd	11/13/13	03006	10/23/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/14/2013			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00322	A. Building B. Wing	10/22/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - INTERNATIONAL 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) Item: ID Prefix	Reg. #	LSC	(Y5) Date Correction Completed
20565	MN Rule 4658.0405 Subp. 3		09/24/2013
20590	MN Rule 4658.0435 Subp. 1		09/24/2013
20830	MN Rule 4658.0520 Subp. 1		09/24/2013
20905	MN Rule 4658.0525 Subp. 4		09/24/2013
20965	MN Rule 4658.0600 Subp. 2		09/24/2013
21015	MN Rule 4658.0610 Subp. 7		09/24/2013
21435	MN Rule 4658.0900 Subp. 1		09/24/2013
21630	MN Rule 4658.1350 Subp. 2 A.I		09/24/2013
21805	MN St. Statute 144.651 Subd. 5		09/24/2013
21830	MN St. Statute 144.651 Subd. 1		09/24/2013

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/sd	11/13/13	18618	10/23/13
CMS RO				

Followup to Survey Completed on: 8/15/2013

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

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 AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: HFW0
Facility ID: 00322

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245318**
2. STATE VENDOR OR MEDICAID NO. (L2) **004015100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS**
(L4) **1402 HIGHWAY 71**
(L5) **INTERNATIONAL FALLS, MN** (L6) **56649**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **08/15/2013** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12. Total Facility Beds **54** (L18)
13. Total Certified Beds **54** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE: Jane Aandal. HFE NEII — Date: 09/16/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL: Kate JohnsTon, Sr. Program Specialist — Date: 10/28/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **06/01/1986** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS
Posted 10/28/2013 CO.
HFW0

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: HFW0

Facility ID: 00322

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.

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;**

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

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

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

DEPARTMENT CONTACT

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

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

by the same deficient practice;

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by 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

regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

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

RECEIVED SEP 1 6 2013 Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164	**F164** All resident nutritional information was removed from the public dining rooms on 8/15/13. All staff will be educated by 9/24/13 on not displaying resident nutritional information in the public. The Director of Dietary Services/designee will complete random audits to monitor that resident nutritional information is not posted publically and results to QA committee for further recommendation.	9-24-13 POC OK 9/23/13 SB

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9-13-13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ____ B. WING ____	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 1	F 164		

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure resident nutritional information was not visible to the public in the main dining room. This affected 9 of 34 residents (R1, R9, R10, R20, R32, R41, R42, R46, R57) who ate in the main dining room.

Findings include:

During the evening meal observations on 8/12/13, at 5:20 p.m. a color coded seating chart was observed posted on the wall next to the entrance doors of the main dining room and also on both sides of the steam table. The charts were dated 8/12/13, and were observed to be visible to all staff, residents and visitors of the facility.

The chart mapped out the table seating assignments and also identified the following information:

R1 was to use an adaptive lip plate.
R9 was to use an adaptive lip plate and was not to have straws.
R10 was to use an adaptive lip plate.
R20 was to use an adaptive lip plate.
R32 was to use an adaptive lip plate.
R41 was to use an adaptive lip plate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ____ B. WING ____	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 2	F 164		

R42 was to have level 1 meats.
R46 was to have cut up food.
R57 was to use an adaptive lip plate.

On 8/12/13, at 5:25 p.m. the certified dietary manager (CDM) stated the color codes on the seating chart identified the dietary needs of each resident and the additional notations such as "lip" indicated special equipment needed for the resident such as a lip plate.

During all days of the survey conducted on 8/12/13, from 4:00 p.m. to 8:00 p.m. on 8/13/13, from 8:00 a.m. to 4:30 p.m. on 8/14/13, from 7:00 a.m. to 5:00 p.m. and on 8/15/13, from 8:00 a.m. to 12:00 p.m. the seating chart was observed to be prominently posted in the main dining room visible to all staff, residents and visitors to read.

The dietary services policy entitled Confidentiality revised in 3/2009, directed staff to maintain in confidence resident information as it related to dietary services. Bullet number six indicated: "Remove lists from areas viewable to the public or other unauthorized staff which include resident- specific information such as:
- Lists of residents using adaptive feeding devices
- Lists of residents on thickened liquids and/or instructions for feeding resident on special diets or protocols
- any care and treatment approaches used with resident"

On 8/14/13, at 12:20 p.m. the CDM confirmed the seating charts provided confidential, personal information regarding individual resident needs during meals. She stated the seating charts should be revised.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	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 who was seated at a table with R32 and R45. R9 was observed to eat his meal independently while the other residents waited for their meal. HM-C and HM-B then began serving the other residents in the dining room. As the meal service continued, HM-C and HM-B were observed to serve the other tables in succession (entire table served within 5 minutes.) Neither of the homemakers served the two other residents sitting with R9. At 5:55 p.m. R32 stood up from the table very angrily. He began walking away from the table. The administrator encouraged R32 to sit down and wait for the meal. R32 yelled "no" and was escorted out of the dining room by the	F 241	**F241** By 9/24/2013, R32, R9, and R45, along with all other residents seated at the same table will be served meals in succession in a timely manner and be provided the required assistance with their dining experience to maintain dignity. By 9/24/2013, education will be provided to all staff regarding serving meals in succession, in a timely manner and providing assistance necessary to maintain dignity. Random meals will be audited by the Director of Admissions & Household Life/designee. Results will be forwarded to the QA committee for further recommendation.	9-24-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 4 administrator. At 6:05 p.m. all residents in the main dining room had received their meal. A room tray was not observed to be dished for R32 who had left the dining room. At 6:50 p.m. all of the residents eating in the main dining room had completed their meals. 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. The dietary services Dignity policy revised on 11/2012, identified the dietary staffs role in providing a dignified dining experience and directed staff to serve all residents at the table at the same time, so residents can eat together. On 8/14/13, at 12:10 p.m. the certified dietary manager (CDM) stated the dietary staff were to serve all of the residents at the same time to promote a dignified dining experience. R43 was not observed to receive dignified continuous assistance with their meal service on 8/12/13. Review of the quarterly Minimum Data Set (MDS) dated 5/10/13, indicated R43 had a memory deficit and required limited assistance of one person for eating and R43 received the evening meal on 8/12/13 at 6:07 p.m. Nursing assistant (NA)-K sat down next to R43 and assisted the resident to eat the	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ____ B. WING ____	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 5	F 241		

meal starting at 6:23 p.m. (15 minutes after the meal was served) It was noted that NA-K then stopped feeding R43 and left the table in the middle of assisting R43 to eat the meal at 6:37 p.m. NA-K did not return to assist the resident to finish with eating the meal until 6:50 p.m. When NA-K returned to assist R43 with eating the meal she did ask the resident if the food was still warm and did not offer to re-warm the meal. NA-K was interviewed upon returning back to the dinning room and assisting R43 to finish eating the evening meal on 8/12/13, at 6:53 p.m. during which she stated that she had to stop feeding R43 and leave the table to assist another resident who was requesting immediate assistance to go to bed.

R43 was again observed during the breakfast meal on 8/14/13, from 7:10 a.m. to 8:25 a.m. R43 was brought to the dining room at 7:10 a.m. and was not provided food and assistance to eat until 8:25 a.m. At 8:12 a.m. NA-L stated R43 required assistance to eat meals and most always had to wait in excess of an hour in the dining room watching other residents eat before staff was available to assist the residents. NA-L further stated that she did not feel that it was "right" that these residents had to wait so long to be provided assistance with eating but felt there was not enough staff available during meals to provide timely assistance with eating.

Review of the Dietary services Dignity policy revised in 11/2012, directed the staff to provide a quiet dining room, but did not address directing the staff to try to stay with one resident until the completion of the meal.

