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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: IBEX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00063

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245237**
2.STATE VENDOR OR MEDICAID NO.
(L2) **385318700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - REDWOOD**
(L4) **FALLS 200 SOUTH DEKALB STREET**
(L5) **REDWOOD FALLS, MN** (L6) **56283**

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 **4/30/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (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
	37			
(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 :
Nicolle Marx, HFE NE II — 04/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 5/15/2014 (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
04/14/1981
(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
05/13/2014
(L33)

DETERMINATION APPROVAL

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective 3/25/2014, the facility is certified for 37 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245237

May 14, 2014

Mr. George Paulson, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, Minnesota 56283

Dear Mr. Paulson:

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 3/25/2014, the above facility is certified for:

37 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 37 skilled nursing facility beds.

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

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

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,

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 14, 2014

Mr. George Paulson, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, Minnesota 56283

RE: Project Number S5237021

Dear Mr. Paulson:

On March 15, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 27, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On April 30, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 7, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 27, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 25, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 27, 2014, effective March 25, 2014 and therefore remedies outlined in our letter to you dated March 15, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

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

Enclosure (s)
cc: Licensing and Certification File

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245237	A. Building B. Wing	4/30/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 03/25/2014	ID Prefix F0428 Reg. # 483.60(c) LSC	Correction Completed 03/25/2014	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 03/25/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By JS/KJ	Date: 5/14/2014	Signature of Surveyor: 27955	Date: 4/30/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/27/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00063	A. Building B. Wing	4/30/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1 AB(** LSC	Correction Completed **03/25/2014**	ID Prefix **21540** Reg. # **MN Rule 4658.1315 Subp. 2** LSC	Correction Completed **03/25/2014**	ID Prefix **21620** Reg. # **MN Rule 4658.1345** LSC	Correction Completed **03/25/2014**
ID Prefix **21942** Reg. # **MN St. Statute 144A.10 Subd. 8** LSC	Correction Completed **03/25/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	JS/KJ	5/14/2014	27955	4/30/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/27/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245237	A. Building B. Wing 01 - MAIN BUILDING 01	4/7/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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 K0062	03/25/2014	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/KJ	Date: 5/14/2014	Signature of Surveyor: 27200	Date: 4/7/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/27/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered 5/14/2014

May 14, 2014

Mr. George Paulson, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, Minnesota 56283

Re: Reinspection Results - Project Number S5237021

Dear Mr. Paulson:

On April 30, 2014 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 April 30, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 — ID: IBEX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00063

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245237**

2.STATE VENDOR OR MEDICAID NO.
(L2) **385318700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - REDWOOD FALLS**
(L4) **200 SOUTH DEKALB STREET**
(L5) **REDWOOD FALLS, MN** (L6) **56283**

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 **02/27/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37			
(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 :
Christine Bodick-Nord, HFE NE II 04/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 04/25/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/14/1981
(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
(L33)

DETERMINATION APPROVAL

CCN: 24-5237

At the time of the standard survey completed February 27, 2014, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.

Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 15, 2014

Mr. George Paulson, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, Minnesota 56283

RE: Project Number S5237021

Dear Mr. Paulson:

On February 27, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

Remedies - 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

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc, Supervisor
St. Cloud Survey Team B
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
sarah.grebenc@state.mn.us

Phone: (320) 223-7365
Fax: (320) 223-7348

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 April 8, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include electronic acknowledgement signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 27, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 27, 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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Sincerely,

Mark Meath

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

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

cc: Licensing and Certification File 5237s14epoc.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	02/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(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's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		3/25/14

