DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

				ND TRANSMITTAL		ID: IBEX			
 MEDICARE/MEDICAID PROVIDER N (L1) 245237 2.STATE VENDOR OR MEDICAID NO. (L2) 385318700 		3. NAME AND AD	Y SOCI DEKAI	E SURVEY AGENCY ETY - REDWOOD LB STREET (L6) 56283	F 4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	acility ID: 00063 _2(L8) 2. Recertification 4. CHOW 6. Complaint			
5. EFFECTIVE DATE CHANGE OF OWN (L9)		7. PROVIDER/SUI 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other mplaint		
6. DATE OF SURVEY 4/30 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 12/31	DATE: (L35)		
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	37 (L18) 37 (L17) 19 SNF	B. Not in Com	nce With equirements	/aivers:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Servin 7. Medical Direct	or		
37 (L37) (L38) 16. STATE SURVEY AGENCY REMARK	(L39)	(L42)	(L43)						
See Attached Remarks	S (II AITEICABLE S		AIION DAIL).						
17. SURVEYOR SIGNATURE <u>Nicolle Marx, H</u>	FE NE II	Date :	04/30/2014	(L19)	18. STATE SURVEY AGENCY AP		Date: <u>llist</u> 5/15/2014 (L20)		
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAI	OFFICE OR SINGLE STAT	E AGENCY			
 DETERMINATION OF ELIGIBILITY X_1. Facility is Eligible to Para 2. Facility is not Eligible 			IPLIANCE WITH CI ITS ACT:	VIL	 Statement of Financi Ownership/Control I Both of the Above : 	al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	u-1513)		
22. ORIGINAL DATE OF PARTICIPATION 04/14/1981	23. LTC AGREEMI BEGINNING		24. LTC AGREEMEN ENDING DATE		26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen	INVOLUNT 05-Fail to Me	eet Health/Safety		
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATIVI A. Suspension o		(L25) (L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>OTHER</u>	eet Agreement Status Change		
(L27)	B. Rescind Sus	pension Date:	(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS				
	(L28)	00140		(L31)					
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION (05/13/2014	OF APPROVAL DAT	E (L33)	DETERMINATION APPRO	VAL			

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY ID: IBEX Facility ID: 00063

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

Page 2 Provider Number: 24-5237 Item 16 Continuation for CMS-1539

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.



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,

> Y ale Compton

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



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,

ato Comston

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

Enclosure (s) cc: Licensing and Certification File

Form Approved

OMB NO. 0938-0390

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245237	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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)	ltem		(Y5)	Date
			Correction					Correction					Correction
ID Prefix	F0329		Completed 03/25/2014		ID Prefix	F0428		Completed 03/25/2014		ID Prefix	F0431		Completed 03/25/2014
	483.25(I)					483.60(c)		-			483.60(b), (d), (d	<u>.</u>)	
LSC					LSC					LSC		- 1	
									+-				
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #			-		Reg. #			
LSC					LSC								
			O a mar a ti a m					Ormertier					O anna ati a a
			Correction Completed					Correction Completed					Correction Completed
ID Prefix			Completed		ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC				<u> </u>	LSC			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix													
Reg. # LSC					Reg. # LSC					Reg. # LSC			
				—	200				+	200			
Reviewed By	Revie	ewed E	Зу	Da	te:	Signature of	Surve	yor:				Date:	
State Agency	/		JS/KJ		5/14/20	014		2795.	5			4/	30/2014
Reviewed By	Revie	ewed E	3y	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed of						-				a Summary of		
	2/27/2014					Unco	orrecte	u Deficiencies	(CMS	-2567) Sent	to the Facility?	YES	NO

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00063	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 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	((5) Da	te	(Y4) Item		(Y	5)	Date	(Y4)	ltem		(Y5)	Date
		Correc	ction				(Correction					Correction
		Comp						Completed					Completed
ID Prefix	21535	03/25/	2014	ID Prefix	2154	40	(03/25/2014		ID Prefix			03/25/2014
	MN Rule4658.1315 Sub			-		ule 4658.1315 Sub					MN Rule 4658.		_
LSC				LSC						LSC			_
		Como						Comontion					Correction
		Correc Comp						Correction Completed					Correction Completed
ID Prefix	21942	03/25/		ID Prefix				Completed		ID Prefix			
Reg. #	MN St. Statute 144A.10	Subd. {		Reg. #						Reg. #			
LSC				LSC									_
		Correc	ction				(Correction					Correction
ID Prefix		Comp	leted	ID Prefix				Completed		ID Prefix			Completed
													_
Reg. # LSC				Reg. # LSC						Reg. # LSC			_
							_		+-				
		Correc	ction				(Correction					Correction
		Comp	leted					Completed					Completed
ID Prefix				ID Prefix						ID Prefix			_
Reg. #				Reg. #						Reg. #			_
LSC				LSC						LSC			
		Correc	rtion					Correction					Correction
		Comp						Completed					Completed
ID Prefix				ID Prefix						ID Prefix			_
Reg. #				Reg. #						Reg. #			
LSC				LSC						LSC			_
Reviewed By		•		Date:		Signature of Sur	vey					Date:	
State Agency		JS/K	J	5/14/20)14			279	955				30/2014
Reviewed By	Reviewe	ed By		Date:		Signature of Sur	vey	/or:				Date:	
CMS RO													
Followup to	Survey Completed on:						-				a Summary of		
	2/27/2014					Uncorrec	cted	Deficiencies		-2567) Sent	to the Facility?	YES	NO
STATE FORM	1: REVISIT REPORT	(5/99)				Page 1 of 1					Event ID:	IBEX12	

