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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: IXK4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00322

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/21/2014** (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 **54** (L18)

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor — 06/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Heath
Enforcement Specialist — 07/02/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 07/10/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/22/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5318

June 6, 2014

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

Dear Mr. Coe:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective May 6, 2014 the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Protecting, Maintaining and Improving the Health of Minnesotans

June 6, 2014

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

RE: Project Number S5318024

Dear Mr. Coe:

On April 7, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 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 May 21, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 27, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 6, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 27, 2014, effective May 6, 2014 and therefore remedies outlined in our letter to you dated April 7, 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.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245318	A. Building B. Wing	5/21/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **05/06/2014**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **05/06/2014**	ID Prefix **F0283** Reg. # **483.20(l)(1)&(2)** LSC	Correction Completed **05/06/2014**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **05/06/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/06/2014**	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

Reviewed By _____ **State Agency**	**Reviewed By** MM/LB	**Date:** 06/06/2014	**Signature of Surveyor:** 28035	**Date:** 05/21/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/27/2014	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IXK4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00322

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

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

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

4. TYPE OF ACTION: **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 **03/27/2014** (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 **54** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

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

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
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE NEII 04/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/20/2014 (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
06/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5318

On March 27, 2014 a standard survey was completed. Deficiencies were found whereby correction is required. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit (PCR) to folow. Refer to the CMS 2567 for both health and life safety code along with the provider's plan of correction.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 7, 2014

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

RE: Project Number S5318024

Dear Mr. Coe:

On March 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:

Lyla Burkman Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 June 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 September 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 5318s14epoc.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to make prompt efforts to resolve grievances verbalized by 1 of 1 resident (R36) reviewed who had requested a room change. Findings include: R36's quarterly Minimum Data Set dated 1/17/14, indicated R36's diagnoses included diabetes, osteoarthritis, degenerative joint disease and joint pain. The MDS also indicated R36 had intact cognition, required extensive assistance with bed	F 166	On 3/26/2014, Household Leader had a conversation with R36 regarding the requested room change. Household Leader educated R36 on why the request could not be honored at the time of the original request and offered resident the option to explore a room closer to the dining room on a different house or to wait until something else became available on her current house. Resident chose to wait until something became available on her current house. All staff will be educated by 5/6/14 on	5/6/14