On 8/15/13, at 10:28 a.m. the director of nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 6 services stated the staff were to assist the residents with their meals with the least amount of interruptions as possible to enhance a dignified dining experience.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide 1 of 3 residents (R56) the opportunity to make choices about bathing frequency. Findings included: R56's diagnoses included blindness and chronic kidney disease. The quarterly Minimum Data Set dated 7/10/13, indicated R56 had intact cognition and required extensive staff assistance for bathing. R56's plan of care (POC) dated 7/23/13, indicated R56 required assistance of one staff to bathe. The POC also indicated R56 received a weekly bath on Saturday mornings. Review of the past month's Bathing Report confirmed R56 had received weekly showers.	F 242	**F242** On 8-15-13 R56 was interviewed by RN on whether if she wanted a second shower a week, it is documented that resident denies making this request and states she gets washed up real good each day. RN asked if she would like a second shower and she stated she would if the staff have time. Second shower was added to R56's schedule each week. No records or interviews from staff indicate and support that the resident had requested a second shower. By 9-24-13 DNS/designee will identify all residents able to make choices about their bathing schedule. By 9/24/13 all staff will be educated on the importance of providing choice about bathing frequency. DNS/designee will perform random audits to ensure residents have the opportunity to make choices about their bathing schedule. Results will be forwarded to QA committee for further recommendation.	9-24-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	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.	F 242		
F 248 SS=D	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 and document review, the facility failed to provide an individualized activity program in order to meet the needs for 2 of 3 residents (R41, R58) reviewed for activities.	F 248	**F248** On 6/14/13 R58's comprehensive activity assessment was completed based on a prior SNF's information and care plan was written as the resident became agitated when interviewed and assessment couldn't be completed and attempts to reach the family were unsuccessful. On 8-19-13 data collection tool and social history was able to be competed in conjunction with the resident's son. By 9/24/13 R41 will be receiving an individualized activity program to meet their needs.	9-24-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 8 Findings include: R41's diagnoses included depression and dementia. The annual Minimum Data Set (MDS) dated 4/9/13, indicated R41 had moderate cognitive impairment and required total staff assistance for locomotion throughout the facility. The MDS also indicated R41's activity preferences such as music, news, group activities, going outside and attending church services were very important to her. The MDS also indicated R41 had stated reading books and newspapers were somewhat important to her. R41's quarterly MDS dated 7/5/13, indicated R41 had moderate cognitive impairment and required total staff assistance with locomotion throughout the facility and extensive staff assistance with all activities of daily living (ADLs). The MDS lacked identification of individual activity preferences. The Activity Interest Data Collection Tool dated 4/29/11, indicated R41's current interests included activities such as Bingo, Twins baseball, worship services, going outside, animal visits, talking/conversing with others and enjoying educational television programs. The quarterly Care Conference note dated 7/17/13, indicated R41 had received one to one visits four times a week with staff, many family members visited and participated in trivia games and cards. The plan of care (POC) dated 7/17/13, directed staff to invite R41 to activities and to have R41 participate in an activities program 2-3 times per week.	F 248	By 9/24/13 the Director of Admissions & Household Life/designee will review all residents to ensure they have and are receiving individualized activity program to meet their needs. Education will be provided to all staff responsible for writing and implementing resident individualized activity programs to meet their needs on the importance of completing and following each residents individualized plan. Director of Admissions & Household Life/designee will perform random audits to ensure residents have an individualized activity plan written and followed. Results will be forwarded to the QA committee for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 9	F 248		

On 8/12/13, the activity calendar indicated an activity of Cash Bingo would be held. R41 was observed to be sleeping in bed during this activity.

On 8/13/13, the activity calendar indicated at 9:30 a.m. there would be morning coffee, at 2:30 p.m. a coffee party would be held followed by Keno at 3:30 p.m.

On 8/13/13, at 1:50 p.m. R41 was observed to be asleep in bed. The main dining room had less than 15 residents drinking coffee and eating snacks. The staff members were not observed to assist R41 to the coffee party. At 3:00 p.m. staff members were observed to assist the residents from the main dining room to the North dining room for Keno. R41 continued to be in bed sleeping. At 3:30 p.m. seventeen residents were present in the North dining room as R41 slept in her bed.

On 8/14/13, at 7:30 a.m. the activity calendar indicated at 9:30 a.m. a morning coffee time would be held, at 1:30 p.m. nail salon would be conducted, at 2:30 p.m. there would be a coffee social and at 3:30 p.m. Catholic Mass would be conducted.

At 9:30 a.m. R41 was observed to be wheeled from the dining room to her room. R41 was not observed to participate in the coffee social. The main dining room was observed to have a few residents (less than 10) finishing their breakfast and 1-2 residents drinking coffee. No formal group activity program was observed in the dining room.

On 8/14/13, at 10:55 a.m. licensed practical nurse (LPN)-C stated R41 usually did not participate in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ____ B. WING ____	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 10	F 248		

the morning coffee time because R41 preferred to go back to bed during that time.

On 8/14/13, at 1:40 p.m. household non-clinical leader (HL)-B stated the homemakers role included providing activities for the residents. She stated the homemakers daily tasks also included serving the residents their meals, doing the dishes and providing the housekeeping tasks in addition to activities.

Review of R41's activity log from 5/14/13 - 8/15/13, revealed the following information:
From 5/14/13 - 6/14/13, R41 participated in six activities.
From 6/15/13 - 7/14/13, R41 participated in seven activities.
From 7/15/13 - 8/14/13, R41 participated in 12 activities.

The documentation related to the activity participation identified R41 as being awake or asleep, responding or no response. The documentation did not identify items such as when a small group discussion was held, what the topic of discussion was or how R41 responded to the discussion. The record lacked documentation related to the one to one activities and what type of activity had been conducted during the one to one activity. Review of the clinical record did not include documentation related to the types of activities completed.

On 8/14/13, at 1:50 p.m. HL-B stated she reviewed the documentation related to activities quarterly and could make adjustments as needed. HL-B confirmed R41 was not being engaged in the activities of interest as directed by the plan of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 248 Continued From page 11 F 248

She added R41 had participated in a small group activity on 8/13/14, at 10:30 a.m. with homemaker (HM)-D.

On 8/14/13, at 2:10 p.m. HM-D stated after breakfast on 8/13/13, R41 sat in a small group in the dining room and had a conversation. HM-D could not recall how long the activity lasted but stated R41 was alert during the activity. HM-D stated it was difficult to provide all of the residents with activities because of the facility change to universal workers. HM-D stated several hours of the day were used to serve the breakfast and noon meal, wash the dishes, clean the resident rooms and bathrooms plus guide activities for the residents. She stated she struggled to ensure activities were completed for residents.

On 8/14/13, at 2:10 p.m. HM-A was observed to be providing nail care in the main dining room. Four residents were participating in the activity. R41 was observed to be sleeping in bed.

On 8/14/13, at 2:15 p.m. the director of household life stated the activity programs were to be completed by the homemakers and the household leaders were to assist with the activities. She stated the facility was currently in a transition phase and felt the residents were participating in activities to their capabilities but the staff were not documenting the activities. She stated R41's family members visited regularly but the visits were not reflective in R41's record.

The Non-Traditional Setting and Activities policy dated 1/2010, identified the universal workers/ homemaker role as the staff members responsible for providing personal care and activities. The blended role staff were to adapt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 12	F 248		

activities to each resident' abilities, needs and interest. The activity director/household leaders were then to monitor the activity programs to ensure all residents were receiving individualized activities.

The facility's Comprehensive Care Plan and Care (POC) Conference policy revised 1/2011, indicated the POC was driven by identified resident issues/conditions and it is a tool representing the best approach to providing and directing care. The facility's Care Plan policy dated 1/2009, indicated the POC reflected the care currently required/provided for the resident.

R58 was not comprehensively assessed for activity interests and provided an ongoing activity program.

R58 was observed on 8/12/13 from 5:00 p.m. to 7:30 p.m.; 8/13/13 from 2:16 p.m. to 3:31 p.m.; and 8/14/13 from 7:03 a.m. to 4:10 p.m. during which the resident was not observed to participate in any organized activities or independently engaged in leisure activities.