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 245237	(Y2) Multiple Constr A. Building B. Wing	01 - MAIN BUILDING 01				
Name of Facility			Street Address, City, State, Zip Code				
GO	OD 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)	ltem		(Y5)	Date
		Correction				Correction					Correction
ID Prefix		Completed 03/25/2014		ID Prefix		Completed		ID Prefix			Completed
Reg. #	NFPA 101			Reg. #				Reg. #			
-	K0062					-					
		Correction Completed				Correction Completed					Correction Completed
ID Prefix				ID Prefix				ID Prefix			
Reg. #				Reg. #				Reg. #			
LSC				LSC		-		LSC			
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix				ID Prefix		-		ID Prefix			
Reg. #				Reg. #		-		Reg. #			
LSC				LSC _				LSC			
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix				ID Prefix _		-		ID Prefix			
Reg. # LSC				Reg. # LSC		-		Reg. #			
								L3C _			
		Correction				Correction					Correction
ID Drefu		Completed		ID Drafiv		Completed					Completed
ID Prefix						-					
Reg. # LSC				Reg. # LSC		-		Reg. # LSC			
								-			
Reviewed By	Review	ed By	Da	te:	Signature of Surve	eyor:				Date:	
State Agency	/	PS/KJ	5	/14/2014		27200)			4	4/7/2014
Reviewed By	/ Review	ed By	Da	te:	Signature of Surve	yor:				Date:	
CMS RO			_								
Followup to	Survey Completed on:				Check for any				-		
	2/27/2014				Uncorrecte	a Denciencies		-2007) Sent to	o the Facility?	YES	NO



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,

ate Comston

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 MI	EDICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: IBEX
	PART I	- TO BE COMP	PLETED BY T	THE STAT	FE SURVEY AGENCY	Facility ID: 00063
1. MEDICARE/MEDICAID PROVIDER 1 (L1) 245237	NO.		IARITAN SOCI	IETY - RE	DWOOD FALLS	 TYPE OF ACTION: <u>2</u>(L8) Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO. (L2) 385318700		(L4) 200 SOUTH (L5) REDWOOD		EET	(L6) 56283	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SU 01 Hospital	IPPLIER CATEGO 05 HHA	RY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 02/27/2	2014 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited1 TJC2 AOA3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS	S:		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of Th	e Following Requirements:
To (b):			Requirements		2. Technical Personnel	6. Scope of Services Limit
12.Total Facility Beds	27 (119)	_	nce Based On:		3. 24 Hour RN 4. 7-Day RN (Rural SNF	7. Medical Director
12. Total Facility Beds	37 (L18)	1	Acceptable POC		5. Life Safety Code	 8. Patient Room Size 9. Beds/Room
13.Total Certified Beds	37 (L17)		mpliance with Prog ents and/or Applied		* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKDOWN	Ň				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
37						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARI	KS (IF APPLICABL	E SHOW LTC CANC	ELLATION DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:
_Christine Bodick-Nor	<u>d, HFE NE</u>	II	04/02/2014	(L19)	Shellae Dietrich, Cer	tification Specialist 04/25/2014
PA	RT II - TO BE	COMPLETED	BY HCFA RI	EGIONA	L OFFICE OR SINGLE ST	ATE AGENCY
19. DETERMINATION OF ELIGIBILITY			MPLIANCE WITH	CIVIL	21. 1. Statement of Finar	
 Facility is Eligible to Par 	ticipate	RI	GHTS ACT:		 Ownership/Contro Both of the Above 	l Interest Disclosure Stmt (HCFA-1513) :
2. Facility is not Eligible	-					
	(L21)					
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEM	1ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	Έ	<u>VOLUNTARY</u> <u>00</u>	INVOLUNTARY
04/14/1981					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	· · · · · · · · · · · · · · · · · · ·
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	D. Danain d Cur	Deter	(L44)			00-Active
	B. Rescind Sus	pension Date.	(L45)			
28. TERMINATION DATE:	20	. INTERMEDIARY/			30. REMARKS	
20. TERMINATION DATE.	29		CINKILK IVO.		Jo. REMARKS	
	(L28)	00140		(L31)		
	(L20)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D	ATE		

(L33)

DETERMINATION APPROVAL

(L32)

DEPARTMENT OF HEALTH AND	HUMAN SERVICES	CENTERS FOR MEDICARE & MEDICAID SERVICE				
	MEDICARE/MEDICAID CERTIFICATION AND T	TRANSMITTAL	ID: IBEX			
	PART I - TO BE COMPLETED BY THE STATE SU	RVEY AGENCY	Facility ID: 00063			
C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS					

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.



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 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

	-	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		C	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245237	B. WING _		02/	27/2014
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- REDWOOD FALLS		200 SOUTH DEKALB STREET		
				REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	00		
	as your allegation of Department's acce	of correction (POC) will serve of compliance upon the otance. Your signature at the age of the CMS-2567 form will ion of compliance.				
F 329 SS=D	revisit of your facilit validate that substa regulations has bee your verification.	acceptable POC an on-site y may be conducted to intial compliance with the en attained in accordance with EGIMEN IS FREE FROM RUGS	F 32	29		3/25/14
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any e reasons above.				
	resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and o record; and residen drugs receive gradu behavioral interven	chensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical its who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these				
LABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE
	ically 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.

