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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: J273

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00087

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245500**
2.STATE VENDOR OR MEDICAID NO.
(L2) **078040500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BETHANY**
(L4) **804 WRIGHT STREET**
(L5) **BRAINERD, MN** (L6) **56401**

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 **04/16/2012** (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 IMR	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 **124** (L18)

13.Total Certified Beds **124** (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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	124			
(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 :
Christy Johnson, Unit Supervisor 05/10/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 05/10/2012 (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
01/01/1988
(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 5/15/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/06/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

Provider Number: 24-5500
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on March 1, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On April 16, 2012, the Minnesota Department of Health (by review of the plan of correction) and on April 12, 2012, the Minnesota Department of Public Safety completed a Post Certification Revisit and determined that the facility had achieved substantial compliance pursuant to the standard survey completed on March 1, 2012, effective April 10, 2012. Therefore, the remedies outlined in our letter dated March 19, 2012 will not be imposed. See attached CMS-2567B for the results of the April 16, 2012 and April 12, 2012 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5500

May 10, 2012

Mr. Michael Deuth, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, Minnesota 56401

Dear Mr. Deuth:

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 April 10, 2012 the above facility is recommended for:

124 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 124 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Nicole Steege

Nicole Steege, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone #: (651) 201-4124 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 10, 2012

Mr. Michael Deuth, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, Minnesota 56401

RE: Project Number S5500022

Dear Mr. Deuth:

On March 19, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 1, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 16, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction, and on April 12, 2012 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 March 1, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 10, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 1, 2012, effective April 10, 2012 and therefore remedies outlined in our letter to you dated March 19, 2012, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Christy Johnson

Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File 5500R12.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245500	A. Building B. Wing	4/16/2012

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

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 **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/10/2012**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **04/10/2012**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **04/10/2012**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **04/10/2012**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** CJ/NCS	**Date:** 5/10/12	**Signature of Surveyor:** 12828	**Date:** 4/16/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/1/2012

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245500	A. Building B. Wing **01 - MAIN BUILDING**	4/12/2012

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0038	**04/10/2012**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/NCS	5/10/12	03006	4/12/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/1/2012

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: J273

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00087

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245500**

2.STATE VENDOR OR MEDICAID NO.
(L2) **078040500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BETHANY**
(L4) **804 WRIGHT STREET**
(L5) **BRAINERD, MN** (L6) **56401**

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 **03/01/2012** (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 IMR	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 **124** (L18)

13.Total Certified Beds **124** (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	IMR
	124			
(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 :
Sharron Williams, HFE-NEII 04/02/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege,Program Specialist 04/06/2012 (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
01/01/1988
(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 4/6/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

Provider Number: 24-5500
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on March 1, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) 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.

Investigation of complaint H5500032 was also investigated at the time of the March 1, 2012 survey, which was found to be unsubstantiated.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 4099

March 16, 2012

Mr. Michael Deuth, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, Minnesota 56401

RE: Project Number S5500022

Dear Mr. Deuth:

On March 1, 2012, 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. In addition, at the time of the March 1, 2012 standard survey the Minnesota Department of Health completed an investigation of complaint number H5500032.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the March 1, 2012 standard survey the Minnesota Department of Health completed an investigation of complaint number H5500032 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Christy Johnson
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933

Telephone: (218) 308-2114

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 April 10, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 10, 2012 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 1, 2012 (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 1, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

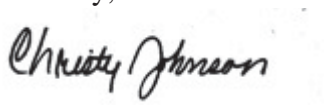
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File 5500S12.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	03/01/2012

RECEIVED
MAR 28 2012
Minnesota Department of Health
Regions

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A standard recertification survey was conducted and complaint investigation was also completed at the time of the standard survey. An investigation of complaint H5500032 was completed. The complaint was unsubstantiated.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the plan of care for 1 of 1 resident (R152) in the sample who required	F 282	F282 1. Resident R152 had care plan updated on 3-6-12 detailing a functional maintenance program which addressed ambulation and range of motion by restorative nursing. Resident R152 care plan interventions updated to Rehab FMP: Ambulate (A) 2 with FWW 30 feet after a meal 3X week. Nursing: (A) 2 with FWW to/from bathroom. Resident may refuse. Resident R99 had the care plan updated on 3/5/12. Referral to Physical and Occupational therapy to evaluate and treat as	4/10/12