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

Electronically Signed | 03/25/2014

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F 329	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure attempts were made to taper a medication dose or clinical rationale for contraindication of tapering was documented in the medical record, for 1 of 5 residents (R2) reviewed for unnecessary medication use. Findings include: R2's current diagnoses, per her most recent history and physical examination notes dated 7/25/13, revealed a diagnoses of single episode major depression. R2's current physician orders dated 2/9/14, revealed orders for Zoloft (an antidepressant medication) 75 milligrams (mg) daily for depression, trazodone (an antidepressant) 100 mg at bedtime (HS) for depression and anxiety, and clonazepam (an anti-anxiety medication) one (1) mg at HS. Physician progress notes dated 8/14/13, indicated R2 was on trazodone and Zoloft for insomnia and depression-type concerns. The note revealed that with chronic pain issues, it was difficult for her to sleep and she needed to continue these medications. The clinical record lacked documented evidence as to why a dose tapering attempt of R2's trazodone was contraindicated. Physician progress notes dated 12/11/13, revealed a contraindication to dose tapering attempts for R2's clonazepam due to concerns of recurrent insomnia; however, the note did not	F 329	1) Resident #2 will have their medication regimen reviewed by the pharmacist by 3/25/14. Care plan will be updated to reflect any changes. Any changes will be communicated to the nursing staff. 2) All residents have a medication regimen review completed monthly by the pharmacist. 3) Staff re-education with the licensed nursing staff on the facilitys' procedure for gradual dose reduction of medications will be completed by 3/25/14. 4) Audits will be completed to ensure the facility procedure is followed with a 10% of resident census audited weekly for a period of 3 months will occur. Audits will be completed by the DNS/designee. Results will be forwarded to the QA committee for recommendations. 5) Date of Completion: 3/25/14	

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F 329	Continued From page 2	F 329		

address R2's use of trazodone.

R2's Monthly Pharmacy Review notes from 2/22/13, through 2/14/14, addressed tapering attempts for R2's Zoloft and clonazepam; however, no irregularities were identified with R2's use of trazodone.

R2's monthly documentation summary dated 1/8/14, revealed she had no mood/behavior issues. R2's computerized documentation for signs and symptoms of depression revealed no behaviors over the previous two months and her monthly sleep monitoring data for 2/14, (done weekly) revealed she was sleeping "okay" to "good."

A psychoactive drug care area assessment (CAA) dated 1/20/14, revealed no mood issues. The CAA noted R2 had no recent dosage changes to her trazodone and had a PHQ-9 (a patient health questionnaire, or tool used to screen for depressive symptoms) interview score of four (minimal depression), which met her current goals.

During observations through out stage I and stage II of the survey from 2/24/14 through 2/27/14, and observations on 2/26/14, at 12:03 p.m. during lunch and at 1:04 p.m., while watching television in her resident room, no behavior concerns were exhibited. No signs or symptoms of depression or anxiety were identified.

During interview on 2/26/14, at 8:33 a.m. licensed practical nurse (LPN)-A said R2 was sleeping better at night. During a follow-up interview on 2/27/14, at 8:55 a.m. LPN-A said she was very

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F 329	Continued From page 3 familiar with R2 and she did not like change. LPN-A reported R2 had anxiety over her new wheelchair for a while, but was better now. LPN-A indicated R2 had no other specific behavior issues. She added, the nursing assistants charted in the kiosk if any significant behavior concerns were present. During interview on 2/26/14, at 1:56 p.m. registered nurse (RN)-B confirmed R2 had been on the 100 mg dose of trazodone, since her admission in 2011. RN-B was unable to locate information to indicate otherwise. During a follow-up interview on 2/27/14, at 10:27 a.m. RN-B could not recall any specific dose reduction attempts for R2's trazodone and indicated she had no specific target behavior monitoring for her antidepressant use because she exhibited no behaviors. During interview on 2/26/14, at 3:33 p.m. the consultant pharmacist (CP) was not able to state if there was a specific rationale for R2's continued use of trazodone at the 100 mg dose. CP confirmed there had been no attempt to taper R2's dose of trazodone. During interview on 2/27/14, at 9:50 a.m. R2's primary physician (MD)-A could not recall any adverse effects for R2 from tapering her antidepressant doses and thought the trazodone was being used both for anxiety and depression. MD-A could not recall specific dosage tapering attempts for R2's trazodone. MD-A confirmed their typical practice was to get residents off of psychoactive drugs whenever possible.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		3/25/14