PRINTED: 04/29/2014

DEPART	MENT OF HEALTH	AND HUMAN SERVICES		Pr		APPROVED
CENTEF	S FOR MEDICARE	& MEDICAID SERVICES		0		0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDINC	E SURVEY PLETED		
		245237	B. WING		02/27/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- REDWOOD FALLS		200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 1	F 329)		
	by: Based on observat review, the facility fa made to taper a me rationale for contrai documented in the residents (R2) revie medication use. Findings include: R2's current diagno history and physical 7/25/13, revealed a major depression. dated 2/9/14, revea antidepressant medication antidepressant medication antidepression and anx anti-anxiety medica Physician progress R2 was on trazodor depression-type con that with chronic pa her to sleep and shi medications. The of documented evider attempt of R2's traz	NT is not met as evidenced ion, interview and document ailed to ensure attempts were edication dose or clinical indication of tapering was medical record, for 1 of 5 wed for unnecessary ses, per her most recent examination notes dated diagnoses of single episode R2's current physician orders led orders for Zoloft (an lication) 75 milligrams (mg) , trazodone (an 0 mg at bedtime (HS) for tiety, and clonazepam (an tion) one (1) mg at HS. notes dated 8/14/13, indicated he and Zoloft for insomnia and ncerns. The note revealed in issues, it was difficult for e needed to continue these clinical record lacked ice as to why a dose tapering odone was contraindicated. notes dated 12/11/13, dication to dose tapering onazepam due to concerns of however, the note did not		 Resident #2 will have their med regimen reviewed by the pharmacis 3/25/14. Care plan will be updated reflect any changes. Any changes communicated to the nursing staff. All residents have a medication regimen review completed monthly pharmacist. Staff re-education with the licens nursing staff on the facilitys' proced gradual dose reduction of medication be completed by 3/25/14. Audits will be completed to ensufacility procedure is followed with a resident census audited weekly for period of 3 months will occur. Audi be completed by the DNS/designee Results will be forwarded to the QA committee for recommendations. Date of Completion: 3/25/14 	st by to will be by the sed lure for ons will ure the 10% of a ts will e.	

If continuation sheet Page 2 of 11

		AND HUMAN SERVICES			FORM	04/29/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245237	B. WING		02/:	27/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- REDWOOD FALLS		200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	Continued From pa address R2's use o	-	F 329			
	2/22/13, through 2/ attempts for R2's Z	nacy Review notes from 14/14, addressed tapering coloft and clonazepam; larities were identified with one.				
	1/8/14, revealed sh issues. R2's composing signs and symptom behaviors over the monthly sleep moni	mentation summary dated le had no mood/behavior uterized documentation for ns of depression revealed no previous two months and her itoring data for 2/14, (done he was sleeping "okay" to				
	dated 1/20/14, reve CAA noted R2 had her trazodone and I questionnaire, or to depressive symptor	g care area assessment (CAA) ealed no mood issues. The no recent dosage changes to had a PHQ-9 (a patient health ool used to screen for ms) interview score of four n), which met her current				
	stage II of the surve 2/27/14, and observe p.m. during lunch a watching television behavior concerns	s through out stage I and ey from 2/24/14 through vations on 2/26/14, at 12:03 and at 1:04 p.m., while in her resident room, no were exhibited. No signs or ession or anxiety were				
	practical nurse (LPI better at night. Dur	2/26/14, at 8:33 a.m. licensed N)-A said R2 was sleeping ring a follow-up interview on n. LPN-A said she was very				

Facility ID: 00063

If continuation sheet Page 3 of 11

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/29/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		245237	B. WING		02/	27/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- REDWOOD FALLS		200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	LPN-A reported R2 wheelchair for a wh LPN-A indicated R2 behavior issues. SI assistants charted i behavior concerns During interview on registered nurse (R on the 100 mg dose admission in 2011. information to indica follow-up interview of RN-B could not reca attempts for R2's tra- had no specific targ antidepressant use behaviors. During interview on consultant pharmac if there was a speci use of trazodone at confirmed there had R2's dose of trazod During interview on primary physician (I adverse effects for antidepressant dose was being used bot MD-A could not rec attempts for R2's tra- their typical practice psychoactive drugs	d she did not like change. had anxiety over her new ile, but was better now. 2 had no other specific he added, the nursing n the kiosk if any significant were present. 2/26/14, at 1:56 p.m. N)-B confirmed R2 had been e of trazodone, since her RN-B was unable to locate ate otherwise. During a on 2/27/14, at 10:27 a.m. all any specific dose reduction azodone and indicated she jet behavior monitoring for her because she exhibited no 2/26/14, at 3:33 p.m. the cist (CP) was not able to state fic rationale for R2's continued the 100 mg dose. CP d been no attempt to taper one. 2/27/14, at 9:50 a.m. R2's MD)-A could not recall any R2 from tapering her es and thought the trazodone th for anxiety and depression. all specific dosage tapering azodone. MD-A confirmed e was to get residents off of whenever possible.	F 329			3/25/14
F 428 SS=D	483.60(c) DRUG R IRREGULAR, ACT	EGIMEN REVIEW, REPORT ON	F 428	5		3/25/14

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/29/2014 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	X3) DATE SURVEY COMPLETED	
		245237	B. WING			02/2	27/2014	
NAME OF F	PROVIDER OR SUPPLIER		·	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
	AMARITAN SOCIETY			2	200 SOUTH DEKALB STREET			
GOOD 3/		- REDWOOD FALLS		F	REDWOOD FALLS, MN 56283			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 428	Continued From pa	ge 4	F 4	28				
		of each resident must be nce a month by a licensed						
	the attending physic	st report any irregularities to cian, and the director of reports must be acted upon.						
	by: Based on observat review, the facility fa pharmacist identifie ongoing use of antio	NT is not met as evidenced ion, interview and document ailed to ensure the consultant d irregularities related to depressant medication for 1 of riewed for unnecessary drug			1) Resident #2 has her medication regimen reviewed monthly by the pharmacist for unecessary drug use Resident #2 will have her medicatio regimen reviewed by the pharmacis 3/25/14.	e. In		
	history and physical 7/25/13, revealed di episode, major. R2's current physici revealed orders for medication) 75 milli depression, Trazodo mg by mouth at bec anxiety and Clonazo medication) 1 mg c	lical record revealed the			 All current residents have their medication regimen reviewed moth the pharmacist for unecessary drug Re-education of licensed staff regarding the importance of unecess medications including gradual dose reduction, duplicate therapy, etc., he 3/20/14. Audits will be completed to ensur facility procedure is followed for unecessary medications with a 10% resident census weekly for a period months. Audits will be completed b DNS/designee. Results will be forw to the QA committee for 	use. ssary eld on re of of 3 by the		