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

Administrator 3-26-12

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

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F 282	Continued From page 1 ambulation services and for 1 of 3 residents (R99) in the sample who required interventions to prevent falls. Findings include: R152 had diagnoses that included weakness, CVA (stroke) with right sided weakness, and hypertension. The plan of care (POC) dated 1/3/12, indicated R152 had an alteration in ambulation. The POC was revised on 1/19/12, to indicate R152 was to ambulate with assist of 2 staff and walker to and from the dining room and bathroom as the nursing functional maintenance program (FMP). On 2/29/12, at 11:10 a.m. nursing assistant (NA) -A stated R152 walked from his bed to the bathroom. NA-A added they did not ambulate him at any other time. Review of the 1/19/12, through 2/29/12, NA-FMP documentation from the palm pilot indicated the nursing FMP: R152 was to walk with FWW (wheeled walker), with assist of 2 staff plus 1 staff to follow with wheel chair and hands on assist-60 feet plus or as tolerated every day, 2 times a day. The Care Plan Approaches Report indicated the following: -from 1/19/12-1/31/12, out of 24 opportunities, R152 was provided ambulation 17 times. -from 2/1/12 -2/29/12, out of 58 opportunities, R152 was provided ambulation 26 times. On 3/1/12, at 8:35 a.m. registered nurse (RN)-A	F 282	indicated. Antiroll breaks were applied to R99 wheelchair on 3/2/12. R99 refuses walker. Care plan updated to: Ambulation (Ind) with FWW prefers to push wheelchair for ambulating. 2. All residents who have restorative programs and / or are a falls risk have the potential to be affected. Review of all residents with FMP programs and fall interventions on the care plan was completed to ensure that all programs and interventions that are in place are current. 3. Staff education on 3/28/12 to look for fall intervention items to ensure that they are in place as care planned. Staff education on 3/28/12 on the process for care plan updates and how to code ambulation distance, frequency and refusals in the handhelds. All nursing staff education on 3/28/12 on communication with resident care when a transfers between units. 4. Visual audits will be done by DNS/designee to ensure that fall prevention devices are in place as care planned. Care plan audits will be done weekly by DNS/designee to ensure that rehab functional maintenance programs and fall interventions are being added to care plan post fall or when a resident is discharged from therapy services. These audits will be completed weekly	

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F 282	Continued From page 2 stated the 1/19/12, POC for ambulation was in the NA's palm pilots. RN-A stated the NAs should have been walking him to and from meals according to PT's recommendation and the 1/19/12, POC. RN-A verified R152's ambulation POC was not followed. On 3/1/12, at 9:05 a.m., NA-B stated R152 was ambulated from his bed to the bathroom when he would agree to walk. NA-B added she had never ambulated R152 or seen R152 ambulate to and from the dining room since R152's transfer to Station 2. At 9:00 a.m. NA-C and NA-B stated that since R152 had been down on Station 2, he had not been walking to the dining room. At 9:05 a.m. RN-A verified the POC was correct and R152 had not been receiving ambulation according to the POC. R99 was diagnosed with Alzheimer's and compression fractures. The plan of care (POC) dated 12/7/11, indicated R99 independently ambulated with the use of a walker and directed staff to ensure a walker was in reach for the resident when in bed or in her wheelchair. In addition, the POC directed staff to ensure an anti-roll back device was on the wheelchair. On 2/28/12, at 2:45 p.m. R99 was observed to lay in her bed. No walker was observed to be within	F 282	X4 weeks, then monthly X2 with results forwarded to the Quality Committee for further recommendations. 5. Completion date 4/10/12	

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F 282	Continued From page 3 the resident's reach and no anit-roll back device was noted on her wheelchair. On 2/29/12, at 6:46 p.m. licensed practical nurse (LPN)-B stated R99 will walk in her room by holding on to things in her room and does not use the walker. She stated R99 has an anti-roll device on her wheelchair. At 7:20 p.m. LPN-B observed R99's wheelchair and stated the device was an anti-tip device, not an anti-roll back. In addition, LPN-B stated R99 did not have a walker in her room that she could see and she was unsure if it was in her closet or if it had been left somewhere. She added she did not recall R99 having her walker much. On 3/1/12, at 7:51 a.m. R99's room was observed. R99's room was noted to have a gray walker in her closet. At approximately 9:15 a.m. NA-E and NA-F stated R99 would hold onto the nightstand and rails when walking and does not use a walker. Both NAs stated R99 did not have a walker in her room and had not had one for awhile. At 9:58 a.m. LPN-A stated she had found R99's walker in another part of the unit and had put it in her room this morning. She stated R99 had an anti-tip device on her wheelchair and not an anti-roll device. At 10:56 a.m. RN-B stated "ideally" they would like R99 to use a walker when ambulating and the walker should be available to use for the resident.	F 282		