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F 428	Continued From page 4 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the consultant pharmacist identified irregularities related to ongoing use of antidepressant medication for 1 of 5 residents (R2) reviewed for unnecessary drug use. Findings include: R2's current diagnoses, per their most recent history and physical examination notes, dated 7/25/13, revealed diagnoses of depression-single episode, major. R2's current physician orders, dated 2/9/14, revealed orders for Zoloft (an antidepressant medication) 75 milligrams (mg) daily for depression, Trazodone (an antidepressant) 100 mg by mouth at bedtime for depression and anxiety and Clonazepam (an anti-anxiety medication) 1 mg orally at bedtime. Review of R2's medical record revealed the following information:	F 428	1) Resident #2 has her medication regimen reviewed monthly by the pharmacist for unecessary drug use. Resident #2 will have her medication regimen reviewed by the pharmacist by 3/25/14. 2) All current residents have their medication regimen reviewed mothly by the pharmacist for unecessary drug use. 3) Re-education of licensed staff regarding the importance of unecessary medications including gradual dose reduction, duplicate therapy, etc., held on 3/20/14. 4) Audits will be completed to ensure facility procedure is followed for unecessary medications with a 10% of resident census weekly for a period of 3 months. Audits will be completed by the DNS/designee. Results will be forwarded to the QA committee for	

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F 428	Continued From page 5 R2's monthly sleep monitoring for February 2014 (done weekly) revealed R2 slept from ok to good. R2's monthly documentation summary, dated 1/8/14, revealed R2 had no mood/behavior issues. R2's computerized documentation related to signs and symptoms of depression revealed no behaviors over the previous two months. The physician visit progress notes, dated 12/11/13, revealed a contraindication to dose reduction of R2's Clonazepam due to recurrent insomnia, however did not address their antidepressant medications. The physician visit progress notes, dated 8/14/13, indicated R2 was on Trazodone and Zoloft for some insomnia and depression type things, with chronic pain issues it is difficult for her to sleep and will need to continue those medications. The clinical record lacked any documentation as to why a dose reduction of R2's Trazodone would be contraindicated. R2's Monthly Pharmacy Review notes revealed the following: 2/14/14 - no comments 1/17/14 - no comments 12/27/13 - no comments 11/30/13 - left note, Clonazepam at HS [night] 10/14/13 - no comments 9/27/13 - no comments 8/28/13 - no comments 7/24/13 - left note on Clonazepam to reduce to PRN [as needed] or change diagnosis [dx] to anxiety 6/24/13 - celebrex indicated in this patient due to	F 428	recommendations. 5) Date of Completion: 3/25/14	

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routine steroid injections
5/11/13 - no comments
4/11/3 - no comments
3/15/13 - decrease in the Zoloft
2/22/13 - left note on Zoloft

A psychoactive drug Care Area Assessment (CAA), dated 1/20/14, revealed no mood issues, and R2 did not trigger for a mood/behavior CAA on their last comprehensive Minimum Data Set (MDS). The psychoactive drug CAA stated R2 had no recent dosage changes to their Trazodone and had a (patient health questionnaire, a tool used to screen for depressive symptoms) PHQ-9 interview score of 4 (minimal depression) which met their current goals.

During interview on 2/26/14, at 1:56 p.m., registered nurse (RN)-B confirmed R2 had always been on the 100 mg of Trazodone since their admission in 2011, was unable to locate information to indicate otherwise.

During interview on 2/26/14, at 3:33 p.m., the consultant pharmacist (CP) was not able to state if there was a specific rationale for the continued use of the Trazodone, deferred to R2's primary doctor and confirmed there had been no attempt at a dose reduction.

During interview on 2/27/14, at 9:50 a.m., the resident's primary physician (MD)-A could not recall any adverse effects for R2 from dose reduction of their antidepressants, and thought the Trazodone was being used both for anxiety and depression. MD-A said they could not recall specific dosage reduction attempts on the Trazodone. MD-A said they would usually try to get residents off of psychoactive drugs if possible.