Facility ID: 00063

If continuation sheet Page 5 of 11

		AND HUMAN SERVICES	-			FORM	04/29/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245237	B. WING			02/3	27/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FALLS			00 SOUTH DEKALB STREET EDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	Continued From pa	age 5	F4	128			
	P2's monthly cloop	monitoring for Ephrupry 2014			recommendations.		
	(done weekly) reve R2's monthly docur 1/8/14, revealed R2 issues. R2's comp related to signs and	monitoring for February 2014 aled R2 slept from ok to good. mentation summary, dated 2 had no mood/behavior uterized documentation d symptoms of depression ors over the previous two			5) Date of Completion: 3/25/14		
	12/11/13, revealed reduction of R2's C	progress notes, dated a contraindication to dose lonazepam due to recurrent did not address their dications.					
	indicated R2 was o some insomnia and chronic pain issues and will need to con clinical record lack	progress notes, dated 8/14/13, n Trazodone and Zoloft for d depression type things, with is it is difficult for her to sleep ntinue those medications. The ed any documentation as to on of R2's Trazodone would be					
	R2's Monthly Pharr the following:	nacy Review notes revealed					
	10/14/13 - no comr 9/27/13 - no comm 8/28/13 - no comm 7/24/13 - left note c PRN [as needed] o anxiety	ents nents , Clonazepam at HS [night] nents ents					

Facility ID: 00063

If continuation sheet Page 6 of 11

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245237	B. WING			02/27/2014		
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
GOOD S	AMARITAN SOCIETY	- REDWOOD FALLS			200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 428	routine steroid inject 5/11/13 - no comment 3/15/13 - decrease 2/22/13 - left note of A psychoactive drug (CAA), dated 1/20/1 and R2 did not trigg on their last compre- (MDS). The psycho- had no recent dosa and had a (patient H used to screen for of interview score of 4 met their current go During interview on registered nurse (R always been on the their admission in 2 information to indicat During interview on consultant pharmad if there was a speci- use of the Trazodor doctor and confirme at a dose reduction During interview on resident's primary p recall any adverse of reduction of their ar the Trazodone was and depression. M specific dosage red Trazodone. MD-As	ctions ents in the Zoloft in Zoloft g Care Area Assessment 14, revealed no mood issues, ger for a mood/behavior CAA ehensive Minimum Data Set bactive drug CAA stated R2 ge changes to their Trazodone health questionnaire, a tool depressive symptoms) PHQ-9 (minimal depression) which bals. 2/26/14, at 1:56 p.m., N)-B confirmed R2 had 100 mg of Trazodone since 2011, was unable to locate ate otherwise. 2/26/14, at 3:33 p.m., the cist (CP) was not able to state fic rationale for the continued he, deferred to R2's primary ed there had been no attempt	F 4	428				

If continuation sheet Page 7 of 11

	-	AND HUMAN SERVICES			FORM	04/29/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245237	B. WING		02/:	27/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FALLS		00 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	Continued From pa	ge 7	F 428			
F 431	said they could not reduction attempts that R2 had no spec for their antidepress behaviors. 483.60(b), (d), (e) D		F 431			3/25/14
SS=D	The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order	UGS & BIOLOGICALS nploy or obtain the services of cist who establishes a system and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically				
	labeled in accordan professional princip appropriate access	als used in the facility must be nee with currently accepted bles, and include the ory and cautionary e expiration date when				
	facility must store a locked compartmer	State and Federal laws, the Ill drugs and biologicals in hts under proper temperature t only authorized personnel to keys.				
	permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976	ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit				

If continuation sheet Page 8 of 11

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/29/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245237	B. WING			02/2	27/2014
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	quantity stored is m be readily detected This REQUIREMEN by: Based on observati review, the facility fivere stored and late resident (R22) revie In addition, expired of 2 residents (R19 storage on the nurs Findings include: During observation on 2/24/14, at 5:04 was observed to act medication inhaled obstructive pulmon- inspection of the m- observed to be four medication should I opened. RN-A susp arrived and been op in the last week. Review of the medi for 2/14, revealed F the Advair Diskus o at night. Review of the Glaxe	bution systems in which the inimal and a missing dose can NT is not met as evidenced tion, interview and document ailed to ensure medications beled properly for 1 of 1 ewed for medication storage. medications were given to 2 , R28) reviewed for medication ing unit. of medication administration p.m., registered nurse (RN)-A lminister Advair Diskus (a for the treatment of chronic ary disease) for R22. Upon edication, no open date was nd. RN-A indicated the have been dated when bected the medication had bened at the facility sometime cation administration record R22 was administered 1 puff of nce in the morning and once	F 4	131	 New medication opened and daresidents #22, #19, and #28. All residents' medications were a for open dates and replaced as nee ensure compliance. Staff re-education on facility proof or dating medications and biological upon opening and time frames for discarding medications and biologic occurred on 3/20/14. Medication carts to be audited w for a time period of 3 months for expiration dates of medications and biologicals to ensure facility procedu followed. Audits to be performed by DNS/designee. Results will be forw to the QA committee for recommendations. Date of Completion: 3/25/14 	audited eded to cedure als cals cals veekly l ure is y the	
	manufacturer) guid use and storage of	elines revised on 1/11, for the Advair Diskus indicated the scarded one month after					