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

Electronically Signed | 04/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 1 mobility, transfers, was non ambulatory and utilized a wheelchair for locomotion on and off of the nursing unit. R36's plan of care (POC) dated 10/29/13, indicated R36 had weakness related to degenerative joint changes and shoulder limitations. The POC also indicated R36 was able to propel self short distance while in the wheelchair and required staff assistance for greater distances. The POC directed staff to transfer R36 with a mechanical standing lift. On 3/25/14, at 1:15 p.m. R36 stated she would like to move to room 316 which was closer to the dining room. R36 explained she currently resided in the room furthest away from the dining room and in order to independently maneuver from the her room to the dining room, she had to pull herself along the wall using the hand rails. She stated this action bothered her right arm. R36 stated she had talked to the household supervisors of non-clinical needs (supervisor-A) about moving to room 316, but did not know why she had not been moved. R36 added room 316 had been vacant for the past month. On 3/25/14, at 3:00 p.m. room 316 was observed vacant. On 3/25/14, at 3:02 p.m. licensed practical nurse (LPN)-A stated room 316 had been empty for the past 3-4 weeks, however, a new resident was scheduled to be admitted into room 316 in a few hours.	F 166	making prompt efforts to resolve grievances. Education will be provided by Director of Admissions & Household Life/designee. Audits will begin 4/15/14 and will consist of asking residents and their families/responsible party for the next quarter during care conferences if they have any outstanding requests that have not received prompt efforts to resolve, if so they will be addressed and documented promptly. Household Leaders/designee will complete audits. Results will be forwarded to the QA committee for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 2 On 3/26/14, at 7:35 a.m. personal care assistant (PCA)- B was observed to wheel R36 in her wheelchair from her room to the dining room. On 3/26/14, at 10:00 a.m. room 316 was observed to be occupied by a new resident. On 3/26/14, at 1:30 p.m. R36 stated she would like to be closer to the dining room so her wrist would not hurt from pulling herself along the wall. She stated she had noticed room 316 now had a new resident in it, but nobody had offered the room to her. R36's clinical record lacked documentation regarding a request to change rooms. On 3/26/14, at 1:40 p.m. supervisor-A stated she had heard through report that R36 had requested to move into room 316. She confirmed room 316 was closer to the nurses desk and it was an "unwritten rule" that the rooms closer to the desk were to be occupied by residents at a higher fall risk, required higher medical assistance or were frequently awake at night. She stated R36 did not need any of the additional assistance and it was good for her to wheel herself. She also stated when R36 was tired, she was encouraged to ask staff members to help her. Supervisor-A stated she could not recall talking to R36 about changing rooms but confirmed she was aware R36 had requested a room change. Supervisor-A stated R36 did not need the additional assistance	F 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 3 so "that was the extent of it." On 3/26/14, at 1:45 p.m. the director of admissions and household life (director)-A confirmed the facility had an "unwritten rule" in each of the household, the rooms directly across from the nurses station were left open for residents who were at a higher risk for fall, required additional nursing interventions or who had been admitted for short term stay. She confirmed R36 had been in the same room since the building had opened in October of 2013. On 3/36/14, at 2:00 p.m. registered nurse (RN)-A stated she was aware R36 had requested to move to room 316. She stated room 316 had been empty for the past 2-3 weeks but the facility had decided to keep that particular room open as a "high risk room." RN-A stated R36 did not have the ability to get to the dining room by herself because of arthritic pain in her shoulders and history of knee surgeries. She stated R36 maneuvered in the facility short distances by pulling herself along with handrails. She confirmed she was aware R36 had requested to change rooms, but she had not addressed the concern with R36. On 3/26/14, at 2:25 p.m. PCA-A stated she had found R36 sitting in room 316 about a week to 10 days ago. She stated R36 was looking around and stated she would like to move into the room. She stated she had reported the request to supervisor-A . She added on 3/25/14, she had noticed R36 sitting in room 316 for a while and then she came out of the room on her own. NA-A	F 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 4 stated since room 316 was saved for other resident's she didn't think anything of it. On 3/26/14, at 2:30 p.m. PCA-B stated he was aware R36 wanted to move into room 316, but stated R36 "can not move there, so we told her." On 3/26/14, at 2:35 p.m. PCA-C stated R36 was sitting in room 316 yesterday. She stated she explained to R36 a new resident would be moving in later that day. She confirmed R36 wanted to be in room 316. The Grievance, Complaints or Concerns policy dated 11/1999, identified "voiced grievances" to include a residents verbalized complaints to center staff. The procedure directed the staff how to investigate, document and attempt to resolve the issue. On 3/27/14, at 9:20 a.m. the director of nurses confirmed the facility had not considered R36's request to change rooms as a personal grievance but stated the facility should have followed up with R36 regarding her request.	