CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: KZFT Facility ID: 00063

	DWNERSHIP (L34)	3. NAME AND AD (L3) GOOD SAM (L4) 200 SOUTH (L5) REDWOOD 7. PROVIDER/SUI 01 Hospital 02 SNF/NF/Dual	ARITAN SOCII DEKALB STRE FALLS, MN PPLIER CATEGOR 05 HHA 06 PRTF	ETY - REI EET RY 09 ESRD 10 NF	(L6) 56283 02 (L7) 13 PTIP 22 CLIA 14 CORF	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 FISCAL YEAR ENDING DATE: (L35)	
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE	12/31	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	43 (L18) 43 (L17)	Compliand1.		am	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNI 5. Life Safety Code	6. Scope of Services Limit 7. Medical Director	
14. LTC CERTIFIED BED BREAKDO)WN				15. FACILITY MEETS		
18 SNF 18/19 SNF 43 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)	
(E37) (E36)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICABL	E SHOW LTC CANCE	ELLATION DATE):	:			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:	
LoAnn Degagne, HFE - NE II 04/13/2018 (L19)					Joanne Simon, Enforcement Specialist 04/13/2018 (L20)		
LoAnn Degagne, HFE	- NE II		04/13/2018	(L19)	Joanne Simon, Enfo	rcement Specialist 04/13/2018 (L20)	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00063

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 245237

A recertification survey was conducted 1/8/18 through 1/11/18, and complaint investigation was also completed at the time of the standard survey. At the time of the survey, an investigation of complaint #H5237013 was completed and was found to be substantiated at F607, F609, and F610.

On 3/7/2018 an onsite PCR was completed and this facility was found not to be in compliance. This facility continued to be non-complaint with F684 and F688. Investigation #H5237013 was found to be corrected.

On 4/5/2017 an onsite PCR was conducted and the facility was found to be in compliance.



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245237

April 13, 2018

Ms. Haley Amundson, Administrator Good Samaritan Society - Redwood Falls 200 South Dekalb Street Redwood Falls, MN 56283

Dear Ms. Amundson:

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 March 29, 2018 the above facility is recommended for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 13, 2018

Ms. Haley Amundson, Administrator Good Samaritan Society - Redwood Falls 200 South Dekalb Street Redwood Falls, MN 56283

RE: Project Number S5237025

Dear Ms. Amundson:

On March 19, 2018, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective March 24, 2018. (42 CFR 488.422)

Also on March 19, 2017, we recommended the enforcement remedy listed below to the Centers for Medicare and Medicaid Services (CMS) for imposition:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective April 11, 2018. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on January 11, 2018, that included an investigation of complaint number H5237013 which was found to be corrected, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on March 7, 2018. The deficiencies not corrected are as follows.

F0684 -- S/S: D -- 483.25 -- Quality Of Care F0688 -- S/S: D -- 483.25(c)(1)-(3) -- Increase/Prevent Decrease In ROM/Mobility

The most serious deficiencies at the time of the revisit were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 5, 2018, the Minnesota Department of Health completed an onsite PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on March 7, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on March 7, 2018, as of March 29, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 29, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to

the remedies outlined in our letter of March 19, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 11, 2018 be rescinded. (42 CFR 488.417 (b))

In our letter of March 19, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)92)9B)(iii)9b) and 1919 (f)(2)(B(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or competency Evaluation Program (NATCEP) for two years from April 11, 2018, due to the denial of payment for new admissions. Since your facility attained substantial compliance on March 29, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective April 11, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective April 11, 2018, is to be rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 13, 2018

Ms. Haley Amundson, Administrator Good Samaritan Society - Redwood Falls 200 South Dekalb Street Redwood Falls, MN 56283

Re: Reinspection Results - Project Number S5237025

Dear Ms. Amundson:

On April 5, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 7, 2018, with orders received by you on March 19, 2018. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

CENTERS FOR MEDICARE & MEDICAID SERVICES

	CARE/MEDICAID CERTIFICATIO I - TO BE COMPLETED BY THE ST		ID: KZFT Facility ID: 00063
MEDICARE/MEDICAID PROVIDER NO. (L1) 245237 2.STATE VENDOR OR MEDICAID NO. (L2) 385318700 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	3. NAME AND ADDRESS OF FACILITY (L3) GOOD SAMARITAN SOCIETY - (L4) 200 SOUTH DEKALB STREET (L5) REDWOOD FALLS, MN 7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESI	(L6) 56283	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
6. DATE OF SURVEY 03/07/2018 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICI 04 SNF 08 OPT/SP 12 RH	14 CORF F/IID 15 ASC	FISCAL YEAR ENDING DATE: (L35) 12/31
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 43 (L18) 13.Total Certified Beds 43 (L17)	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On:	And/Or Approved Waivers Of Th 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
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 43 (L37) (L38) (L39)	Requirements and/or Applied Waivers: ICF IID (L42) (L43)	* Code: B * 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L12) (L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLICAB See Attached Remarks	LE SHOW LTC CANCELLATION DATE):		
17. SURVEYOR SIGNATURE Lisa Ciesinski, HFF- NF II	Date : 03/19/2018 (L1	18. STATE SURVEY AGENCY A	procement Specialist 03/20/2018
PART II - TO B	E COMPLETED BY HCFA REGION	<u>′ </u>	ATE 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 Finar2. Ownership/Contro3. Both of the Above	l Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 04/14/1981 23. LTC AGREE BEGINNING		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure	(L30) INVOLUNTARY 05-Fail to Meet Health/Safety
A. Suspension	(L25) IVE SANCTIONS on of Admissions: (L44) ISSPENSION Date:	02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	** - *** **