R58 diagnoses included dementia, chronic obstructive pulmonary disease and osteoporosis.

R58's admission MDS dated 6/10/13, indicated R58 had severe cognitive impairment. The MDS also indicated the following activities were "very important" to R58: having books and magazines available for reading; listening to music; being around animal and pets; keeping up with the news; doing things with groups of people; participating in favorite leisure activities; going outside to get fresh air when the weather is good; and participating in religious activities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ___ B. WING ___	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 13	F 248		

R58's activity assessment was blank, not completed. R58's individual activity preferences (e.g., favorite color, favorite activity, family, religious practices, hobbies) had not been assessed; the residents strengths (e.g., makes own choices, ambulates, independent with wheelchair mobility, has own computer, independent with the use of one hand); and work experience had not been assessed.

R58's POC dated 6/20/13, for activities indicated: "Alteration in socialization related to dementia with behavioral disturbances manifested by a history of inappropriate sexual behaviors towards females." Interventions included : "Independent interests: resident likes to spend time with his family. He likes outdoor activities, watching TV, (sports), bingo. Escort to groups such as Bingo, special events, outdoor activities."

Review of the facility policy Activity Services Involvement in the Admission Process revised 6/10, indicated the following related to activity assessment: 7. The activity services department participates in the Resident Assessment Instrument (RAI) process. 8. Complete assigned sections of the Initial Interdisciplinary Data Collection Tool prior to the first required MDS. 9. The Activity Interest Data Collection Tool may be initiated upon admission and is completed prior to the resident's initial care planning meeting. 10. Develop an individualized care plan based on assessment information by day 21 of admission or prior to the initial care conference.

On 8/15/13, at 9:11 a.m. the non-clinical household leader-A who was responsible for the completion of R58's activity assessment stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 14 she had not completed R58's comprehensive activity assessment because R58 had became agitated when approached about activity interests. She stated she had called R58's son and had asked him to assist with completing the assessment but he had not done so. The non-clinical household leader confirmed she had not attempted to call R58's two daughters to provide input on the residents activity interests.	F 248		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement fall interventions (alarms) for 2 of 3 residents (R48, R36) according to the plan of care (POC); failed to provide timely repositioning for 1 of 2 residents (R26) as directed by the POC, failed to provide an individualized activity program for 1 of 3 residents (R41) as directed by the POC and failed to provide dietary interventions for 1 of 3 (R58) resident as directed by the POC. Findings include: R48's diagnoses included a fractured right femur, Alzheimer's disease. The current POC dated 6/12/13, indicated R48 was at risk for falls and directed staff to provide two body pillows when in bed, TABs fall alarm to	F 282	**F282** As of 8/16/13 R48 and R36 fall interventions are being followed per their plan of care. As of 8/14/13 R26 is being repositioned according to care plan. By 9/24/13 R41 will be receiving an individualized activity program per their plan of care. As of 9/10/13 R58 is receiving nutritional interventions per their plan of care	9-24-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 282 Continued From page 15
the bed and chair, keep bed locked and in the low position and keep the call light within reach.

On 8/13/13, at 11:03 a.m. R48 was observed to attempt to sit up on the edge of the bed. The tabs clip fall alarm was observed attached to R48's sweater, however, the alarm box was lying to the right of R48's pillow. The bed clip alarm did not sound when R48 sat on the edge which caused the intervention to be ineffective. At this time the surveyor notified nursing assistant (NA)-A.

On 8/14/13, during continuous observations from 6:57 a.m. until 8:53 a.m. R48 was observed seated in his wheelchair at the table in the main dining room. R48 did not have his wheelchair clip fall alarm on the chair. At 8:53 a.m. R48 was observed to attempt to stand up. There was no nursing staff present in the dining room. At 8:54 a.m. R48 was observed to attempt to stand up again. At this time, Homemaker (HM)-D was observed to approach R48 and asked him what he was trying to do and assisted R48 from the table. At 8:55 a.m. HM-D as observed to assist R48 out of the dining room and down the East hallway with the alarm still off.

On 8/14/13, At 12:32 p.m. NA-C stated earlier she had seen R48's bed clip alarm unhooked from his shirt so she had attached the clip alarm to R48's sock and went to notify a nurse. NA-C verified the bed alarm should be attached to the head or foot board of the bed.

On 8/14/13, at 12:35 p.m. NA-A stated yesterday he had placed R48's alarm box next to the pillow because the alarm holder box was not on the

F 282

As of 9/24/13 all current and newly admitted residents care planned for a personal alarm for a fall intervention will be identified. As of 9/24/13 all current and newly admitted residents having a pressure sore and whom are care planned for an individualized repositioning plan will be identified. By 9/24/13 the Director of Admissions & Household Life/designee will review all residents to ensure they are receiving activities per their plan of care. By 9/24/13 the Dietary Director/designee will review all residents with weight loss below ideal body weight to ensure nutritional interventions have been implemented. Education will be provided to all staff responsible for implementing resident individualized activity programs to meet their needs and the importance of completing and following each residents individualized plan of care. Staff responsible for assessing and implementing nutritional needs per care plan will be educated by 9-24-13 on the importance of doing so to attempt to minimize further weight loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 282 Continued From page 16
headboard. NA-A verified R48 did not have his clip alarm applied this morning.

At 12:53 p.m. registered nurse (RN)-A stated the alarm box should be attached to the head board. RN-A also stated last week they had trialed the clip alarm on R48's sock, so the alarm box was placed on the foot of the bed. In addition, RN-A stated she was not aware that R48 did not have an alarm on the wheelchair. RN-A verified R48 was a fall risk and the POC had not been followed.

On 8/15/13, at 9:06 a.m. NA-B stated she thought R48 no longer used the wheelchair alarm.

The facility failed to implement the TABs fall alarm in order to minimize falls as directed by the POC.

R36's diagnoses included a stroke and a left fractured ankle which was surgically repaired. R36's POC dated 8/5/13, directed staff to place a personal clip alarm (which will alert the staff when the resident stands) on R36 when in bed or the wheelchair.
On 8/14/13, at 7:08 a.m. R36 was observed lying in bed sleeping. The personal clip alarm was located on her table next to her bed. However, the clip alarm was not clipped to R36 nor affixed to a stable surface which rendered it ineffective.
On 8/14/13, at 7:39 a.m. NA-C confirmed R36's clip alarm had not been attached to her when she was lying in bed. NA-C also confirmed the clip alarm had been sitting on R36's table unattached.
On 8/15/13, at 8:25 a.m. RN-C confirmed R36's POC directed staff to place a personal clip alarm on when in bed or the wheelchair. RN-C stated staff were expected to follow the POC as written.

F 282
On 8/13/13 and 8/14/13 staff involved in incidents were educated on the importance of placement of personal alarms for those persons care planned for fall interventions. As of 9/24/13 all staff will be educated on the importance of placement of personal alarms for those persons care planned for fall interventions. On 8/13/13 & 8/14/13 nursing staff providing care to R26 were educated on the importance of timely repositioning and following the individualized plan of care. By 9/24/13 all nursing staff will be educated on the importance of timely repositioning in accordance with the plan of care for those persons with a pressure ulcer.