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F 282	Continued From page 4 At 11:30 a.m. RN-B observed R99's wheelchair and stated no anti-roll back device was attached to her wheelchair. She stated she was unsure when this had been removed and verified it was still on the POC. She further stated a walker should be available for use with ambulation according to the POC.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide planned ambulation services for 1 of 1 resident (R152) in the sample who had been identified to require these services. Findings include: R152 was admitted to the facility on 11/28/11, and had diagnoses that included weakness, CVA (stroke) with right sided weakness, and hypertension. The admission Minimum Data Set (MDS) dated 12/05/11, indicated R152 was cognitively impaired and required extensive assist with transfers and did not walk. The Care Area Assessment (CAA) dated 12/9/11, indicated R152 was unable to ambulate due to weakness. The CAA also indicated R152 was currently working with physical therapy (PT). An initial PT evaluation was completed 11/29/11,	F 311	F311 1. Resident R152 had care plan updated on 3-6-12 detailing a functional maintenance program which addressed ambulation and range of motion by restorative nursing. Resident R152 care plan interventions updated to Rehab FMP: Ambulate (A) 2 with FWW 30 feet after a meal 3X week. Nursing: (A) 2 with FWW to/from bathroom. Resident may refuse. 2. All residents who have restorative programs have the potential to be affected. Review of all residents with FMP programs on the care plan was completed to ensure that all programs that are in place are current. 3. All nursing staff education on 3/28/12 on the process for care plan updates and how to code ambulation distance, frequency and refusals in the handhelds. All nursing staff education on 3/28/12 on communication with resident care when a transfers between units. 4. Care plan audits will be done	4/10/12

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F 311	Continued From page 5 with skilled services provided until discharge on 1/26/12. The discharge note indicated R152 ambulated 30-70 feet with a FWW (wheeled walker) and was to continue with the nursing FMP (functional maintenance program) . The plan of care (POC) dated 1/3/12, indicated R152 had an alteration in ambulation. The POC was revised on 1/19/12, to indicate R152 was to ambulate with assist of 2 staff and walker to and from the dining room and bathroom as the nursing FMP. Review of the nurse progress notes indicated: -1/25/12, R152 ambulated to the dining room and refused to ambulate back. -1/26/12, R 152 was discontinued from PT to nursing-FMP and ambulated to and from the dining room. -1/27/12, R152 ambulated in hallway x4, approximately 50-60 feet each time. -1/30/12, R152 ambulated to and from the dining room. -2/01/12, R152 ambulated to and from the dining room at the supper meal. -2/15/12, R152 ambulated to the dining room x 2 and once to the restroom. -2/6/12, R152 refused to walk with staff. -2/9/12, R152 was transferred from Station 6 to Station 2. On 2/29/12, at 11:10 a.m. nursing assistant (NA) -A stated R152 walked from his bed to the bathroom. NA-A added they did not ambulate him at any other time. Review of the 1/19/12, through 2/29/12, NA-FMP documentation from the palm pilot indicated the	F 311	weekly by DNS/designee to ensure that rehab functional maintenance programs are being added or updated to the plan of care when a resident is discharged from therapy services. These audits will be completed weekly X4 weeks, then monthly X2 with results forwarded to the Quality Committee for further recommendations. 5. Completion date 4/10/12	