F 166		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced	F 176		5/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 5 by: Based on observation, interview and document review, the facility failed to ensure the safe practice of self-administration of nebulizer treatments for 1 of 2 residents (R33) observed self administering a nebulizer treatment. Findings Include: R33's quarterly Minimum Data Set (MDS) dated 12/27/13, indicated R33 had severe cognitive impairment. The MDS also indicated R33 had diagnoses of chronic obstructive pulmonary disease (COPD) and dementia. On 3/26/14, at 8:09 a.m. R33 was observed in bed, lying on her back with her eyes closed. The nebulizer mask was observed lying on the floor with the machine running. Licensed practical nurse (LPN)-B was observed on the phone at the time and stated, "I am busy with meds." The following observations were made: At 8:12 a.m. LPN-B went into the medication room. At 8:13 a.m. LPN-B came out of the medication room and spoke with registered nurse (RN)-A. At 8:18 a.m. LPN-B was administering medications in the dining room. At 8:19 a.m. the nebulizer mask continued to lie on the floor with the machine running. At 8:21 a.m. LPN-B went into the medication room. At 8:24 a.m. LPN-B continued down the hallway with her scheduled medication administration. At 8:28 a.m. R33's nebulizer mask remained on the floor with the machine running. At 8:40 a.m. the nebulizer mask remained on the floor with the machine running.	F 176	As of 3/31/14, R33 is receiving her nebulizer treatment according to policy and procedure. R33 is not able to self-administer nebulizer treatments. On 3/27/15 LPN was re-educated on proper administration of nebulizer treatments for those persons determined to not be appropriate for self-administration of medications. By 5/6/14, all current and newly admitted residents receiving nebulizer treatments will be identified. DNS/designee will educate all Licensed Nursing staff on the proper administration of nebulizer treatments, including the Self-Administration of Medications procedure by 5/6/14. DNS and/or designee will complete audits on proper nebulizer treatment administration three times weekly for four weeks, then one time weekly for four weeks. Results to QA for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 6 At this time, personal care assistants (PCA)-B and PCA-E entered the room. PCA-B picked the mask up off the floor and stated 2-3 times a year he had found the mask on the floor. PCA-B laid the mask on the night stand and shut the nebulizer machine off. PCA-E stated LPN-B would have started the nebulizer medication. At 8:48 a.m. LPN-B stated she had placed the mask on R33 and started the nebulizer machine for R33 between 7:45-8:00 a.m. LPN-B stated, "I usually stick close by in the area and check on her." LPN-B added R33 had been in a "mood" yesterday and today and would not eat or take medications. LPN-B stated R33 was receiving a Duoneb medication, and confirmed R33 did not have a physician's order to self-administer medications. R33's current physician's order dated 3/18/14, indicated Duoneb (for treatment of bronchospasm) solution 3 cubic centimeters (CC) to inhale three times a day for COPD. On 3/27/14, at 8:05 a.m. registered nurse (RN)-A stated LPN-B was very well aware that R33 could not self-administer her medication. In addition, RN-A stated R33 should not be left alone during the nebulizer medication treatment. RN-A stated the first step in the Resident Self-Administration of Medication procedure would be for the resident to request to self administer her medications. RN-A stated R33 was not be capable of making this request. The Resident Self-Administration procedure	F 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 7 revised 1/11, indicated the interdisciplinary team would make a determination for each resident who expressed a desire to self-administer medications if the resident can do so safely.	F 176		
F 283 SS=D	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a recapitulation of the resident's stay for 1 of 1 resident (R53) reviewed who was discharged from the facility. Findings include: R53 was admitted to the facility on 10/3/13. The hospital discharge summary dated 10/3/13, identified R53 with multiple diagnoses including diabetes mellitus, history of knee surgery and pressure ulcer. The Interdisciplinary Progress Notes (nurses notes) dated 12/2/13, indicated R53 was seen at a local clinic and required physical therapy treatments. No further documentation was included in the clinical record. The census record indicated R53 was discharged from the facility. A recapitulation was lacking from the record.	F 283	Recapitulation completed on R53 on 4/11/14. By 5/6/14 all current and newly admitted residents discharged between 3/28/14 and 5/6/14 will be identified. By 5/6/14 all RN□s and HHL□s will receive training on the Discharge Summary Policy and Procedure. On 3/26/14, RN responsible for R53 was educated on Discharge Summary Policy and Procedure. DNS and/or designee will complete audits on resident recapitulation of stay for every discharge for 6 weeks or 6 discharges whichever takes place first. Results to QA for further recommendation.	