Audits will be completed to insure that those residents having a personal alarm as a fall intervention are having them place in accordance with the plan of care. Audits will be completed 2x weekly for four weeks. DNS/designee will complete audits to insure that those residents with a pressure ulcer are repositioned in accordance with their individualized plan of care. Audits will be completed 2x weekly for four weeks. Director of Admissions & Household Life/designee will perform random audits to ensure residents have an individualized activity plan written and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 17 R26 did not receive assistance with repositioning as directed by the POC. R26's POC dated 7/3/13, directed staff to assist repositioning every 1.5 hours while in the wheelchair and every 2 hours while in bed. On 8/13/13, during continuous observations from 2:30 p.m. until 4:20 p.m. R26 was observed to remain seated in her wheelchair without repositioning assistance. At 4:15 p.m. NA-I stated R26 was last repositioned at 1:40 p.m. a total of two hours and 40 minutes earlier. At this time NA-I was observed to assist R26 to stand. On 8/14/13, at 1:30 p.m. RN-C verified R26's POC directed staff to assist with repositioning every 1.5 hours while in the wheelchair. RN-C stated R26 should have bee repositioned as the POC directed. R41 did not receive an individualized activity program as directed by the plan of care. R41's POC dated 7/17/13, directed staff to invite R41 to activities and to have R41 participate in activities program 2-3 times per week. During the survey conducted on 8/12/13, from 4:00 p.m. to 8:00 p.m. on 8/13/13, from 8:00 a.m. to 4:00 p.m. on 8/14/13, from 7:00 a.m. to 3:30 p.m. and on 8/15/13, from 8:00 a.m. to 12:00 p.m. R41 was not observed to participate in any of the organized activities provided by the facility. Review of R41's activity log from 5/14/13 - 8/15/13, revealed the following information: From 5/14/13 - 6/14/13, R41 participated in six	F 282	followed. Dietary Director/designee will complete weekly random audits beginning Sept.1st on residents with weight loss below ideal body weight to ensure their nutritional needs have been assessed and interventions are being implemented per plan of care. Audit results will be forwarded to the QA committee for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 18	F 282		

activities.
From 6/15/13 - 7/14/13, R41 participated in seven activities.
From 7/15/13 - 8/14/13, R41 participated in 12 activities.

On 8/14/13, at 1:50 p.m. household non clinical leader HL-B confirmed R41 was not being engaged in the activities of interest as directed by the plan of care.

R58 was below ideal body weight; had ongoing weight loss since admission and was not consistently provided weight loss interventions according to the POC.

R58 had diagnoses that included, but were not limited to: dementia, chronic obstructive pulmonary disease and osteoporosis.

The POC dated 6/19/13, indicated the following interventions related to weight loss that included: Enlive juice (a high protein supplement) three times a day; Fortified foods; Supplements three times a day; Diet regular level 4 thin liquids; May be fed by feeding assistant; enjoys candy chocolate; tootsie rolls; medication as needed for gastritis.

During continuous observations on 8/14/13, from 7:03 a.m. to 12:51 p.m. R58 was not offered the breakfast meal nor offered any food until 12:22 p.m. in which R58 was offered the noon meal.

On 8/14/13, at 9:06 a.m. NA-J stated R58 was usually not offered the breakfast meal because R58 generally slept in until after 10:00 a.m. therefore, R58 was only offered the noon meal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 19 which was served at 11:30 a.m. 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, however, R58 did not receive the fortified mashed potatoes. Further review of the care plan dated 6/19/13, revealed that there is no care planned interventions that addressed the resident missing the breakfast meal daily. The residents supplement intake records were reviewed from 8/1/13-8/14/13, during which it was noted the resident had not been offered high calorie nutritional supplements 3 times a day on any of the days. The resident had been offered supplements three times a day according to the care plan on 2 of the 14 days; had been offered one nutritional supplement on 5 of the 14 days; and there are no high caloric supplements recorded as offered on 7 of the 14 days. On 8/15/13, at 10:31 a.m. the certified dietary manager (CDM) confirmed R58's POC lacked interventions related to R58 repeatedly missing the breakfast meal daily. Additionally, The CDM verified R58 was not provided with fortified foods and supplements as directed by the POC. The facility's Comprehensive Care Plan and Care Conference policy revised date 1/2011, indicated the POC created by identified resident issues/conditions and it was used as a tool which directed the best approach to providing and directing care. The facility's Care Plan policy dated 1/2009,	F 282		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 20 revealed the POC reflected the care currently required/provided for the resident.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning assistance for two hours and forty minutes for 1 of 2 residents (R26) reviewed with a pressure ulcer. Findings include: R26's diagnoses included cachexia (loss of muscle mass), failure to thrive, malnutrition, status post amputation/gangrene of the finger tips, status post colon cancer, diabetes and a decline in health condition. R26's quarterly Minimum Data Set (MDS) dated 6/23/13, indicated R26 had moderate cognitive impairments and required extensive assistance with all activities of daily living. The MDS also indicated R26 had an unstageable pressure ulcer. The Pressure Ulcer Care Area Assessment	F 314	**F314** As of 8/14/13 R26 is being repositioned according to care plan. As of 9/24/13 all current and newly admitted residents having a pressure sore and whom are care planned for an individualized repositioning plan will be identified. On 8/13/13 & 8/14/13 nursing staff providing care to R26 were educated on the importance of timely repositioning and following the individualized plan of care. By 9/24/13 all nursing staff will be educated on the importance of timely repositioning in accordance with the plan of care for those persons with a pressure ulcer. DNS/designee will complete audits to insure that those residents with a pressure ulcer are repositioned in accordance with their individualized plan of care. Audits will be completed 2x weekly for four weeks with results reported to QA for further recommendations.	9-24-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ____ B. WING ____	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 21	F 314		

(CAA) 3/27/13, indicated R26 was admitted the the facility with an unstageable ulcer on the coccyx/buttocks. The CAA also indicated R26 was educated on the risks versus benefits of refusals to get out of bed and repositioning. The Cognitive Loss / Dementia CAA dated 4/1/13, indicated R26 was admitted from the hospital in a debilitated state with open lesions on left and right hand fingers related to gangrene with autoamputations.

R26's plan of care (POC) dated 7/3/13, indicated R26 had moderate cognitive impairment, alteration in health status related to decreased weight, failure to thrive, open wounds secondary to gangrene and a decline in condition and diabetes. The POC indicated R26 was at risk for impaired skin integrity related to weight loss, muscle weakness, metabolic alteration and malnutrition. The POC also indicated R26 had been educated on the need for frequent repositioning. Additionally, the POC indicated R26 refused any vascular diagnostic work up for arterial ulcers. The POC directed staff to assist R26 with repositioning every 1.5 hours while in the wheelchair and every 2 hours while in bed.

The Positioning Assessment and Evaluation form dated 4/3/13, indicated R26 was admitted to the facility with a coccyx pressure ulcer. The form also indicated R26 was at high risk for pressure related ulcers due to health co-morbidities and refusal to get out of bed. The form also indicated R26 was educated on skin integrity as well as the risk versus benefits of repositioning. The assessment concluded R26 was to be repositioned every 1.5 hours while in the wheelchair and every two hours while in bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ___ B. WING ___	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 22	F 314		

Continued From page 22

The Initial Interdisciplinary Data Collection Tool dated 4/7/13, indicated R26 was admitted to the facility with a 4.5 centimeter (cm) by 1.5 cm coccyx wound.

The Positioning Assessment and Evaluation form dated 7/2/13, indicated R26 had chronic diarrhea which increased the risk for further development of pressure ulcers. The form also indicated R26 continued to have two pressure ulcers which was improved from four, previously. The assessment concluded R26 was to be repositioned with staff assist every 1.5 hours while in wheelchair and every 2 hours while in bed.

The Braden Scale for Predicting Pressure Sore Risk dated 7/10/13, indicated R26 was at high risk for the development of pressure sores.

The Interdisciplinary Progress Notes dated 7/13/13, indicated the coccyx wound was healed. The notes had not indicated the wound had reopened.

The Wound Flow Sheets last entry related to the coccyx wound indicated the wound was healed on 7/13/13. There were no further notes related to the coccyx wound.