If continuation sheet Page 9 of 11

CENTEI STATEMENT AND PLAN C		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245237	· ,	ING _		FORM MB NO. (X3) DATE COM	04/29/2014 APPROVED 0938-0391 E SURVEY PLETED 27/2014
GOOD S	AMARITAN SOCIETY	- REDWOOD FALLS			00 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	overwrap pouch or used (when the dos whichever comes fi During inspection o 2/24/14, at 6:50 p.m R (short acting insu observed to be ope date of 12/30/13, or time, RN-A stated tl written on the vial w know when the med days after opening. medication was pre reviewing R19's cha expired medication recently as 2/24/14. Review of the Food insulin storage infor revealed insulin pro are stored unrefrige unopened will conti Further inspection of vial of Lantus (long diabetes) was obse handwritten date of medication was pre R28 had received th (2/24/14). Review of the Sano manufacturer) guidu use and storage of discarded 28 days a	ioisture-protective foil after all blisters have been be indicator reads "0"), rst. f the east medication cart on h., a multi-dose vial of Novolin lin used to treat diabetes) was ned and had a handwritten in the side of the vial. At that he handwritten date was to be when it was opened so staff dication expired, which was 30 RN-A indicated the scribed for R19 and after art, RN-A confirmed the had been administered as and Drug Administration's rmation last updated 7/10/13, ducts contained in vials which erated either opened or nue to work for up to 28 days. of the east cart, a multi dose acting insulin used to treat trved to be opened with a 1/10/14. RN-A indicated the escribed for R28 and confirmed he expired medication that day	F 4	131			

If continuation sheet Page 10 of 11

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	04/29/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245237	B. WING	<u>،</u>		02/	27/2014
NAME OF I	PROVIDER OR SUPPLIER		-	ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FALLS			200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 431	Continued From pa	age 10	F ·	431	1		
	indicated the facility place for checking in expired medications was that the nurses medications prior to expiration dates. Rl insulin's should not the expiration date have been dated w of those medication and then they shou weather they are en During interview on consulting pharmac be discarded after 3 Review of the facility of Medication last re medications design should have a label promote administra should have the op Review of the facility medication storage manufacturer guida revealed Advair Dis removed from the f month after remova insulin vials should discarded 28 days a	n 2/26/14, at 3:39 p.m., the cist stated all insulin's should					

Facility ID: 00063

If continuation sheet Page 11 of 11

		AND HUMAN SERVICES	-	FL	837027 0		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION 1 - MAIN BUILDING 01		E SURVEY PLETED
		245237	B. WING			02/2	27/2014
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- REDWOOD FALLS			0 SOUTH DEKALB STREET EDWOOD FALLS, MN 56283		
	OUR MADY OTA	TEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETION DATE
K 000	INITIAL COMMENT	ſS	кc	000			
Ē.	FIRE SAFETY						
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.			÷		
285	Minnesota Departm Fire Marshal Division the time of this sum Redwood Falls was compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National I (NFPA) Standard 1 Chapter 19 Existing PLEASE RETURN	R THE FIRE SAFETY			EPOC	1.	
LABORATOR	Health Care Fire In State Fire Marshal 445 Minnesota Stre St. Paul, MN 55101	spections Division eet, Suite 145	NATURE		TITLE		(X6) DATE
	ically 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.

PRINTED: 03/26/2014

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING 01 - MAIN BUILDING 01				E SURVEY PLETED
		245237	B. WING			02/2	27/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DEKALB STREET		
GOOD S	AMARITAN SOCIETY	- REDWOOD FALLS			REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000 K 062 SS=E	By eMail to: Marian. Whitney@s THE PLAN OF COU DEFICIENCY MUS FOLLOWING INFO 1. A description of w to correct the defici 2. The actual, or pro 3. The name and/o responsible for corr prevent a reoccurre Good Samaritan So one-story building w is fully fire sprinkler determined to be of The original building with building additio The facility has a fin detection in the cor corridors which is n department notifica capacity of 37 beds time of the survey. The requirement at NOT MET as evide NFPA 101 LIFE SA Required automatic condition and are in	tate.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE ORMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. ociety Redwood Falls is a with no basement. The facility protected, and was f Type II(000) construction. g was constructed in 1962, ons in 1966 and 1975. re alarm system with smoke ridors and spaces open to the nonitored for automatic fire tion. The facility has a a and had a census of 37 at 42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD c sprinkler systems are ained in reliable operating respected and tested	KO	000			3/25/14
	periodically. 19.7	7.6, 4.6.12, NFPA 13, NFPA 25,					

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Facility ID: 00063

If continuation sheet Page 2 of 3

PRINTED: 03/26/2014

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SU		
		245237	B. WING	3. WING		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FALLS		200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 062	Continued From pa 9.7.5	ge 2	K 06	2		
	Based on observat maintain its fire spr with NFPA 101 (200 and NFPA 13 (1999 Code (2007) Section emergency, this de affect 18 of 37 resid	ficient practice could adversely dents.		 The hole penetrating a section drop-ceiling tile in shower room #17 been repaired by replacing it with a tile on 2/28/14. Safety committee will audit room monthly for 90 days. To ensure that there will be no 	10 has new n #110	
	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			ré-occurence, all staff will be re-edu to observe for potential safety issue scheduled all staff meetings.		
		via direct observation.	28			

Facility ID: 00063

If continuation sheet Page 3 of 3

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PRINTED: 03/26/2014



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 <u>only a suggestion</u> 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 Meeth

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

PRINTED: 04/08/2014 FORM APPROVED

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER	· · ·	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00063	B. WING		02/2	7/2014
NAME OF I	PROVIDER OR SUPPLIER	STF	REET ADDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY) SOUTH DEKALB DWOOD FALLS, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has bee	ued it is d ation nce of en bw. to red on will e item			
	that may result from orders provided tha the Department with	hearing on any assessm n non-compliance with th t a written request is mac hin 15 days of receipt of a ent for non-compliance.	ese de to			
	surveyors of this De above provider and were issued. When please sign and dat page in the line ma Director's or Provid	rS: 25th, 26th, and 27th, 201 epartment's staff visited t the following licensing o n corrections are complet te on the bottom of the fin rked with "Laboratory er/Supplier Representativ	he rders ted, rst	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	ftware. to	
	epartment of Health	ER/SUPPLIER REPRESENTATIV	/E'S SIGNATURE	TITLE		(X6) DATE