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F 428	Continued From page 7 During interview on 2/27/14, at 10:27 a.m., RN-B said they could not recall any specific dose reduction attempts on the Trazodone for R2, and that R2 had no specific target behavior monitoring for their antidepressants because R2 exhibited no behaviors.	F 428		
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. 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	F 431		3/25/14

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F 431	Continued From page 8 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored and labeled properly for 1 of 1 resident (R22) reviewed for medication storage. In addition, expired medications were given to 2 of 2 residents (R19, R28) reviewed for medication storage on the nursing unit. Findings include: During observation of medication administration on 2/24/14, at 5:04 p.m., registered nurse (RN)-A was observed to administer Advair Diskus (a medication inhaled for the treatment of chronic obstructive pulmonary disease) for R22. Upon inspection of the medication, no open date was observed to be found. RN-A indicated the medication should have been dated when opened. RN-A suspected the medication had arrived and been opened at the facility sometime in the last week. Review of the medication administration record for 2/14, revealed R22 was administered 1 puff of the Advair Diskus once in the morning and once at night. Review of the GlaxoSmithKline's (Advair Diskus manufacturer) guidelines revised on 1/11, for the use and storage of Advair Diskus indicated the device should be discarded one month after	F 431	1) New medication opened and dated for residents #22, #19, and #28. 2) All residents' medications were audited for open dates and replaced as needed to ensure compliance. 3) Staff re-education on facility procedure for dating medications and biologicals upon opening and time frames for discarding medications and biologicals occurred on 3/20/14. 4) Medication carts to be audited weekly for a time period of 3 months for expiration dates of medications and biologicals to ensure facility procedure is followed. Audits to be performed by the DNS/designee. Results will be forwarded to the QA committee for recommendations. 5) Date of Completion: 3/25/14	

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removal from the moisture-protective foil overwrap pouch or after all blisters have been used (when the dose indicator reads "0"), whichever comes first.

During inspection of the east medication cart on 2/24/14, at 6:50 p.m., a multi-dose vial of Novolin R (short acting insulin used to treat diabetes) was observed to be opened and had a handwritten date of 12/30/13, on the side of the vial. At that time, RN-A stated the handwritten date was to be written on the vial when it was opened so staff know when the medication expired, which was 30 days after opening. RN-A indicated the medication was prescribed for R19 and after reviewing R19's chart, RN-A confirmed the expired medication had been administered as recently as 2/24/14.

Review of the Food and Drug Administration's insulin storage information last updated 7/10/13, revealed insulin products contained in vials which are stored unrefrigerated either opened or unopened will continue to work for up to 28 days.

Further inspection of the east cart, a multi dose vial of Lantus (long acting insulin used to treat diabetes) was observed to be opened with a handwritten date of 1/10/14. RN-A indicated the medication was prescribed for R28 and confirmed R28 had received the expired medication that day (2/24/14).

Review of the Sanofi-Aventis's (Lantus manufacturer) guidelines revised on 3/07, for the use and storage of Lantus indicated vials must be discarded 28 days after opening. Therefore, this medication should have been discarded on 1/27/14.

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F 431	Continued From page 10 During interview on 2/25/14, at 2:15 p.m., RN-B indicated the facility did not have a process in place for checking me medication carts for expired medications. RN-B stated the expectation was that the nurses would be checking medications prior to each administration for expiration dates. RN-B confirmed the expired insulin's should not have been administered past the expiration date and the Advair Diskus should have been dated when opened, stating that each of those medications were only good for 30 days and then they should be getting rid of them weather they are empty or not. During interview on 2/26/14, at 3:39 p.m., the consulting pharmacist stated all insulin's should be discarded after 30 days. Review of the facility policy titled, Administration of Medication last revised 1/14, revealed medications designed for multiple administration should have a label affixed in a manner to promote administration and the multi-dose vial should have the open date listed on the label. Review of the facility recommended minimum medication storage parameters (based on manufacturer guidance) last revised on 9/13/13, revealed Advair Diskus should be dated when removed from the foil pouch and discarded one month after removal. The policy also identified all insulin vials should be dated when opened and discarded 28 days after opening except for Novolin R which could be used for up to 42 days after opening.	F 431		

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	245237	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2014**

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GOOD SAMARITAN SOCIETY - REDWOOD FALLS	**200 SOUTH DEKALB STREET** **REDWOOD FALLS, MN 56283**

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K 000	INITIAL COMMENTS FIRE SAFETY 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. 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, State Fire Marshal Division, on February 27, 2014. At the time of this survey, Good Samaritan Society Redwood Falls was found not to be 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 Occupancies. 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 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/25/2014