On 8/13/13, at 2:30 p.m. R26 was observed to wheel herself into the dining room for coffee time. She remained in the dining room unit 3:10 p.m. at which time R26 was assisted to the North dining room for an activity (Keno card game). R26 was observed to remain in the North dining room until 4:10 p.m. at which time she was assisted back to her room. At no time during the activities was R26 observed to be assisted or encouraged to reposition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 23	F 314		

On 8/13/13, at 4:15 p.m. nursing assistant (NA)-I stated she had arrived at the facility at 2:00 p.m. and R26 had been in activities all afternoon. NA-I checked the computerized nursing assistant documentation and reported R26 had last been assisted with repositioning at 1:40 p.m.

On 8/13/13, at 4:20 p.m. NA-I assisted R26 into the west shower room and cued her to stand while holding onto the railings on the wall. R26 was able to stand for 20 seconds, sat for 20 seconds and stood again for 20 seconds with the assistance of NA-I. NA-I did not check R26's skin at that time. R26's wheelchair was observed equipped with a pressure redistribution cushion. NA-I confirmed R26 had last been assisted with repositioning at 1:40 p.m. a total of 2 hours and 40 minutes earlier.

On 8/14/13, at 8:40 a.m. R26 was observed to receive morning cares by NA-C. R26's coccyx area was observed to have a large intact bandage over the coccyx area.

On 8/14/13, at 1:10 p.m. registered nurse (RN)-C completed wound care on R26's coccyx region. While removing the dressing, RN-C reported the coccyx wound had been healed but R26 still had an open area on her left ischial tuberosity. However, upon removing the old dressing RN-C reported R26's coccyx wound had reopened. RN-C stated she was unaware of when the wound had reopened. The wound measured 2.5 cm x 1.2 cm with a small amount of yellow slough at the base of the wound.

On 8/14/13, at 1:30 p.m. RN-C verified R26 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 24 to be assisted with repositioning every 1.5 hours when in the wheelchair as the POC directed. The Pressure Ulcer: Skin Assessment and Prevention policy and procedure updated on 1/2012, stated : "Residents who are unable to reposition themselves independently should be repositioned as often as directed by the care plan approaches."	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement fall interventions (alarms) for 2 of 3 residents (R48, R36) as directed by the individual plan of care (POC). Findings include: R48's diagnoses included a fractured right femur and Alzheimer's disease. The initial Minimum Data Set (MDS) dated 3/4/13, indicated R48 had a history of falls prior to admission. The Fall Care Area Assessment dated 3/13/13, indicated R48 was at high risk for falls.	F 323	**F323** As of 8/16/13 R48 and R36 had their fall interventions in place. As of 9/24/13 all current and newly admitted residents care planned for a personal alarm for a fall intervention will be identified. On 8/13/13 and 8/14/13 staff involved in incidents were educated on the importance of placement of personal alarms for those persons care planned for fall interventions. As of 9/24/13 all staff will be educated on the importance of placement of personal alarms for those persons care planned for fall interventions. Audits will be completed to insure that those residents having a personal alarm as a fall intervention are having them place in accordance with the plan of care. Audits will be completed 2x weekly for four weeks with result to QA for further recommendations.	9-24-13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 25 The quarterly MDS dated 5/31/13, indicated R48 had severe cognitive impairment, was non ambulatory, required extensive staff assistance for mobility and had fallen since last assessment period. R48's current POC dated 6/12/13, indicated R48 was at risk for falls and directed staff to implement the following fall interventions: 2 body pillows when in bed, TABs alarm to bed and chair, bed in low position and locked, and call light within reach. The Falls Data Collection Tool dated 6/4/13, indicated R48 was at high risk for falls. The Incident Report (IR) dated 5/26/13, at 5:45 a.m. indicated R48 was found lying on the floor on the left side of the bed. The IR also indicated the bed TAB alarm was laying on the bed but was not sounding. IR dated 6/4/13, at 3:00 a.m. indicated R48 was found lying on the floor. The IR also indicated the TAB alarm string appeared too long as the string did not separate to activate the alarm. The alarm did not sound. The IR also indicated two body pillows were not in place. On 8/13/13, at 11:03 a.m. R48 was observed to attempt to sit up on the edge of the bed. The TABs clip alarm was observed attached to R48's sweater, however, the alarm box was lying on the bed, to the right of R48's pillow not affixed to a permanent surface. The bed clip alarm did not sound when R48 sat on the edge of the bed which caused the intervention to be ineffective. At this time the surveyor notified nursing assistant (NA)-A.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 26 On 8/14/13, at 6:57 a.m. R48 was observed seated in the wheelchair at a table in the main dining room. R48 did not have his wheelchair clip alarm on the chair. Continuous observation from this time until 8:55 a.m. revealed the following: At 8:53 a.m. R48 was observed to attempt to stand up from the wheelchair and then sit back down. There was no nursing staff present in the dining room. At 8:54 a.m. R48 was observed to attempt to stand up again. Homemaker (HM)-D was observed to approach R48 and asked him what he was trying to do. At this time HM-D assisted R48 away from the table and R48 self propelled his wheelchair, with his feet towards the middle of the dining room. At 8:55 a.m. HM-D was observed to wheel R48 out of the dining room and down the East hallway. At 8:59 a.m. nursing assistant (NA)-B was observed to assist R48 into the bathroom. At 9:07 a.m. NA-B was observed to transfer R48 back into the wheelchair and then into bed. NA-B was observed to attach the The TAB clip alarm to R48's shirt. The alarm box holder was attached to the head of the bed (HOB). On 8/14/13, at 12:32 p.m. NA-C stated the alarm should be attached to either the HOB or foot of the bed (FOB). NA-C also stated previously she had seen R48's bed clip alarm unhooked from R48's shirt therefore, she had attached the clip alarm to R48's sock and notified the nurse.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 27	F 323		

On 8/14/13, at 12:35 p.m. NA-A stated yesterday he had to lay the alarm box next to R48's pillow because the holder for the alarm box was not on the bed. NA-A stated today the alarm holder box was attached to the HOB. NA-A also stated he had noticed that R48 did not have his clip alarm applied this a.m. NA-A stated NA-B had provided a.m. cares for R48.

On 8/14/13, at 12:53 p.m. registered nurse (RN) -A stated the alarm box should have been attached to the HOB. RN-A stated last week they had trialed the clip alarm on R48's sock, therefore, the alarm box was placed on the FOB. RN-A stated typically they would have a separate alarm box for the wheelchair and the bed so staff did not have to move the alarm from the bed to the chair. Additionally, RN-A stated she was not aware R48 did not have an alarm on the wheelchair. RN-A verified R48 was a fall risk and the POC had not been followed.

On 8/15/13, at 9:06 a.m. NA-B stated R48 did have a wheelchair alarm when he was first admitted and also used a floor mat at one point. NA-B stated since the floor mat was no longer used she thought the wheelchair alarm was no longer being used since there was not one on the wheelchair.

The Facility's policy & procedure for alarms revised 10/08, indicated the charge nurse will ensure that staff are knowledgeable regarding the alarm system.

R36 had a history of falls and the facility failed to implement the TABs fall alarm as directed by the POC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 28	F 323		

R36's diagnoses included congested heart failure (decrease in heart function to pump blood), diabetes, hypertension (high blood pressure), osteoporosis, cataracts, cerebral vascular accident (stroke) and a left fractured ankle which was surgically repaired on 8/6/13.

R36's annual MDS dated 4/30/13, indicated R36 was cognitively intact and independent with walking, toileting and transferring. R36's significant change MDS dated 8/13/13, indicated R36 was moderately cognitively impaired, which demonstrated a decline in cognition and required increased staff assistance for mobility.

R36's current POC dated 8/5/13, directed staff to place a TABs personal clip alarm on R36 when in bed or wheelchair.

R36's Fall Data Collection Tool dated 8/7/13, indicated R36 was at a high risk for falls.