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F 311	Continued From page 6 nursing FMP: R152 was to walk with FWW, with assist of 2 staff plus 1 staff to follow with wheel chair and hands on assist-60 feet plus or as tolerated every day, 2 times a day. The Care Plan Approaches Report indicated the following: -from 1/19/12-1/31/12, out of 24 opportunities, R152 was provided ambulation 17 times. -from 2/1/12 -2/29/12, out of 58 opportunities, R152 was provided ambulation 26 times. On 3/1/12, at 8:35 a.m. registered nurse (RN)-A stated both the 1/19/12, POC for ambulation was in the NA's palm pilots. RN-A stated the NAs should have been walking him to and from meals according to PT's recommendation and the 1/19/12, POC. RN-A verified R152's ambulation POC was not followed. RN-A stated R152 could still ambulate the distance of 30-70 feet as when discharged from PT on 1/26/12. At 9:00 a.m. RN-A stated yesterday (2/29/12) she asked the staff about R152's ambulation and the staff stated R152 was ambulating to and from the bathroom. RN-A stated at that time she changed R152's POC indicating ambulate to and from bathroom from his bed to the bathroom. The revised POC as of 2/29/12 (during survey), indicated the nursing FMP for R152 was to ambulate with assist of 2 staff and walker to and from the bathroom. On 3/1/12, at 9:05 a.m., NA-B stated R152 was	F 311		

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F 311	Continued From page 7 ambulated from his bed to the bathroom when he would agree to walk. NA-B added she had never ambulated R152 or seen R152 ambulate to and from the dining room since R152's transfer to Station 2. At that time, NA-B showed the surveyor her palm pilot indicating R152 was to be ambulated to and from the dining room. NA-B added R152 would not be able to ambulate that far and she had never seen him ambulate that far. At 9:00 a.m. NA-C and NA-B stated that since R152 had been down on Station 2, he had not been walking to the dining room. NA-C added R152 was just too weak. At 9:05 a.m. RN-A stated R152 had not been receiving ambulation services as PT had recommended. At 11:15 a.m. NA-C and NA-B ambulated R152 with a transfer belt and a FWW to the bathroom. R152 then ambulated back to his wheelchair. The Range of Motion and Ambulation Programs policy, revised 1/12, indicated a program would include each type of activity, carried out for a specific length on a regular basis. The policy indicated an order for a restorative ambulation program would be obtained to implement the program.	F 311		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	F323 1. Resident R99 had the care plan updated on 3/5/12. Antiroll breaks were applied to R99 wheelchair on 3/2/12.	4/10/12

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F 323	Continued From page 8 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure planned fall interventions had been implemented to minimize the risk of further falls and or accidents for 1 of 3 residents (R99) reviewed who were identified at risk for falls and/or injury. Findings include: R99 was diagnosed with Alzheimer's and history of compression fractures. The quarterly Minimum Data Set (MDS) dated 2/17/12, indicated R99 had moderate cognitive impairment and required supervision with ambulation (walking) and required limited assistance from staff while toileting. The MDS indicated R99 was not steady while moving from seated to standing position. The MDS further indicated R99 had one fall with no injury, one fall with injury that was not a major injury and one fall with a major injury since the last assessment period. The Falls Risk Assessment dated 2/11/12, indicated R99 was at high risk for falls due to factors such as a history of multiple falls, age, gait, and mobility concerns.	F 323	R99 refuses walker. Care plan updated to: Ambulation (Ind) with FWW prefers to push wheelchair for ambulating. 2. All residents at risk for falls have the potential to be affected. Review of all residents with fall interventions on the care plan was completed to ensure that all interventions that are in place are current. 3. Staff education on 3/28/12 to look for fall intervention items to ensure that they are in place as care planned. 4. Visual audits will be done by DNS/designee to ensure that fall prevention devices are in place as care planned. Care plan audits will be done weekly by DNS/designee to ensure fall interventions are being added to care plan. These audits will be completed weekly X4 weeks, then monthly X2 with results forwarded to the Quality Committee for further recommendations. 5. Completion date 4/10/12	

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F 323	Continued From page 9 The Falls Care Area Assessment (CAA) dated 6/14/11, indicated R99's risk factors for falls included alteration in cognition, cardiac disease, anxiety, depression, and a history of hypoglycemia. The CAA indicated R99 had been steady with ambulation when nursing intervenes with self ambulation. The plan of care dated 12/7/11, indicated R99 independently ambulated with the use of a walker and directed staff to ensure a walker was in reach for the resident when in bed or in her wheelchair. In addition, the POC directed staff to ensure an anti-roll back device was on the wheelchair. A review of the clinical record's nursing notes, physician notes, and physician orders from 6/7/11 to 2/29/12, indicated R99 had a history of multiple falls that had been comprehensively assessed by the facility. R99 was also identified to have a history of urinary tract infections and urinary retention while at the facility which had required urology follow ups and the intermittent use of an indwelling Foley catheter as well the temporary use of a suprapubic catheter. Medication changes had also occurred. The prior fall assessments from 6/16/11 to 1/31/12, indicated R99's fall interventions should include the use of a walker with ambulation and an antitroll back device on her wheelchair to prevent her wheelchair from rolling back when standing. Additional review of R99's clinical record indicated: On 12/16/11, the Interdisciplinary Progress Notes indicated R99 was started on Seroquel for anger, resistance to care and negative statements.	F 323		