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
	245237	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	**200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283**

(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 By eMail to: Marian.Whitney@state.mn.us 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. Good Samaritan Society Redwood Falls is a one-story building with no basement. The facility is fully fire sprinkler protected, and was determined to be of Type II(000) construction. The original building was constructed in 1962, with building additions in 1966 and 1975. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 37 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25,	K 062		3/25/14

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K 062	Continued From page 2 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain its fire sprinkler system in accordance with NFPA 101 (2000) Chapter 19, Section 19.3.5 and NFPA 13 (1999) and Minnesota State Fire Code (2007) Section 901.10. In a fire emergency, this deficient practice could adversely affect 18 of 37 residents. FINDINGS INCLUDE: On 02/27/2014 at 1:20 PM, observation observation revealed a hole penetrating a section of drop-ceiling tile in Shower Room #110. This penetration (hole) could delay the sprinkler response time, due to hot gases bypassing the fire sprinkler. This finding was verified with the facility's chief building engineer, via direct observation.	K 062	1) The hole penetrating a section of drop-ceiling tile in shower room #110 has been repaired by replacing it with a new tile on 2/28/14. 2) Safety committee will audit room #110 monthly for 90 days. 3) To ensure that there will be no re-occurence, all staff will be re-educated to observe for potential safety issues at all scheduled all staff meetings.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
March 15, 2014

Mr. George Paulson, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, Minnesota 56283

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5237021

Dear Mr. Paulson:

The above facility was surveyed on February 24, 2014 through February 27, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

You must indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Sarah Grebenc at (320) 223-7365 or email: sarah.grebenc@state.mn.us.

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

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

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

Sincerely,

Mark Meath

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

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00063	A. BUILDING: _____ B. WING _____	02/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FAL	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 24th, 25th, 26th, and 27th, 2014, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 signature." Make a copy of these orders for your records and return the original to the address below: Minnesota Department of Health 3333 West Division St., Suite 212, St. Cloud, MN 56301 c/o Sarah Grebenc, Unit Supervisor 320-223-7365	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in	21535		3/25/14

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21535	Continued From page 2 part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the consultant pharmacist identified irregularities related to ongoing use of antidepressant medication for 1 of 5 residents (R2) reviewed for unnecessary drug use. Findings include: R2's current diagnoses, per their most recent history and physical examination notes, dated 7/25/13, revealed diagnoses of depression-single episode, major. R2's current physician orders, dated 2/9/14, revealed orders for Zoloft (an antidepressant medication) 75 milligrams (mg) daily for depression, Trazodone (an antidepressant) 100 mg by mouth at bedtime for depression and anxiety and Clonazepam (an anti-anxiety medication) 1 mg orally at bedtime. Review of R2's medical record revealed the following information:	21535	1) Resident #2 will have their medication regimen reviewed by the pharmacist by 3/25/14. Care plan will be updated to reflect any changes. Any changes will be communicated to the nursing staff. 2) All residents have a medication regimen review completed monthly by the pharmacist. 3) Staff re-education with the licensed nursing staff on the facilitys' procedure for gradual dose reduction of medications will be completed by 3/25/14. 4) Audits will be completed to ensure the facility procedure is followed with a 10% of resident census audited weekly for a period of 3 months will occur. Audits will be completed by the DNS/designee. Results will be forwarded to the QA committee for recommendations. 5) Date of Completion: 3/25/14	

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21535	Continued From page 3 R2's monthly sleep monitoring for February 2014 (done weekly) revealed R2 slept from ok to good. R2's monthly documentation summary, dated 1/8/14, revealed R2 had no mood/behavior issues. R2's computerized documentation related to signs and symptoms of depression revealed no behaviors over the previous two months. The physician visit progress notes, dated 12/11/13, revealed a contraindication to dose reduction of R2's Clonazepam due to recurrent insomnia, however did not address their antidepressant medications. The physician visit progress notes, dated 8/14/13, indicated R2 was on Trazodone and Zoloft for some insomnia and depression type things, with chronic pain issues it is difficult for her to sleep and will need to continue those medications. The clinical record lacked any documentation as to why a dose reduction of R2's Trazodone would be contraindicated. R2's Monthly Pharmacy Review notes revealed the following: 2/14/14 - no comments 1/17/14 - no comments 12/27/13 - no comments 11/30/13 - left note, Clonazepam at HS [night] 10/14/13 - no comments 9/27/13 - no comments 8/28/13 - no comments 7/24/13 - left note on Clonazepam to reduce to PRN [as needed] or change diagnosis [dx] to anxiety 6/24/13 - celebrex indicated in this patient due to routine steroid injections	21535		