R36's Mobilization Support Data Collection Tool dated 8/8/13, indicated R36 was not able to place any weight on her left leg and required extensive assist to transfer

Review of R36's IR's revealed the following:
IR dated 8/4/13 at 6:35 p.m. indicated when staff responded to R36's bathroom call light R36 was found on the bathroom floor lying on her stomach. The report also indicated R36 had hit hear head, however no apparent injury noted. The report indicated immediate interventions put into place to prevent future falls was to remind R36 to ask staff for assistance to bathroom, TABs on the wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 29	F 323		

IR dated 7/31/13, at 3:20 a.m. indicated staff responded to R36's call for help and found R36 on the floor next to her closet in the prone position. The report also indicated R36 had only Ted support hose on her feet. No apparent injury. Additionally, the report indicated R36 was incontinent of urine at the time of the fall with increased confusion noted. The report indicated immediate interventions put into place was to educate R36 not to get up or walk with only support hose on feet without proper gripper type footwear and directed staff to check R36 and offer help when going to bed.

IR dated 7/30/13, at 4:02 a.m. indicated R36 was found sitting on the floor in own room. The report indicated R36 stated her legs had buckled under her and no apparent injuries. The report also indicted immediate interventions put into place consisted of : ask R36 if she thought her blood sugar (BS) was low in which R36 denied. However, R36's BS was found to be 52 in which the staff provided R36 with orange juice and crackers which increased BS to 119 at 5:45 a.m.

IR dated 6/13/13, at 9:40 a.m. indicated R36 was observed walking up bus steps which on the first step R36's leg/knee buckled and R36 crouching on the first and second steps with no apparent injury. Immediate interventions put into place included to educate R36 on use of the bus lift versus using the steps.

IR dated 2/20/13, at 4:20 p.m. indicated R36 was found sitting on the floor, next to her bed and had complained of her hands hurting. The report indicated R36 sustained a skin tear on both right and left hands and a bruised knuckle. Immediate interventions put into place included educating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 30	F 323		

R36 to wear shoes.

IR dated 11/24/12, at 7:30 p.m. indicated R36 had reported she had tripped over her dirty linen bag and had fallen backwards. However, the report indicated R36 stated she had gotten herself back up and sat on the couch. The report indicated no apparent injuries noted. The report also indicated immediate interventions implement included to add a hook to the closet in order for R36 to hang her linen bag in the room in order to prevent R36 from placing it on the floor. The report also indicated risk versus benefits of falls and fall interventions discussed with R36 however, indicated R36 refused due to desire to maintain independence.

IR dated 11/22/12, at 12:05 a.m. indicated staff responded to the sound of a loud thump and found R36 lying on her back on the floor with legs stretched under walker. The report indicated R36 sustained a 2.0 inch (in.) X 1.5 in. contusion to the back of her head. The report indicated R36 required emergency room treatment which consisted of placement of two staple to the back of the head. While at the emergency room R36 was diagnosed with a urinary tract infection (UTI) and found to be hypoglycemic. The report indicated the immediate interventions put into place consisted of Bactrim X seven days for the UTI, add an evening snack, decrease the evening dose of Lantus insulin to prevent hypoglycemia. The report also indicated R36 was educated and instructed to request staff assistance and not to mobilize when feeling hypoglycemic.

IR dated 11/16/12, at 3:00 a.m. indicated when staff responded to R36's call light, R36 was found

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 31 on the floor next to the bed. R36 stated she had rolled out of bed. The report indicated R36 sustained a 0.5 in. elbow scrape. In addition, the report indicated immediate interventions put into place included to educate R36 and staff to position body closer to wall when lying left sided to prevent roll onto floor. Nurse's Note (NN) dated 7/30/13, indicated R36 had complained of left ankle soreness, however, R36 had demonstrated ability to bear own weight. NN dated 7/31/13, indicated R36 had denied pain and confusion. NN dated 8/1/13, indicated R36 stated the left ankle pain had improved and therefore R36 declined to be seen by the physician. NN dated 8/2/13, indicated R36 had complained of left ankle / foot pain with notable swelling. The note further indicated a physician was contacted and orders for an xray was received. A follow up NN at 2:00 p.m. indicated R36 had a bimalleolar fracture and orders were received to send R36 to the emergency department. R36 was admitted to the hospital for surgical repair of the fracture. On 8/14/13, at 7:08 a.m. R36 was observed lying in her bed sleeping. The personal clip alarm (which will alert staff when the resident stands) was located on her table next to her bed. However, the clip alarm was not clipped to R36 nor affixed to a stable surface rendering it ineffective. On 8/14/13, at 7:39 a.m. NA-C verified R36's clip alarm box had been sitting on the table, unattached to a permanent surface. NA-C also	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 32 confirmed R36's clip alarm had not been attached to her when she was lying in bed and stated it should have been. On 8/15/13, at 8:25 a.m. RN-C confirmed R36's POC directed staff to utilize a TABs alarm when R36 was in bed or wheelchair. RN-C verified staff were expected to follow the POC as written. The facility's Comprehensive Care Plan and Care Conference policy revised date 1/2011, revealed the POC is driven by identified resident issues/conditions and it is a tool representing the best approach to providing and directing care. The facility's Care Plan policy dated 1/2009, reveals the POC reflects the care currently required/provided for the resident.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and implement nutritional interventions for 1 of 3 residents (R58) with weight loss and below ideal body weight in order to minimize further weight loss as the plan	F 325	**F325** R58 was assessed for nutritional interventions and they were implemented on 9/10/13 in attempt to minimize further weight loss. By 9-24-13 the Dietary Director/designee will audit all residents with weight loss below ideal body weight to ensure their nutritional needs are assessed and interventions have been implemented. Staff responsible for assessing and implementing nutritional needs per care plan will be educated by 9-24-13 on the importance of doing so to attempt to minimize further weight loss.	9-24-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 33 of care (POC) directed. Findings include: R58's diagnoses included dementia, chronic obstructive pulmonary disease and osteoporosis. R58's admission Minimum Data Set (MDS) dated 6/10/13, indicated R58 had severe cognitive impairment, was independent with eating after set up and weighed 138 pounds. R58's current POC directed staff to provide R58 with Enlive juice (a high protein supplement) three times a day; Fortified foods; Supplements three times a day; Diet regular level 4 thin liquids; May be fed by feeding assistant; enjoys candy chocolate; tootsie rolls and medications as needed for gastritis. The POC lacked indication of R58's plan for missing the breakfast meal daily. On 8/14/13, during continuous observation from 7:03 a.m. until 12:51 p.m. R58 was not offered the breakfast meal and was not offered any food until 12:22 p.m. at which time R58 was offered the noon meal. During the continuous observations, at 9:06 a.m. nursing assistant (NA)-J stated R58 was usually not offered the breakfast meal because R58 generally slept in until after 10:00 a.m. therefore, NA-J stated R58 was only offered the noon meal which was served at 11:30 a.m. daily. R58's Nutritional Assessment form completed 6/13/13, indicated R58's ideal weight range was 149-183 pounds. The form also indicated R58's admit weight was 138 (below ideal weight).	F 325	Dietary Director/designee will complete weekly random audits beginning Sept.1st on residents with weight loss below ideal body weight to ensure their nutritional needs have been assessed and interventions are being implemented per plan of care. Audit results will be forwarded to QA committee for further recommendation.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 34 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 since admission). R58 was 19.2 pounds below the lowest range of ideal body weight. 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. R58's supplement intake records from 8/1/13-8/14/13, 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 supplement on 5 of the 14 days; and there are no high caloric 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 R58 had slept past the time 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 to increase the residents caloric intake. She confirmed R58 should have received fortified mashed potatoes during the 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.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 35	F 371		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that food was served under sanitary conditions due to contaminated glove use. This had the potential to affect all 51 residents in the facility. Findings include: On 8/12/13, at 5:41 p.m. homemaker (HM)-C was observed to dish R9's evening meal up from the steam table while wearing gloves. HM-C carried the meal to R9, set it on the table and returned to the steam table. At 5:43 p.m. HM-B was observed to dish up R10's plate while wearing gloves, carried the plate to R10's table, moved R10's glass which he had been drinking from, placed the plate on the table and returned to the steam table. HM-B was not observed to change her gloves upon returning to the steam table. At 5:57 p.m. HM-B was observed to serve R29	F 371	**F371** Effective 9/1/13, glove use has been terminated, replaced by proper hand washing and proper use of parchment paper, as to ensure serving food under sanitary conditions. By 9-24-13 education has been provided to all staff serving food on ensuring food is served under sanitary conditions. Director of Dietary/designee will perform random audits to ensure meals are served under sanitary conditions. Results will be forwarded to the QA committee for further recommendations.	9-24-13

F 371 Continued From page 36 F 371

his meal, walked into the kitchen, returned with a sharp knife and cut R29's meal. She then returned to the steam table and picked up a clip board and pencil. HM-B then walked over to R54 and asked him what he would like for supper. HM-B documented R54's responses on the clip board and returned to the steam table. HM-B was not observed to change her gloves prior to dishing up the next meal.