5/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 283	Continued From page 8 On 3/27/14, at 8:40 a.m. registered nurse (RN)-B stated R53 was seen in the clinic the morning of 12/2/13. The clinic staff called later that afternoon and directed R53 to be transported to the local rural hospital for inpatient therapy. R53 was then transferred into a larger hospital and R53's family did not wish to hold R53's bed at the facility. R53's record was then closed. RN-B confirmed R53's clinical record did not contain any information related to the hospital transfer and also lacked a recapitulation of R53's stay. On 3/27/14, at 9:00 a.m. the director of nurses confirmed information related to how, when and why R53 was transferred from the facility to the hospital was lacking from the clinical record. She also confirmed the record did not contain a recapitulation of R53's needs while at the facility. The Discharge Summary policy dated 9/2010, directed the staff to complete a recapitulation of the residents stay including summary of course of treatment and condition at discharge.	F 283		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		5/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 9 by: Based on observation, interview and document review, the facility failed to ensure ground food items were served at proper hot temperatures for 3 of 3 residents (R33, R65, R28) who required ground food on the Kempton Cottage neighborhood. The facility also failed to maintain cold foods in the Kempton Cottage Neighborhood which had the potential to affect 4 identified residents (R65, R72 , R36, R17) and had the potential to affect the remaining 12 residents dining in the Kempton Cottage. In addition, the facility failed to maintain proper dishwasher rinse cycle temperatures in 2 of 3 resident neighborhoods (Dove Island and Voyager's Haven) which had the potential to affect all 34 residents residing in the neighborhoods. Findings include: Kempton Court Kitchenette: On 3/26/14, at 11:46 a.m. homemaker (H)-A prepared the Kempton Court kitchenette for the noon meal. H-A placed the prepared meal items into the counter top steam table well. The meal consisted of hamburger steak, broccoli, peas, mashed potatoes, gravely, bun and a custard desert. The steam wells were observed to have regular textured foods, ground meat and pureed vegetables. H-A checked the temperature of each food item. The regular textured foods were noted to be over 140 degrees Fahrenheit (F), however, the temperature of the ground meat, pureed meat and pureed vegetables were observed to be at 108 degrees F. The temperature of the custard desert was observed to at 65 degrees F. H-A did not attempt to reheat the hot food items, nor did she attempt to cool the desert.	F 371	Effective 3/27/14 ground foods were served at proper hot temperatures for R33, R65 and R28. Also effective 3/27/14 cold foods were served at the proper temperatures for R65, R72 and R17.Education regarding these proper temperatures will be provided to all Homemakers and Household Leaders. This education will include the proper way to temp foods, logging/documenting the temps, and how food should be stored prior to serving in order to serve at the proper temperatures. This education will be provided by the Director of Dietary Services and the Director of Admissions and Household Life by 5/6/14. Director of Dietary Services/designee will audit random meals weekly for 4 weeks to ensure foods are served at the proper temperatures. Results will be forwarded to the QA committee for further recommendation. By 5/6/14 the facility will maintain proper dishwasher rinse cycle temperatures for all households. Education will be provided to all Homemakers and Household Leaders about the proper temperatures for the dishwashers rinse cycle, how to check these temperatures, what to do if it does not reach proper temperature and how to document these temperatures. The Director of Dietary Services and the Director of Admissions and Household Life will provide education by 5/6/14. Director of Dietary Services/designee will audit dishwasher temp documentation weekly for 4 weeks. The Director of Dietary Services will provide the results to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 10 At 11:59 a.m. H-A began dishing the noon meal to the 17 residents in Kempton Cottage. Three cognitively impaired residents, R33, R65 and R28 were observed to be served the ground meat and pureed vegetables. H-A then served 16 residents including R33, R65, R28 and R17 custard. At 12:17 p.m. all 17 residents in Kempton Cottage had received the noon meal. On 3/26/14, at 12:18 p.m. the certified dietary manager (CDM) was observed to check the temperature of the ground meat. The remaining ground meat was observed to be at 68 degrees F. There were no additional pureed vegetables to monitor. The temperature of the custard was 68 degrees F. The CDM stated the facility did not routinely check the temperatures of the food at the end of meal service. She stated the hot food items were to be served at 135 degrees or warmer and cold foods were to be served at 40 degrees F or cooler. She stated when H-A noted the temperatures were below 135 degrees F, she should have warmed the food to 135 degrees F to ensure the food was safe. She stated H-A could have placed the custard into the refrigerator to ensure it was served at a safe temperature. The CDM stated the non clinical household supervisors were to be monitoring the food service at each meal. She confirmed she had not monitored the food service in the neighborhood dining room. On 3/26/14, at 2:05 p.m. the non-clinical household supervisor (supervisor)-A stated she had not been involved with monitoring the food to ensure the food was served at safe temperatures.	F 371	the QA committee for further review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 11	F 371		