Electronically Signed

6899

PRINTED: 04/08/2014 FORM APPROVED

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED	
		00063			02/27/2014		
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
iood s	AMARITAN SOCIETY		TH DEKALB DD FALLS, N				
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2 000	Continued From page 1		2 000				
	records and return below: Minnesota Departm	St., Suite 212, St. Cloud, MN		The assigned tag number app far left column entitled "ID Pre- The state statute/rule out of co- listed in the "Summary Statem Deficiencies" column and repla Comply" portion of the correcti This column also includes the which are in violation of the sta after the statement, "This Rule as evidence by." Following the findings are the Suggested Me Correction and Time period for PLEASE DISREGARD THE H THE FOURTH COLUMN WHI STATES, "PROVIDER'S PLAN CORRECTION." THIS APPLI FEDERAL DEFICIENCIES ON WILL APPEAR ON EACH PAC THERE IS NO REQUIREMEN SUBMIT A PLAN OF CORRECT VIOLATIONS OF MINNESOTA STATUTES/RULES.	efix Tag." ompliance is ent of aces the "To on order. findings ate statute is not met surveyors ethod of r Correction. EADING OF CH N OF ES TO NLY. THIS GE.		
21535	MN Rule4658.1315 Drug Usage; Gene	Subp.1 ABCD Unnecessary ral	21535			3/25/14	
	must be free from t unnecessary drug i A. in excessive therapy; B. for excessiv C. without ade D. in the prese which indicate the o discontinued.	al. A resident's drug regimen unnecessary drugs. An s any drug when used: dose, including duplicate drug e duration; quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00063	B. WING		02/27	7/2014
AME OF F	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		,
	AMARITAN SOCIETY	200 501	TH DEKALB			
1000 3/	AMANITAN SOCIETY	REDWOOD FAL REDWOO	OD FALLS, N	IN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLE DATE
21535	Continued From pa	ige 2	21535			
	with provisions in the Code of Federal Re 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Finance This standard is inter available through the	e nursing home must comply he Interpretive Guidelines for egulations, title 42, section Appendix P of the State , Guidance to Surveyors for acilities, published by the Ith and Human Services, sing Administration, April 1992. corporated by reference. It is he Minitex interlibrary loan te Law Library. It is not change.				
	by: Based on observat review, the facility f pharmacist identifie ongoing use of anti	ent is not met as evidenced ion, interview and document ailed to ensure the consultant ed irregularities related to depressant medication for 1 of viewed for unnecessary drug		1) Resident #2 will have their m regimen reviewed by the pharma 3/25/14. Care plan will be updat reflect any changes. Any chang communicated to the nursing sta	acist by ed to es will be aff.	
	Findings include:			2) All residents have a medicati regimen review completed mont pharmacist.		
	history and physica 7/25/13, revealed d episode, major.	bees, per their most recent I examination notes, dated liagnoses of depression-single		3) Staff re-education with the lic nursing staff on the facilitys' proc gradual dose reduction of medic be completed by 3/25/14.	cedure for	
	revealed orders for medication) 75 mill depression, Trazod mg by mouth at bee anxiety and Clonaz medication) 1 mg o	-		4) Audits will be completed to en facility procedure is followed with resident census audited weekly period of 3 months will occur. A be completed by the DNS/design Results will be forwarded to the committee for recommendations	n a 10% of for a udits will nee. QA	
	Review of R2's me following informatic epartment of Health	dical record revealed the n:		5) Date of Completion: 3/25/14		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00063	B. WING		02/	27/2014
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	·	
GOOD SA	AMARITAN SOCIETY	' - REDWOOD FΔI	TH DEKALB S OD FALLS, MN			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21535	Continued From pa	age 3	21535			
	(done weekly) reve R2's monthly docu 1/8/14, revealed R2 issues. R2's comp related to signs and	o monitoring for February 2014 ealed R2 slept from ok to good. mentation summary, dated 2 had no mood/behavior puterized documentation d symptoms of depression iors over the previous two				
	12/11/13, revealed reduction of R2's C	progress notes, dated a contraindication to dose Clonazepam due to recurrent did not address their dications.				
	indicated R2 was c some insomnia and chronic pain issues and will need to co clinical record lack	progress notes, dated 8/14/13 on Trazodone and Zoloft for d depression type things, with s it is difficult for her to sleep ntinue those medications. The ed any documentation as to on of R2's Trazodone would be	•			
	R2's Monthly Pharr the following:	macy Review notes revealed				
	10/14/13 - no comm 9/27/13 - no comm 8/28/13 - no comm 7/24/13 - left note of	ients ments , Clonazepam at HS [night] ments ients				
		indicated in this patient due to ctions				

Minnesc	ta Department of He	ealth			FORM APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00063	B. WING		02/27/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY		TH DEKALB DD FALLS, M		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
21535	•	-	21535		
	5/11/13 - no comm 4/11/3 - no comme 3/15/13 - decrease 2/22/13 - left note o	nts in the Zoloft			
	(CAA), dated 1/20/ and R2 did not trig on their last compr (MDS). The psych had no recent dosa and had a (patient used to screen for	g Care Area Assessment 14, revealed no mood issues, ger for a mood/behavior CAA ehensive Minimum Data Set oactive drug CAA stated R2 age changes to their Trazodone health questionnaire, a tool depressive symptoms) PHQ-9 4 (minimal depression) which pals.			
	registered nurse (F always been on the	n 2/26/14, at 1:56 p.m., RN)-B confirmed R2 had e 100 mg of Trazodone since 2011, was unable to locate cate otherwise.			
	consultant pharma if there was a spec use of the Trazodo	n 2/26/14, at 3:33 p.m., the cist (CP) was not able to state ific rationale for the continued ne, deferred to R2's primary ed there had been no attempt n.			
	resident's primary recall any adverse reduction of their a the Trazodone was and depression. M specific dosage rec Trazodone. MD-A	n 2/27/14, at 9:50 a.m., the ohysician (MD)-A could not effects for R2 from dose ntidepressants, and thought being used both for anxiety ID-A said they could not recall duction attempts on the said they would usually try to psychoactive drugs if possible.			
Minnesota D STATE FOR	epartment of Health	n 2/27/14, at 10:27 a.m., RN-B	6899	IBEX11	If continuation sheet 5 of 14
					continuation sheet 0 01 14