HM-B and HM-C continued to serve the evening meal without removing their gloves or washing their hands. At 6:05 p.m. the last meal was served from the Main kitchen dining room.

On 8/12/13, at 6:00 p.m. table mates R38 and R20 were observed to receive their evening meals. Nursing assistant (NA)-H was observed to be wearing gloves as she assisted R38 with his meal.

At 6:06 p.m. NA-H was observed to stand up from the table and walk over to R20. She stood as she fed R20 3-4 bites of food and then returned to R38 gave him 1-2 bites of food and then walked to assist another resident at another table. At 6:07 NA-H returned to R38 and continued to assist him to eat. NA-H was not observed to change her gloves or wash her hands in between the residents.

At 6:09 p.m. NA-H left R38 and filled R17's coffee cup who was sitting on the opposite side of the dining room room. She then went to the fluids cart, obtained a glass of milk for R7 and returned to R38 and fed him another bite of food.

At 6:10 p.m. R60 joined R38 and R20 at the table. NA-H attempted to assist both R60 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 37	F 371		

R38 with their meals at the same time.

At 6:12 p.m. NA-H again left R38 and R60 walked around the table and stood while she assisted R20 with two bites of her meal, cued her to eat and returned to R38 and R60.

At 6:20 p.m. R38 began to cough. NA-H covered R38's mouth while coughing. NA-H did not remove the contaminated gloves.

At 6:25 p.m. NA-H left R38 and assisted R20 with a few bites of her meal. At 6:26 p.m. NA-H returned to R38.

At 6:28 p.m. NA-H stood up and left R38 as she assisted R68 with her walker and directed R68 out of the dining room. NA-H then returned to R38.

At 6:39 p.m. NA-H again left R38 and walked around the table to assist R20 with a few bites of food.

At 6:42 p.m. NA-H then returned to R38.

At no time during the dining observation of NA-H was she observed to change her gloves or wash her hands.

At 6:46 p.m. NA-H confirmed she had not removed her gloves or washed her hands while assisting multiple residents.

During the noon meal on 8/14/13, at 11:45 a.m. HM-A was observed to serve the residents in the Main dining room milk and juice from a serving cart. She was observed to be wearing gloves as

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ____ B. WING ____	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 371 Continued From page 38 F 371

she picked up each of the individual glasses and filled them. On several occasions, HM-A walked to the juice station and removed additional cups and glasses from the cupboard in the dining room.

At 11:50 a.m. HM-A was observed to serve R28 her meal. HM-A was observed to touch the table and the back of the chair with her gloved hands as she returned to the steam table. She then opened a bucket of crackers and removed the crackers with her gloved hand, placed them on a plate and served them to R28. HM-A was not observed to change her gloves prior to returning to the steam table.

At 11:55 a.m. with the same gloved hands, HM-A was observed to deliver a plate to a tablemate of R28. She placed the plate on the table, picked up an item of garbage off of the table, carried it to the garbage can and returned to the steam table.

At 11:57 a.m. the certified dietary manager (CDM) began to observe the meal delivery system. She stated the gloves are to be changed any time a staff member touches an unclean surface such as a resident, a piece of furniture or the staff touches their clothing. She stated the facility has done several educational classes on proper glove use in the dining room.

At 12:00 p.m. the CDM observed HM-A drop an item onto the floor, pick it up and walk into the kitchen. She stated the kitchen was equipped with a hand washing station, as HM-A returned to the dining room. The CDM stated HM-A could not have washed her hands and changed her gloves in the amount of time she was in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 39 kitchen. The dietary service policy entitled Gloves revised on 5/2009 , directed the staff to limit the potential for cross-contamination during the food service by using gloves when appropriate. The policy directed the staff to wear gloves when handling ready to eat foods. The policy stated: "Note: The use of gloves does not eliminate the need for proper hand washing or good hygiene." On 8/14/13, at 12:46 p.m. HM-A stated she had not washed her hands or changed her gloves during the meal service and should have.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	**F431** As of 8/13/13 R12's Fentanyl patches are being appropriately disposed of and reconciled. By 9/24/13 all current and newly admitted residents prescribed a Fentanyl patch will be identified. By 9/24/13 all nurses will be educated on the appropriate disposal and reconciliation of Fentanyl patches. Audits of the facility wide Narcotic Record will be completed twice weekly for four weeks to insure that Fentanyl patches are correctly disposed of and reconciled. Report to QA for further recommendations.	9-24-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ____ B. WING ____	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 40	F 431		

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based interview and document review, the facility failed to ensure appropriate disposal and reconciliation of controlled substances for 1 of 1 resident (R12) who was prescribed a Fentanyl (narcotic) patch.

Findings include:

During medication storage review on 8/13/13, at 2:00 p.m. licensed practical nurse (LPN)-A stated two staff members were to witness the removal and disposal of a Fentanyl patch. LPN-A also stated the Fentanyl patches were then to be disposed of down the sewer with both staff members signing the narcotic log book to verify this process was followed.

Upon review of the narcotic log book for R12, entry dated 8/5/13, revealed R12's Fentanyl patch had been removed on 8/5/13, and the patch had been lost and unable to be found again.

On 8/13/13, at 2:10 p.m. LPN-A stated if a Fentanyl patch was unaccounted for an incident

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING ______ B. WING ______	08/15/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 41 report should be completed and the charge nurse and director of nursing (DON) notified. LPN-A stated she was unsure if an incident report had been completed. On 8/14/13, at 11:47 a.m. registered nurse (RN) -B stated she was unaware of the missing Fentanyl patch and confirmed she was unable to locate an incident report for the unaccounted 8/5/13, Fentanyl patch. RN-B verified the facility's policy was to complete an incident report for any unaccounted for narcotic. On 8/14/13, at 11:50 a.m. the director of nursing (DON) confirmed she was unaware of the missing Fentanyl patch and stated she did not have an incident report for the 8/5/13, unaccounted for Fentanyl patch. The DON verified it was facility policy to complete an incident report when a narcotic medication was missing. On 8/14/13, at 2:09 p.m. RN-D provided a copy of a memo dated 6/18/13, from the DON which directed staff to have two nursing staff witness the removal and destruction of each Fentanyl patch. On 8/15/13, at 8:50 p.m. the DON verified the facility had no policy developed specific for administration, monitoring and destruction of Fentanyl patches.	F 431		

F 5318021

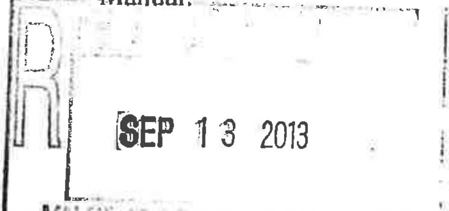
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING 01 - MAIN BUILDING 01 B. WING _______	08/14/2013

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 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 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	POC ok 9-16-13 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 7305 of the State Operations Manual.	