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F 323	Continued From page 10 On 12/29/11, at 12:50 p.m. Incident Details indicated R99 was found scooting herself out into the hallways on her buttock. R99 stated she was standing up to use the toilet and fell backwards into the wall, slid down to the floor onto her bottom, and instead of using call light she scooted herself out into the hall on her butt. R99 had gripper socks on and sustained no injury. The Investigation dated 12/29/11, indicated R99 was educated on the use of the call light and alarms had not been effective in the past for the resident and made her very unhappy. On 1/7/12, 6:10 p.m. the Incident Details indicated R99 was found sitting on the floor of her room after getting out of her wheelchair. R99 was noted to have gripper socks on. No injury was sustained. The Investigation dated 1/7/12, indicated R99 had a low blood sugar just prior to the fall and became dizzy when attempting to self transfer herself. The staff felt the low blood sugar was a contributing factor to R99's fall. R99 was placed on 30 minute safety checks at this time and her low blood sugar was treated. On 1/20/12, the Interdisciplinary Progress Notes indicated R99's Seroquel was increase again for continued behavior. On 1/3/1/12, at 4:40 p.m. the Incident Detail indicated R99 was in her room with her family. The family reported R99 had fallen over backwards while getting pants out of her closet. The Investigation dated 1/31/12, indicated R99 was ambulating without the use of a walker and the resident and family were reeducated on the	F 323		

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F 323	Continued From page 11 importance of the use of her walker. The Interdisciplinary Progress Notes indicated on 2/6/12, after R99 had complained about pain and difficulty taking deep breaths, R99 was noted to have rib fractures. No further falls were identified. On 2/28/12, at 2:45 p.m. R99 was observed to lay in her bed. While visiting with R99, she appeared alert and oriented with a deficit in memory recall. No walker was observed to be within the resident's reach and no anti-roll back device was noted on her wheelchair. On 2/29/12, at 6:46 p.m. licensed practical nursing (LPN)-B stated R99 has had a lot of falls and it seemed like it was often when she was getting up and toileting. LPN-B stated R99 will walk in her room by holding on to things in her room and does not use the walker. She stated R99 had an anti-roll device on her wheelchair. At 7:20 p.m. LPN-B observed R99's wheelchair and stated the device was an anti-tip device, not an anti-roll back. In addition, LPN-B stated R99 did not have a walker in her room that she could see. She added she was unsure if it was in her closet or if it had been left somewhere. She also stated she did not recall R99 using her walker much. On 3/1/12, at 7:51 a.m. R99's room was observed. A gray walker was noted in her closet. R99 had been eating breakfast at this time. At approximately 9:15 a.m. nursing assistant (NA)	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

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F 323	Continued From page 12 -E and NA-F stated R99 will hold on to the nightstand and rails when walking and does not use a walker. Both NAs stated R99 did not have a walker in her room and had not had one for awhile. At 9:58 a.m. LPN-A stated R99 attempts to walk in her room without a walker. She stated she found R99's walker in another part of the unit and had put it in her room that morning. She stated R99 has an anti-tip device on her wheelchair and not an anti-roll device. At 10:56 a.m. registered nurse (RN)-B stated that "ideally" they would like R99 to use a walker when ambulating and the walker should be available for the resident's use. RN-B stated R99 had improved significantly with the start of Seroquel and falls had become more infrequent. She stated R99's urinary retention had improved and she was becoming more cooperative. At 11:30 a.m. RN-B observed R99's wheelchair and verified no anti-roll back device was attached to her wheelchair. She stated she was unsure when this had been removed. She stated it was still on the POC. She further stated a walker should be available for R99's use with ambulation according to the POC. At 12:59 p.m. family member(FM)-A stated she was with R99 when she fell on 1/31/12. She stated they were aware R99 should be walking with a walker and should receive assistance with ambulation; however, added R99 does not accept help from anyone including family. She stated the staff checks frequently on R99 and does everything they can to prevent her from	F 323		