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00063	B. WING		02/	27/2014
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻			
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	TH DEKALB S DD FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	ige 5	21535			
	reduction attempts that R2 had no spe	recall any specific dose on the Trazodone for R2, and cific target behavior monitoring sants because R2 exhibited no				
	The director of nurs review policies and pharmacy reviews. pharmacist could in for medication use requirements as wr order. A system of implemented with th	he facility's Quality ssurance committee to ensure				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
21540	MN Rule 4658.131 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			3/25/14
	monitor each reside unnecessary drug u home's policies and pharmacist must re resident's attending physician does not home's recommend adequate justification believes the residen adversely affected, matter to the medic medical director is in the medical director	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the port any irregularity to the g physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the cal director for review if the not the attending physician. If r determines that the attending have adequate justification for				

TATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		00063	B. WING		02/27/2014
GOOD S	PROVIDER OR SUPPLIER	- REDWOOD FAL	TH DEKALB DD FALLS, N		
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21540	the order and if the change the order, t review to the Qualit (QAA) committee r the attending phys the consulting phar directly to the QAA. This MN Requirem by: Based on observat review, the facility f made to taper a me rationale for contra documented in the residents (R2) revie medication use. Findings include: R2's current diagno history and physica 7/25/13, revealed a major depression. dated 2/9/14, revea antidepressant med daily for depression antidepressant medication anti-anxiety medica Physician progress R2 was on trazodor depression-type co that with chronic pa her to sleep and sh medications. The of documented evider	attending physician does not he matter must be referred for ty Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter ent is not met as evidenced ion, interview and document ailed to ensure attempts were edication dose or clinical indication of tapering was medical record, for 1 of 5 ewed for unnecessary oses, per her most recent I examination notes dated a diagnoses of single episode R2's current physician orders iled orders for Zoloft (an dication) 75 milligrams (mg)		 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 3/25/14. All current residents have their medication regimen reviewed mothly the pharmacist for unecessary drug of 3) Re-education of licensed staff regarding the importance of unecess medications including gradual dose reduction, duplicate therapy, etc., he 3/20/14. Audits will be completed to ensur facility procedure is followed for unecessary medications with a 10% resident census weekly for a period of months. Audits will be completed by DNS/designee. Results will be forwat to the QA committee for recommendations. Date of Completion: 3/25/14 	by by use. sary Id on e of of 3 the

STATEMEN	It of Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00063	 В. WING		02/	27/2014
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		ITH DEKALB S OD FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	age 7	21540			
	revealed a contrain attempts for R2's c recurrent insomnia address R2's use of R2's Monthly Pharr 2/22/13, through 2/ attempts for R2's Z however, no irregul R2's use of trazodo R2's monthly docur 1/8/14, revealed sh issues. R2's comp signs and symptom behaviors over the monthly sleep mon	nacy Review notes from 14/14, addressed tapering oloft and clonazepam; arities were identified with				
	dated 1/20/14, reve CAA noted R2 had her trazodone and questionnaire, or to depressive sympto (minimal depressio goals.	g care area assessment (CAA ealed no mood issues. The no recent dosage changes to had a PHQ-9 (a patient health ool used to screen for ms) interview score of four n), which met her current				
	stage II of the surve 2/27/14, and obser p.m. during lunch a watching television behavior concerns	s through out stage I and ey from 2/24/14 through vations on 2/26/14, at 12:03 and at 1:04 p.m., while in her resident room, no were exhibited. No signs or ession or anxiety were				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00063	B. WING		02/	27/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	TH DEKALB S OD FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21540	During interview on practical nurse (LPI better at night. Dur 2/27/14, at 8:55 a.m familiar with R2 and LPN-A reported R2 wheelchair for a wh LPN-A indicated R2 behavior issues. S assistants charted is behavior concerns During interview on registered nurse (R on the 100 mg dose admission in 2011. information to indic follow-up interview RN-B could not rec attempts for R2's tr had no specific targ antidepressant use behaviors. During interview on consultant pharmac if there was a speci use of trazodone at confirmed there has R2's dose of trazod During interview on primary physician (adverse effects for antidepressant dos was being used bot MD-A could not rec attempts for R2's tr	 2/26/14, at 8:33 a.m. licensed N)-A said R2 was sleeping ring a follow-up interview on n. LPN-A said she was very d she did not like change. had anxiety over her new hile, but was better now. 2 had no other specific he added, the nursing in the kiosk if any significant were present. 2/26/14, at 1:56 p.m. RN)-B confirmed R2 had been e of trazodone, since her RN-B was unable to locate ate otherwise. During a on 2/27/14, at 10:27 a.m. all any specific dose reduction razodone and indicated she get behavior monitoring for her because she exhibited no 2/26/14, at 3:33 p.m. the cist (CP) was not able to state ific rationale for R2's continued the 100 mg dose. CP d been no attempt to taper 		DEFICIENC		