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21535	Continued From page 4 5/11/13 - no comments 4/11/3 - no comments 3/15/13 - decrease in the Zoloft 2/22/13 - left note on Zoloft A psychoactive drug Care Area Assessment (CAA), dated 1/20/14, revealed no mood issues, and R2 did not trigger for a mood/behavior CAA on their last comprehensive Minimum Data Set (MDS). The psychoactive drug CAA stated R2 had no recent dosage changes to their Trazodone and had a (patient health questionnaire, a tool used to screen for depressive symptoms) PHQ-9 interview score of 4 (minimal depression) which met their current goals. During interview on 2/26/14, at 1:56 p.m., registered nurse (RN)-B confirmed R2 had always been on the 100 mg of Trazodone since their admission in 2011, was unable to locate information to indicate otherwise. During interview on 2/26/14, at 3:33 p.m., the consultant pharmacist (CP) was not able to state if there was a specific rationale for the continued use of the Trazodone, deferred to R2's primary doctor and confirmed there had been no attempt at a dose reduction. During interview on 2/27/14, at 9:50 a.m., the resident's primary physician (MD)-A could not recall any adverse effects for R2 from dose reduction of their antidepressants, and thought the Trazodone was being used both for anxiety and depression. MD-A said they could not recall specific dosage reduction attempts on the Trazodone. MD-A said they would usually try to get residents off of psychoactive drugs if possible. During interview on 2/27/14, at 10:27 a.m., RN-B	21535		

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21535	Continued From page 5 said they could not recall any specific dose reduction attempts on the Trazodone for R2, and that R2 had no specific target behavior monitoring for their antidepressants because R2 exhibited no behaviors. SUGGESTED METHOD OF CORRECTION: The director of nursing or pharmacist could review policies and procedures related to pharmacy reviews. The director of nursing or pharmacist could in-service all staff responsible for medication use on the need to meet the requirements as written under this licensing order. A system of auditing could be implemented with the facility's Quality Assessment and Assurance committee to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for	21540		3/25/14

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21540	Continued From page 6 the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure attempts were made to taper a medication dose or clinical rationale for contraindication of tapering was documented in the medical record, for 1 of 5 residents (R2) reviewed for unnecessary medication use. Findings include: R2's current diagnoses, per her most recent history and physical examination notes dated 7/25/13, revealed a diagnoses of single episode major depression. R2's current physician orders dated 2/9/14, revealed orders for Zoloft (an antidepressant medication) 75 milligrams (mg) daily for depression, trazodone (an antidepressant) 100 mg at bedtime (HS) for depression and anxiety, and clonazepam (an anti-anxiety medication) one (1) mg at HS. Physician progress notes dated 8/14/13, indicated R2 was on trazodone and Zoloft for insomnia and depression-type concerns. The note revealed that with chronic pain issues, it was difficult for her to sleep and she needed to continue these medications. The clinical record lacked documented evidence as to why a dose tapering attempt of R2's trazodone was contraindicated.	21540	1) Resident #2 has her medication regimen reviewed monthly by the pharmacist for unecessary drug use. Resident #2 will have her medication regimen reviewed by the pharmacist by 3/25/14. 2) All current residents have their medication regimen reviewed mothly by the pharmacist for unecessary drug use. 3) Re-education of licensed staff regarding the importance of unecessary medications including gradual dose reduction, duplicate therapy, etc., held on 3/20/14. 4) Audits will be completed to ensure facility procedure is followed for unecessary medications with a 10% of resident census weekly for a period of 3 months. Audits will be completed by the DNS/designee. Results will be forwarded to the QA committee for recommendations. 5) Date of Completion: 3/25/14	