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F 323	Continued From page 13 self-transferring. FM-A stated the family has been made aware of the risk and benefits of R99 ambulating independently and wished to allow R99 to remain as independent as able.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure clean steamers, hood filters, juice machines, coffee machines, microwaves, freezers, and refrigerators, and ensure proper refrigerator temperatures, and to maintain clean surfaces in the kitchen to ensure adequate sanitary conditions for food service. This practice had the potential to affect all 101 residents residing in the facility. Findings include: On 2/27/12, at 1:08 p.m. during the initial kitchen tour, the top of the steamers was observed with a yellow grease-like build up. The vent hood filters over the steamers were coated with old grease-like congealed matter and dirt/dust.	F 371	F371 1. Juice and coffee machines are being cleaned per manufacturer recommendations by dietary staff. Steamers are being wiped down daily. Hoods are being cleaned per facility policy. Pipe hanger has been removed. All microwaves are being wiped clean after all meals. Freezers gaskets for station 2 have been ordered and will be installed upon receipt. Stations 2 and 5 freezer has been de-frosted and cleaned. Refrigerator/freezer on station 3 has been replaced and temperatures will be monitored. Refrigerators are being checked for cleanliness daily and cleaned as needed. Therapy cold packs are no longer being stored with food items. Cleaning lists (which include but are not limited to: juice and coffee machines, steamers, hoods, microwaves, refrigerators/freezers) are being updated and checked per audit schedule. 2. All residents have the potential to be affected by this. 3. Re-education on kitchen sanitation, cleaning schedules and documentation	4/30/12

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F 371	Continued From page 14 At this time, dietary aide (DA)-B stated the the steamers were used everyday and verified they appeared dirty. DA-B added she thought the steamers were cleaned a few weeks ago. On 2/29/12, at 1:32 p.m. the sanitation tour was completed with the dietary supervisor (DS). The DS indicated the hood filters had been cleaned on 2/27/12, at 3:00 p.m. The DS verified the steamers were sticky and greasy and could be cleaned. The DS indicated the steamers should be cleaned monthly, however, documentation of the cleaning for January and February of 2012, was lacking. The pipe hanger attached to the inside of the hood was covered with dust and dirt debris. The DS verified the pipe hanger should be cleaned monthly with the hood and was last cleaned on 12/14/11. A Bunn juice dispenser was observed on a counter outside of the kitchen in the main dining room. The manufacturer's recommendation was specific for daily, weekly and monthly cleaning and was posted on the side of the juice machine. The DS verified the last time the juice dispenser was cleaned was on 2/4/12. The DS stated, "We try to do it daily." The Bunn juice dispenser had manufacturer's recommendations for cleaning as follows: daily parts washing, remove and wash dispenser nozzle(s), mixing elements, drip tray and drip cover in a mild detergent and rinse. Wipe splash panel, area around nozzle(s), and refrigerated compartment with a clean damp cloth. Weekly rinse procedure remove product containers fill the cleaning container with warm water and dispense	F 371	of cleaning tasks will be completed with dietary staff before April 10, 2012. 4. Observation audits, cleaning list audits and temperature audits will be completed by dietary supervisor or designee five times per week times 3 weeks, three times weekly times 2 weeks and then two times weekly for a month with results reported to the QA committee for further recommendations. 5. Date corrective action completed 4/10/2012.	

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F 371	Continued From page 15 until the water runs clear. Monthly rinse procedure fill the clear plastic cleaning container with food grade sanitizer dispense until it runs clear, let sit for 15 minutes rinse with clean water. A Douwe Egberts coffee dispenser was observed on a counter outside of the kitchen in the main dining room. The DS verified the coffee dispenser was last cleaned on 2/4/12. The DS stated, "We try to do it daily." The Douwe Egberts Coffee Machine had manufacturer's recommendations inside the door for cleaning as follows: Daily, remove drip tray and wash with mild detergent, rinse with fresh water. Clean the outlet troughs, remove each trough and wash with mild detergent and rinse with fresh water. Weekly: remove trough support and clean with mild detergent and rinse and replace. Remove coffee packs and clean cooling compartment with a clean cloth. At 2:15 p.m. the Station 2 kitchenette was toured with the DS. The microwave was dirty with dried on spills of various colors. The DS indicated it was last cleaned on 2/6/12, and should be cleaned daily after each meal service. A Bunn juice dispenser was observed on the counter in the kitchenette. At this time, the DS indicated the last time the juice dispenser was cleaned was on 2/6/12. A Douwe Egberts coffee dispenser was observed on a counter in the kitchenette. The DS indicated the coffee dispenser was cleaned last on 2/6/12. Under the counter, a small freezer's gasket top	F 371		