The Food Temperatures policy dated March 2009, directed the staff to ensure hot foods which are potentially hazardous be served above 135 degrees F and cold foods were to be served below 41 degrees F.

The kitchen dishwasher on the Dove Island neighborhood failed to consistently meet the required rinse cycle temperature of 180 degrees Fahrenheit to ensure sanitation.
Findings include:
On 3/26/14, at 1:15 p.m. during the kitchen tour of the Dove Island neighborhood with homemaker (H)-C, the dishwasher rinse cycle temperature was observed to reach 180 degrees Fahrenheit. At that time H-C stated the dishwasher wash and rinse cycles should be documented in the facility's log book with each meal time.
Dove Island neighborhood's Dish Machine Temperature Log revealed:
· For the month of January 2014:
o The log lacked documentation for the final rinse cycle 55 out of 93 opportunities.
o The documented rinse cycle did not meet the required 180 degrees Fahrenheit 18 out of 38 rinse cycles monitored.
· For the month of February 2014:
o The log lacked documentation for the final rinse cycle 46 out of 84 opportunities.
o The documented rinse cycle did not meet the required 180 degrees Fahrenheit 33 out of the 53 rinse cycles monitored.
· For the month of March 2014:
o The log lacked documentation for the final rinse cycle 59 out of 78 opportunities.
o The documented rinse cycle did not meet the required 180 degrees Fahrenheit 19 out of 22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 12 rinse cycles monitored. On 3/26/14, at 2:00 p.m. the certified dietary manager (CDM) verified the rinse cycle temperature was to be at 180 degrees Fahrenheit and the recorded temperature was supposed to documented on the log sheet. The CDM stated the neighbor hood kitchen's were not her responsibility and added the non-clinical household lead (supervisor) monitored the temperature log sheet. On 3/27/14, at 9:30 a.m. the non- clinical household supervisor - B confirmed the Dish Machine Temperature Log was not being completed according to the facility policy. She stated she had not known they were incomplete until the day before (3/26/14). The kitchen dishwasher on Voyager's Haven neighborhood failed to consistently meet the required rinse cycle temperature of 180 degrees Fahrenheit to ensure sanitation. Findings include: On 3/26/14, at 1:00 p.m. during the kitchen tour of the Voyager's Haven neighborhood with homemaker (H)-B, the dishwasher rinse cycle temperature was observed to reach 176 degrees Fahrenheit. Voyager's Haven neighborhood's Dish Machine Temperature Log revealed: · For the month of January 2014: o The log lacked documentation for the final rinse cycle 48 out of 93 opportunities. o The documented rinse cycle did not meet the required 180 degrees Fahrenheit 32 out of 45 rinse cycles monitored. · For the month of February 2014:	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 13 o The log lacked documentation for the final rinse cycle 46 out of 84 opportunities. o The documented rinse cycle did not meet the required 180 degrees Fahrenheit 32 out of the 38 rinse cycles monitored. · For the month of March 2014: o The log lacked documentation for the final rinse cycle 42 out of 78 opportunities. o The documented rinse cycle did not meet the required 180 degrees Fahrenheit 34 out of 36 rinse cycles monitored. On 3/27/14, at 9:10 a.m. H-B confirmed the dishwasher wash and rinse cycles should have been documented in the facility's log book with each meal time. The facility's Dishwashing policy dated March 2009, directed staff to check and record rinse cycle temperatures to assure rinse cycle temperatures where maintained at 180 degrees Fahrenheit.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		5/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 14 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was completed by the nurse for 1 of 2 residents (R33) observed during wound care. Findings include: On 3/26/14, at 10:37 a.m. Licensed Practical Nurse (LPN)-B was observed to enter R33's room, wash her hands, remove R33's left boot and apply gloves.	