DC: 09.24.2013

EXIT: 08.15.2013



SEP 13 2013

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 9-13-12

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 ogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING 01 - MAIN BUILDING 01 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		

Or by email to:
Marian.Whitney@state.mn.us and
Barbara.Lundberg@state.mn.us

Fax Number 651-215-0525

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

The Good Samaritan Society International Falls was constructed at two different times. The original building (Building 01) was built in 1963, is a 1-story building, with a partial basement, and was determined to be of a Type II (111) construction. The main level of the 1963 building is sprinkler protected and all but a 2000 sq ft portion of the basement is sprinkler protected. In 1979 an addition (Building 02), was constructed to the north of building 01, which is 1-story with a basement, was determined to be Type II(000) construction, is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition) and separated from the 1963 building with a 2 hour fire barrier.

Automatic smoke detectors that are on the fire alarm system are near doors that are held open

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING 01 - MAIN BUILDING 01 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 with magnetic devices and down the corridors with extended spacing in the building in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Additional automatic smoke detection is in all common use spaces and single station smoke detectors are in the sleeping rooms of the 1963 building. Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code 2007 edition and the fire alarm system is monitored for automatic fire department notification. The building is divided into 5 smoke zones, 3 on the main floor and 2 on the basement level. The facility has a capacity of 64 beds and had a census of 52 at the time of the survey. Because the original 1963 building is only partially sprinkler protected and is separated form the 1979 building which is sprinkler protected the facility was surveyed as two separate buildings. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET in Building 01 as evidenced by:	K 000		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper	K 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING 01 - MAIN BUILDING 01 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 3 switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Observations indicated that the facility is not completely protected by an automatic fire sprinkler system as required by Centers for Medicaid Medicare Services (CMS) letter S&C-09-04. This deficient practice would allow a fire to start in a non-sprinkler protected area to grow to a point that may overwhelm the automatic fire sprinkler system, which will negatively impact all 57 residents, any visitors and the staff in the facility. Findings include: Based on observations during the facility tour on August 14, 2013 between 10:00 am and 12:00 pm, by surveyor 03006, it was determined that the following areas do not have automatic fire sprinkler protection: 1. The basement laundry room, 2. The basement offices, 3. The basement locker room, and 4 The west basement storage room. The Director of Maintenance and his staff verified these findings during the tour of the facility and during the exit conference.	K 056	K 056 This deficiency will be resolved when we move out of this building. We will be moving to the new facility at 2201 Keenan Drive October 1st 2013. Gary Hooker Facilities Director	10-1-13
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's	K 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING 01 - MAIN BUILDING 01 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 4 specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Observations and an interview with staff revealed that the 1963 building's heating ventilating and air conditioning (HVAC) system is using the corridor as part of the air distribution system. The deficient practice of using the corridor as an air handling plenum could allow the products of combustion to move from the room of fire origin through the corridor complicating the evacuation of all 57 residents, any visitors and the staff in the facility. Findings include: Based on observations and an interview with the Director of Maintenance during the facility tour on August 14, 2013 between 10:00 am and 12:00 pm, by surveyor 03006, it was determined that the facility's HVAC system uses the corridor to supply make-up air for the exhaust fans in the sleeping room bathrooms in the 1963 building and does not meet the exception to NFPA 90A, 1999 edition, Section 2-3.11.1 "Egress Corridors" that allows air transfer caused by pressure differentials through corridors. The Administrator, the Director of Maintenance and his staff verified this finding during the tour of the facility and during the exit conference. Annual Waiver Previously approved.	K 067	K 067 Request for waiver- "Unsprinklered Buildings" was previously approved. We will be moving out of this building by October 1st, 2013. We will be moving to the new facility at 2201 Keenan Drive. Gary Hooker Facilities Director	10-1-13
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING 01 - MAIN BUILDING 01 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 5 under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: A review of facility maintenance records and an interview with staff revealed that the emergency generator is not tested in accordance with NFPA 110 The Standard for Emergency and Standby Power Systems 1999 edition section 6-4.2. This deficient practice could allow the generator to have a problem that would go unnoticed by staff and which could negatively impact the all 57 residents, any visitors and the staff in the facility. Findings include: Based on a review of the Good Samaritan Society International Falls, generator logs and an interview with the Director of Maintenance, prior to the facility tour on August 14, 2013 at approximately 9:45 am , by surveyor 03006, it was determined that the generator was run monthly under load, but is was not 30 percent of its nameplate rating as required by NFPA 110 not was the exhaust gas temperature taken. No documentation of an annual load bank test was available for review. The Director of Maintenance and his staff verified these findings during the tour of the facility and during the exit conference.	K 144	K 144 The generator will be moved to the 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 1st 2013. Gary Hooker Facilities Director	10-1-13

F5318021

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

PRINTED: 09/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING 02 - 1979 ADDITION 02 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 1979 Building 02 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 02 Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	POC ok 9-16-13 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 7305 of the State Operations Manual.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 9-13-12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING 02 - 1979 ADDITION 02 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Good Samaritan Society International Falls was constructed at two different times. The original building (Building 01) was built in 1963, is a 1-story building, with a partial basement, and was determined to be of a Type II (111) construction. The main level of the 1963 building is sprinkler protected and all but a 2000 sq ft portion of the basement is sprinkler protected. In 1979 an addition (Building 02), was constructed to the north of building 01, which is 1-story with a basement, was determined to be Type II(000) construction, is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition) and separated from the 1963 building with a 2 hour fire barrier. Automatic smoke detectors that are on the fire alarm system are near doors that are held open	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING 02 - 1979 ADDITION 02 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 with magnetic devices and down the corridors with extended spacing in the building in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Additional automatic smoke detection is in all common use spaces and single station smoke detectors are in the sleeping rooms of the 1963 building. Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code 2007 edition and the fire alarm system is monitored for automatic fire department notification. The building is divided into 5 smoke zones, 3 on the main floor and 2 on the basement level. The facility has a capacity of 64 beds and had a census of 52 at the time of the survey. Because the original 1963 building is only partially sprinkler protected and is separated form the 1979 building which is sprinkler protected the facility was surveyed as two separate buildings. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET in Building 02 as evidenced by:	K 000		
K 033 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1	K 033		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING 02 - 1979 ADDITION 02 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 033	Continued From page 3 This STANDARD is not met as evidenced by: Observations and testing of stairway doors revealed that one of two stairway doors tested is not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.1.1. This deficient practice could affect 22 residents, any visitors and the staff in the north wing of this facility and the stairway allowed smoke to travel up through the stairway. Findings include: Based on observations and testing of stairway doors during the facility tour on August 14, 2013 between 10:00 am and 12:00 pm, by surveyor 03006, it was determined the north stairway door on the main level has an electronic strike plate that allows the door to become free swinging, so the door is not positive latching when the latch is released. The Director of Maintenance verified this finding during the facility tour and during the exit conference.	K 033	K 033 This deficiency will be resolved when we move out of this building. We will be moving to the new location at 2201 Keenan Drive on October 1st 2013. Gary Hooker Facilities Director	10-1-13
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by:	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING 02 - 1979 ADDITION 02 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 4 A review of facility maintenance records and an interview with staff revealed that the emergency generator is not tested in accordance with NFPA 110 The Standard for Emergency and Standby Power Systems 1999 edition section 6-4.2. This deficient practice could allow the generator to have a problem that would go unnoticed by staff and which could negatively impact the all 57 residents, any visitors and the staff in the facility. Findings include: Based on a review of the Good Samaritan Society International Falls, generator logs and an interview with the Director of Maintenance, prior to the facility tour on August 14, 2013 at approximately 9:45 am , by surveyor 03006, it was determined that the generator was run monthly under load, but is was not 30 percent of its nameplate rating as required by NFPA 110 not was the exhaust gas temperature taken. No documentation of an annual load bank test was available for review. The Director of Maintenance and his staff verified these findings during the tour of the facility and during the exit conference.	K 144	K 144 The generator will be moved to the 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 1st 2013. Gary Hooker Facilities Director	10-7-13