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21540	Continued From page 7 Physician progress notes dated 12/11/13, revealed a contraindication to dose tapering attempts for R2's clonazepam due to concerns of recurrent insomnia; however, the note did not address R2's use of trazodone. R2's Monthly Pharmacy Review notes from 2/22/13, through 2/14/14, addressed tapering attempts for R2's Zoloft and clonazepam; however, no irregularities were identified with R2's use of trazodone. R2's monthly documentation summary dated 1/8/14, revealed she had no mood/behavior issues. R2's computerized documentation for signs and symptoms of depression revealed no behaviors over the previous two months and her monthly sleep monitoring data for 2/14, (done weekly) revealed she was sleeping "okay" to "good." A psychoactive drug care area assessment (CAA) dated 1/20/14, revealed no mood issues. The CAA noted R2 had no recent dosage changes to her trazodone and had a PHQ-9 (a patient health questionnaire, or tool used to screen for depressive symptoms) interview score of four (minimal depression), which met her current goals. During observations through out stage I and stage II of the survey from 2/24/14 through 2/27/14, and observations on 2/26/14, at 12:03 p.m. during lunch and at 1:04 p.m., while watching television in her resident room, no behavior concerns were exhibited. No signs or symptoms of depression or anxiety were identified.	21540		

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21540	Continued From page 8 During interview on 2/26/14, at 8:33 a.m. licensed practical nurse (LPN)-A said R2 was sleeping better at night. During a follow-up interview on 2/27/14, at 8:55 a.m. LPN-A said she was very familiar with R2 and she did not like change. LPN-A reported R2 had anxiety over her new wheelchair for a while, but was better now. LPN-A indicated R2 had no other specific behavior issues. She added, the nursing assistants charted in the kiosk if any significant behavior concerns were present. During interview on 2/26/14, at 1:56 p.m. registered nurse (RN)-B confirmed R2 had been on the 100 mg dose of trazodone, since her admission in 2011. RN-B was unable to locate information to indicate otherwise. During a follow-up interview on 2/27/14, at 10:27 a.m. RN-B could not recall any specific dose reduction attempts for R2's trazodone and indicated she had no specific target behavior monitoring for her antidepressant use because she exhibited no behaviors. During interview on 2/26/14, at 3:33 p.m. the consultant pharmacist (CP) was not able to state if there was a specific rationale for R2's continued use of trazodone at the 100 mg dose. CP confirmed there had been no attempt to taper R2's dose of trazodone. During interview on 2/27/14, at 9:50 a.m. R2's primary physician (MD)-A could not recall any adverse effects for R2 from tapering her antidepressant doses and thought the trazodone was being used both for anxiety and depression. MD-A could not recall specific dosage tapering attempts for R2's trazodone. MD-A confirmed their typical practice was to get residents off of psychoactive drugs whenever possible.	21540		

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	00063	A. BUILDING: _____ B. WING _____	02/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FAL	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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21540	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The director of nursing or pharmacist could in-service all staff responsible for medication use on the need to meet the requirements as written under this licensing order and conduct audits as necessary. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21540		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored and labeled properly for 1 of 1 resident (R22) reviewed for medication storage. In addition, expired medications were given to 2 of 2 residents (R19, R28) reviewed for medication storage on the nursing unit. Findings include: During observation of medication administration on 2/24/14, at 5:04 p.m., registered nurse (RN)-A was observed to administer Advair Diskus (a medication inhaled for the treatment of chronic obstructive pulmonary disease) for R22. Upon inspection of the medication, no open date was observed to be found. RN-A indicated the medication should have been dated when opened. RN-A suspected the medication had arrived and been opened at the facility sometime	21620	1) New medication opened and dated for residents #22, #19, and #28. 2) All residents' medications were audited for open dates and replaced as needed to ensure compliance. 3) Staff re-education on facility procedure for dating medications and biologicals upon opening and time frames for discarding medications and biologicals occurred on 3/20/14. 4) Medication carts to be audited weekly for a time period of 3 months for expiration dates of medications and biologicals to ensure facility procedure is followed. Audits to be performed by the DNS/designee. Results will be forwarded to the QA committee for	3/25/14