F 441	As of 3/26/14, R33 is receiving wound care in accordance with proper hand hygiene. All current and newly admitted residents receiving wound care will be identified by 5/6/14. DNS/designee will educate all Licensed Nursing staff Wound Dressing Change Policy and Procedure and GSS Hand Hygiene by 5/6/14. On 3/26/14, LPN□s on duty were re-educated on proper policy and procedure. DNS and/or designee to complete audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 15 LPN-B was observed to cut R33's left calf wound dressing (Kling) off with a scissors and remove a gauze pad from the wound. LPN-B cleansed the left calf area with wound cleanser and gauze. LPN-B removed her gloves, applied clean gloves and applied Vaseline to the leg, followed by a gauze pad and Kling. LPN-B then removed her gloves and reapplied the left heel boot. Following the above observation, LPN-B was observed to remove R33's right heel boot and apply gloves. LPN-B was observed to cut the Kling off the right leg and remove the gauze pad covering the wound. LPN-B used wound cleanser to remove the mepilex (absorbent soft silicone foam) pads off the wound. There were two healing areas observed on R33's right lower leg. LPN-B removed her gloves and applied clean gloves. LPN-B cut new mepilex dressings and applied them to the leg wound. LPN-B again removed her gloves and applied new gloves. LPN-B then applied Vaseline to the leg wound and removed her gloves, applied clean gloves followed by application of a gauze pad and Kling to the wound. At 10:51 a.m. LPN-B verified she had not washed her hands or used any alcohol hand based sanitizer during the wound treatment. LPN-B stated she would have to check the policy regarding hand washing. At this time, LPN-B was observed to reapply R33's right heel boot. At 10:54 a.m. LPN-B was observed to bag up the garbage from the dressing changes and wash her hands in R33's bathroom. On 3/27/14, at 8:12 registered nurse (RN)-A stated between the removal of the dirty dressing and the application of the clean dressing she	F 441	insuring that proper hand hygiene is being completed during wound dressing changes in accordance with GSS Policy and Procedure. Audits to be completed two times weekly for eight weeks. Results to QA for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 16 would expect hand hygiene to be done. RN-A stated this was an "issue." On 3/27/14, at 11:38 a.m. RN-A documented two intact scabs on the left lower extremity measuring 1.0 centimeter (CM) by 0.3 centimeter and 0.1 cm by 0.2 cm. R33 had dry thick scaly skin noted on the leg. The Wound Dressing Change procedure revised 11/13, indicated hand hygiene was to be performed after removal of the soiled dressing and glove removal. The Hand Hygiene and Hand Washing procedure revised 11/11, indicated after having contact with a resident's skin/wounds and after glove removal hand hygiene would be performed.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING **03 - 2013 BUILDING** B. WING _____	**03/25/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATION/	**2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 03 2013 Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Good Samaritan Society International Falls 03 2013 Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancy. The Good Samaritan Society International Falls is a new 1-story building, no basement, and was determined to be Type V (111) construction. The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition) with quick response sprinkler heads. The building is separated from the new assisted living building with a 2-hour fire barrier. The facility has automatic smoke detectors that are on the fire alarm system, throughout the corridor system, in all areas open to the corridor and in all sleeping rooms. It is installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition) and the Minnesota State Fire Code 2007 edition. The fire alarm system is monitored for automatic fire department notification. The building is divided into 3 smoke compartments by 1-hour smoke barriers and 2-hour fire barriers.	K 000		

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING **03 - 2013 BUILDING** B. WING _____	**03/25/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	**2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 The facility has a capacity of 64 beds and had a census of 51 at the time of the inspection. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) are MET.	K 000		