	ota Department of He				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED
		00063	B. WING	02	2/27/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- REDWOOD EAL	'H DEKALB D FALLS, M		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
21540	Continued From pa	ge 9	21540		
	The director of nurs in-service all staff re on the need to mee under this licensing necessary.	HOD OF CORRECTION: ing or pharmacist could esponsible for medication use t the requirements as written order and conduct audits as			
21620	MN Rule 4658.1345 Drugs used in the n in accordance with	ursing home must be labeled	21620		3/25/14
	by: Based on observati review, the facility fa were stored and lab resident (R22) revie In addition, expired of 2 residents (R19 storage on the nurs Findings include: During observation on 2/24/14, at 5:04 was observed to ad medication inhaled obstructive pulmona inspection of the me observed to be four medication should h opened. RN-A susp	ent is not met as evidenced on, interview and document ailed to ensure medications beled properly for 1 of 1 ewed for medication storage. medications were given to 2 , R28) reviewed for medication ing unit. of medication administration p.m., registered nurse (RN)-A minister Advair Diskus (a for the treatment of chronic ary disease) for R22. Upon edication, no open date was nd. RN-A indicated the nave been dated when ected the medication had pened at the facility sometime		 New medication opened and dated for residents #22, #19, and #28. All residents' medications were audited for open dates and replaced as needed to ensure compliance. 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. Medication carts to be audited weekly for a time period of 3 months for expirated 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 	e on

IBEX11

If continuation sheet 10 of 14

STATEMEN	<u>ta Department of He</u> TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
				:		
		00063	B. WING		02/	27/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		TH DEKALB DD FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLE ⁻ DATE
21620	Continued From pa	age 10	21620			
	in the last week.			recommendations.		
	for 2/14, revealed F	ication administration record R22 was administered 1 puff of once in the morning and once		5) Date of Completion: 3/25	5/14	
	manufacturer) guid use and storage of device should be di removal from the m overwrap pouch or	oSmithKline's (Advair Diskus elines revised on 1/11, for the Advair Diskus indicated the iscarded one month after noisture-protective foil after all blisters have been se indicator reads "0"), irst.				
	2/24/14, at 6:50 p.r R (short acting insu observed to be ope date of 12/30/13, o time, RN-A stated t written on the vial v know when the me days after opening. medication was pre reviewing R19's ch	of the east medication cart on n., a multi-dose vial of Novolin ulin used to treat diabetes) was ened and had a handwritten n the side of the vial. At that he handwritten date was to be when it was opened so staff dication expired, which was 30 RN-A indicated the escribed for R19 and after art, RN-A confirmed the had been administered as				
	insulin storage info revealed insulin pro are stored unrefrige	and Drug Administration's rmation last updated 7/10/13, oducts contained in vials which erated either opened or inue to work for up to 28 days.				
	vial of Lantus (long diabetes) was obse	of the east cart, a multi dose acting insulin used to treat erved to be opened with a f 1/10/14. RN-A indicated the				

TATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		E SURVEY PLETED
IND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED
		00063	B. WING		02/	27/2014
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		TH DEKALB S DD FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21620	Continued From pa	ge 11	21620			
	medication was prescribed for R28 and confirmed R28 had received the expired medication that day (2/24/14).					
	manufacturer) guid use and storage of discarded 28 days	ofi-Aventis's (Lantus elines revised on 3/07, for the Lantus indicated vials must be after opening. Therefore, this have been discarded on				
	indicated the facility place for checking in expired medications was that the nurses medications prior to expiration dates. RI insulin's should not the expiration date have been dated w of those medication	2/25/14, at 2:15 p.m., RN-B v did not have a process in me medication carts for s. RN-B stated the expectation s would be checking b each administration for N-B confirmed the expired have been administered past and the Advair Diskus should hen opened, stating that each has were only good for 30 days Id be getting rid of them mpty or not.				
		2/26/14, at 3:39 p.m., the cist stated all insulin's should 30 days.				
	of Medication last r medications design should have a label promote administra	ty policy titled, Administration evised 1/14, revealed led for multiple administration I affixed in a manner to tion and the multi-dose vial en date listed on the label.				
	medication storage manufacturer guida	ty recommended minimum parameters (based on ance) last revised on 9/13/13, skus should be dated when				

	NT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		00063	B. WING		02/27/2014
IAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE	02/21/2014
OOD S	AMARITAN SOCIETY		TH DEKALB		
(X4) ID	SUMMARY ST		DD FALLS, MI	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLET
21620	Continued From pa	age 12	21620		
	month after remova insulin vials should discarded 28 days Novolin R which co after opening. SUGGESTED MET The director of nurs in-service all staff r on the need to mee under this licensing	ioil pouch and discarded one al. The policy also identified all be dated when opened and after opening except for build be used for up to 42 days THOD OF CORRECTION: sing or pharmacist could esponsible for medication use et the requirements as written g order R CORRECTION: Twenty One			
21942	Resident and Fami Resident advisory of boarding care hom advisory council an fewer than three per participating. If one function, the nursin home shall docume council or councils year. This subdivision residents and famil 144.651, subdivision This MN Requirem by: Based on interview	council. Each nursing home or e shall establish a resident id a family council, unless ersons express an interest in e or both councils do not ig home or boarding care ent its attempts to establish the at least once each calendar ion does not alter the rights of lies provided by section on 27.		 Family council meeting held on 3/20/14. 	3/25/14

STATE FORM

IBEX11

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		00063	B. WING		02/2	7/2014
	PROVIDER OR SUPPLIER		TH DEKALB			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	DD FALLS, N ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLET DATE
21942	During interview on social services des did not have a fami when an attempt to During follow up int a.m., the SSD state attempted to form a December of 2011. The Family Counci date February 2002 provide a family co year. SUGGESTED MET The administrator of individual to be res to establish a famil would need to docu council, and identify the calendar year.	12/25/14, at 9:24 a.m., the signee (SSD) stated the facility ily council, and was unsure of o form one was last made. terview on 2/25/14, at 10:17 ed the facility had not a family council since	1	 quarterly. 3) Social Services Designee w re-educated on importance of family council meeting 2/25/14 4) Summary of family council will be forwarded to the QA correcommendations. 5) Date of Completion: 3/25/1 	offering neetings nmittee for	