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21620	Continued From page 10 in the last week. Review of the medication administration record for 2/14, revealed R22 was administered 1 puff of the Advair Diskus once in the morning and once at night. Review of the GlaxoSmithKline's (Advair Diskus manufacturer) guidelines revised on 1/11, for the use and storage of Advair Diskus indicated the device should be discarded one month after removal from the moisture-protective foil overwrap pouch or after all blisters have been used (when the dose indicator reads "0"), whichever comes first. During inspection of the east medication cart on 2/24/14, at 6:50 p.m., a multi-dose vial of Novolin R (short acting insulin used to treat diabetes) was observed to be opened and had a handwritten date of 12/30/13, on the side of the vial. At that time, RN-A stated the handwritten date was to be written on the vial when it was opened so staff know when the medication expired, which was 30 days after opening. RN-A indicated the medication was prescribed for R19 and after reviewing R19's chart, RN-A confirmed the expired medication had been administered as recently as 2/24/14. Review of the Food and Drug Administration's insulin storage information last updated 7/10/13, revealed insulin products contained in vials which are stored unrefrigerated either opened or unopened will continue to work for up to 28 days. Further inspection of the east cart, a multi dose vial of Lantus (long acting insulin used to treat diabetes) was observed to be opened with a handwritten date of 1/10/14. RN-A indicated the	21620	recommendations. 5) Date of Completion: 3/25/14	

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21620	Continued From page 11 medication was prescribed for R28 and confirmed R28 had received the expired medication that day (2/24/14). Review of the Sanofi-Aventis's (Lantus manufacturer) guidelines revised on 3/07, for the use and storage of Lantus indicated vials must be discarded 28 days after opening. Therefore, this medication should have been discarded on 1/27/14. During interview on 2/25/14, at 2:15 p.m., RN-B indicated the facility did not have a process in place for checking me medication carts for expired medications. RN-B stated the expectation was that the nurses would be checking medications prior to each administration for expiration dates. RN-B confirmed the expired insulin's should not have been administered past the expiration date and the Advair Diskus should have been dated when opened, stating that each of those medications were only good for 30 days and then they should be getting rid of them weather they are empty or not. During interview on 2/26/14, at 3:39 p.m., the consulting pharmacist stated all insulin's should be discarded after 30 days. Review of the facility policy titled, Administration of Medication last revised 1/14, revealed medications designed for multiple administration should have a label affixed in a manner to promote administration and the multi-dose vial should have the open date listed on the label. Review of the facility recommended minimum medication storage parameters (based on manufacturer guidance) last revised on 9/13/13, revealed Advair Diskus should be dated when	21620		

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21620	Continued From page 12 removed from the foil pouch and discarded one month after removal. The policy also identified all insulin vials should be dated when opened and discarded 28 days after opening except for Novolin R which could be used for up to 42 days after opening. SUGGESTED METHOD OF CORRECTION: The director of nursing or pharmacist could in-service all staff responsible for medication use on the need to meet the requirements as written under this licensing order TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21620		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure an attempt to form a family council was made within the last year.	21942	1) Family council meeting held on 3/20/14. 2) Family council meetings to be held	3/25/14

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21942	Continued From page 13 During interview on 2/25/14, at 9:24 a.m., the social services designee (SSD) stated the facility did not have a family council, and was unsure of when an attempt to form one was last made. During follow up interview on 2/25/14, at 10:17 a.m., the SSD stated the facility had not attempted to form a family council since December of 2011. The Family Council/Group policy, last revision date February 2002, identified the center will provide a family council meeting at least twice a year. SUGGESTED METHOD OF CORRECTION: The administrator or designee could delegate an individual to be responsible for the annual attempt to establish a family council/group. That individual would need to document it's efforts at forming a council, and identify when the attempt occurred in the calendar year. TIME OF CORRECTION: Twenty One (21) days	21942	quarterly. 3) Social Services Designee was re-educated on importance of offering family council meeting 2/25/14. 4) Summary of family council meetings will be forwarded to the QA committee for recommendations. 5) Date of Completion: 3/25/14	