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F 371	Continued From page 16 was very dirty and pulled away from the frame. The frame on the main body had chipped enamel. The freezer had 2 inches of frost on the top shelf and there was a dark stain on the bottom. The DS verified this and stated, "It's probably popsicle that thawed and froze." The DS indicated there was not a cleaning schedule for the freezer and stated, " I would guess it would be cleaned with the fridge." A standard house-hold size refrigerator was in the kitchenette and had crumbs on the bottom and a red sticky residue on the bottom and also on top of a pop can. The DS threw the can in the trash and verified it was "sticky" and should be cleaned daily. At 2:39 p.m. the Station 3 kitchenette was toured with the DS. There was a microwave oven on the counter that was dirty with crumbs and spills. A Bunn juice dispenser was on the counter. The kitchen cleaning schedule had initials that indicated it was cleaned 16 of 29 days in February, however, the cleaning procedure could not be verified. A Douwe Egberts coffee dispenser was observed, but the cleaning schedule could not be verified. There was a standard household size refrigerator in the kitchenette and the thermometer read 46 degrees Fahrenheit (F) at 3:39 p.m. The DS indicated the policy was to record the temperature daily. The DS put a new thermometer in the refrigerator at 3:45 p.m. The recorded temperatures were : 2/24/12, 46 degrees F, 2/26/12, 45 degrees F, 2/27/12, 46 degrees F, 2/28/12, 44 degrees F and 2/29/12, 45 degrees F. The refrigerator had crumbs and residue spillage	F 371		

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F 371	Continued From page 17 on the bottom. The refrigerator contained: 8 boxes of 46 oz. assorted juices, 8 cartons of half gallon milk, 18 small boxes of ensure, 3 cartons of mighty shakes and 12- 6 packs of assorted fruit snacks and pudding snacks, There were also 8 cans of assorted soda pop. There was a small freezer in the kitchenette. The top of the handle on the freezer door was cracked and the entire width of the freezer was embedded with residue. These findings were confirmed by the DS at that time. When asked about last time the freezer was cleaned, the DS stated it had been about 2 months ago. At 2:57 p.m. the kitchenette that served the 500/600 wings was toured with the DS. There was a microwave oven on the counter that had dried food of various consistency. This was verified by the DS at that time, who stated, "It needs cleaning." There was some frost in the freezer along with ice cream cups on the top shelf, and two blue gel ice packs labeled "therapy department" on the bottom. The DS indicated the ice packs were not supposed to be there. There was a Douwe Egberts coffee dispenser and a Bunn juice dispenser on the counter. The cleaning check list had dates missing and the DS could not verify when they were last cleaned. At 5:21 p.m. the DS stated the policy for hood filters are weekly cleaning. The facility procedure titled Sanitation of Non-Food Contact Surfaces, undated, read: "hoods and filters-clean inside and outside daily, have a cleaning schedule in place for the hood either by a commercial company or the maintenance department, schedule weekly	F 371		

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F 371	Continued From page 18 cleaning of the filters, in the dishwasher or other method." On 3/1/12, 9:19 a.m. DA-A was interviewed and stated she thought the coffee and juice machines were to be cleaned once a week. She added she was not sure who was responsible for the cleaning of the machines in the main dining room because she was working on Station 3. She stated she had only cleaned the machines once or twice. She stated on Station 3, the cooks help clean the juice and coffee machine at noon. She added the cooks also help clean the refrigerator and the microwave. DA-A stated staff were suppose to let the DS know when the temperature in the refrigerator was below 41 degrees F. She stated there was only weekly cleaning of the coffee machine by wiping it down and running hot water through it. At 9:36 a.m. the temperature in the refrigerator on station 3 was 46 degrees F. The facility procedure titled Equipment Sanitation, revised 5/04, read; "follow manufacturer's instructions for disassembly and cleaning. For refrigerated units it reads: schedule regular cleaning, spills should be cleaned immediately, gaskets on doors need regular cleaning, defrost on a scheduled basis." The facility policy and procedure titled Food Storage, revised 3/09, required refrigerator temperatures to be kept between 35 and 40 degrees. On 3/1/12, at 10:59 a.m. the DS stated, "I told	F 371		

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F 371	Continued From page 19 maintenance that the refrigerator in station 3 has to be replaced." On 3/1/12, at 11:58 a.m. when asked for a policy for cold food storage which would address the therapy gel packs stored in the refrigerator, the DS could not locate a policy. However, she verified the gel packs should not be stored with the food. .	F 371		

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

F5500021

PRINTED: 03/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Good Samaritan Society Bethany 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: PATRICK SHEEHAN SUPERVISOR STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST PAUL, MN 55101-5145 Email: pat.sheehan@state.mn.us	K 000	RECEIVED APR - 2 2012 MINNESOTA DEPARTMENT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POCK PS 4-2-12	

DC: 04.10.2012

EXIT: 03.01.2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	3-26-12

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

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K 000	Continued From page 1 Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Good Samaritan Society Bethany is a 1-story building without a basement. The building was constructed at six different times. The original building was constructed in 1969, is 1- story and was determined to be of Type II(000) construction. In 1974, two, 1-story additions were constructed, one to the south west and one to the east side of the original building, that were determined to be of Type II(111) construction and are separated with 2- hour fire barriers form the existing building. In 1980 an 1- story addition was constructed to the south and east of the 1974 south addition, was determined to be Type II (111) construction and is separated with a 2- hour fire barrier. In 1983 a small 1- story connecting link was added to the south of the 1980 addition to connect the facility to an apartment building and was determined to be Type V (000) construction. This link is not separated from the facility but a 2-hour fire barrier is between the link and the apartment building. In 1994 the Physical Therapy 1- story addition was added to the north of the original building and was determined to be	K 000		

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K 000	Continued From page 2 Type II (111) construction. In 1998 an 1- story addition was constructed to the north of the 1960 building and 1974 addition, was determined to be Type V(111) construction and is separated by a 2-hour fire barrier. The main level is divided into 11 smoke zones by 30 minute and 90 minute fire barriers. The entire building is protected by a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition with quick response heads in the 1998 addition and standard response heads in all other areas. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridor system, in common areas and in all sleeping rooms that is installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and is monitored for automatic fire department notification. Other hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 140 beds and had a census of 104 at the time of the survey. Because the original building and its additions meet the construction types allowed for existing buildings, this facility was surveyed as a single building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily	K 038		

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K 038	Continued From page 3 accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: An interview with staff, observations and testing of all the exit doors revealed that two exit and a set of exit access doors are or would lock against egress and do not comply with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 7.2.1.5.,4 nor the CMS program letter about locked exits. This deficient practice could negatively affect all residents, staff and visitors of wing effected if they need to be quickly evacuated the facility. Findings include: During the facility tour on March 1, 2012, between 10:00 am and 1:00 pm, An interview with the Director of Maintenance (RN) revealed that the Station 4 wing is no longer a dementia unit, and observations and testing of exit and cross corridor doors revealed that the two direct exit doors are and the smoke barrier doors can be locked against egress and do not comply with the CMS program letter that allows exit door locking under certain situations. The Director of Maintenance (RN) verified this finding during the inspection and with the Administer (MD) at the exit conference.	K 038	K038 The magnetic door holders were removed from the two smoke barrier doors in the hall (the old locked unit). The access codes were posted with signage at the three exit doors. Date of completion: April 10, 2012 Richard Nelson, Director of Maintenance	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245500	MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	DATE SURVEY COMPLETE: 3/1/2012
NAME OF PROVIDER OR SUPPLIER: GOOD SAMARITAN SOCIETY - BETHANY	STREET ADDRESS, CITY, STATE, ZIP CODE: 804 WRIGHT STREET BRAINERD, MN		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 076	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Observations revealed that the facility has a compressed gas cylinders manifold room that is not properly signed in accordance with the requirements of NFPA 99 section 8-3.1.11.3. This deficient practice could affect the staff using the room the compress cylinders are in. Findings include: During the facility tour on March 1, 2012, between 10:00 am and 1:00 pm, observations revealed that the oxygen manifold room in the 1998 addition was not signed "CAUTION Oxidizing Gases Stored Within NO SMOKING" as required. The Director of Maintenance (RN) verified this finding during the inspection and with the Administer (MD) at the exit conference. RECEIVED APR 2 2012

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

The above isolated deficiencies pose no actual harm to the residents