(L45)

30. REMARKS

DETERMINATION APPROVAL

(L31)

(L33)

29. INTERMEDIARY/CARRIER NO.

32. DETERMINATION OF APPROVAL DATE

00140

03/06/2018

(L28)

(L32)

28. TERMINATION DATE:

31. RO RECEIPT OF CMS-1539

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00063

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 245237

A recertification survey was conducted 1/8/18 through 1/11/18, and complaint investigation was also completed at the time of the standard survey. At the time of the survey, an investigati of complaint #H5237013 was completed and was found to be substantiated at F607, F609, and F610

On 3/7/2018 a onsite PCR was completed and this facility was found not to be in complaince. This facility continued to be non complaint with F684 and F688. Investigation #H5237013 was found to be corrected.

On 4/5/2017 a onsite PCR was conducted and the facility was found to be in compliance.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 19, 2018

Ms. Haley Amundson, Administrator Good Samaritan Society - Redwood Falls 200 South Dekalb Street Redwood Falls, MN 56283

RE: Project Number S5237025 and H5237013

Dear Ms. Amundson:

On January 26, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 11, 2018 that included an investigation of complaint number H5237013. 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 March 7, 2018, the Minnesota Department of Health and on February 13, 2018, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 11, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 9, 2018. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on January 11, 2018. The deficiencies not corrected are as follows:

F0684 -- S/S: D -- 483.25 -- Quality Of Care F0688 -- S/S: D -- 483.25(c)(1)-(3) -- Increase/Prevent Decrease In ROM/Mobility

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the the electronically delivered CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

State Monitoring effective March 24, 2018. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the

following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective April 11, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective April 11, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 11, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Good Samaritan Society - Redwood Falls is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 11, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us

Phone: (320) 223-7343 Fax: (320) 223-7348

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.

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 remedy be imposed:

• 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the

second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 April 11, 2018 (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 Health Regulation Division 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 electronic 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. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

> Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program Minnesota Department of Health

Kumalu Fishe Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On ,			
Ι,	,		, received
	(Name)(Please Print)	(Title)(Please Print)	
the Notio	ce of Penalty Assessment dated an	d licensing orders issued to:	
	Good Samaritan Society - Red	dwood Falls	
	200 South Dekalb Street		
	Redwood Falls, MN 56283		
The Pena	alty Assessments and licensing orde	ers attached hereto have beer	n corrected as of .
Signed:			, Date
	(Name)(Please Print)	(Title)(Please Print)	
	DELIVERY OF LICENS	SING PENALTY ASSESSMENT N	NOTICE
On ,			
l,			_, of the Health Regulation
Division,			
	(Name)(Please Print)		
Minneso	ta Department of Health, delivered	the Notice of Penalty Assess	ment dated and issued to:
	Good Samaritan Society - Red	dwood Falls	
	200 South Dekalb Street		
	Redwood Falls, MN 56283		
The Noti	ce of Penalty Assessment was hand		
	, Date	(Name)(Please Print)	
(Title)(P	lease Print)		
Signed:			, Date
JIBITCU.	(Name)(Please Print)	 (Title)(Please Print)	, Dute

PRINTED: 03/26/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	FIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245237	B. WING		1	-C 07/2018
NAME OF F	PROVIDER OR SUPPLIER	270201		STREET ADDRESS, CITY, STATE, ZIP CODE	03/	0772016
GOOD S	AMARITAN SOCIETY	- REDWOOD FALLS		200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
{E 000}	Initial Comments		{E 00	00}		
	Preparedness at th on 1-11-18.	tion issued in Emergency e recertification survey exited				
{F 000}	INITIAL COMMENT	ΓS	{F 00	00}		
	completed on 03/06 found to have NOT issued on the surve	dification revisit (PCR) was 6/2018 to 03/07/2018 and corrected all the citations by exited 1/11/18. Based on the lined that the facility is not in ince.				
	substantiated at the survey was reviewe	nplaint investigation found e time of the recertification ed for compliance. H5237013 rrected at the time of this visit.				
{F 684} SS=D	signature is not req page of the CMS-2 submission of the F verification of comp Quality of Care	nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as bliance.	{F 68	34}		3/29/18
	applies to all treatm facility residents. Be assessment of a re that residents recei accordance with propractice, the compressive plan, and the real This REQUIREMENT	fundamental principle that nent and care provided to assed on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered residents' choices. NT is not met as evidenced		Droporation and over their of the		
I	Daseu on observa	tion, interview, and document		Preparation and execution of thi	,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE 03/26/2018

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.

Electronically Signed

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ATION NILIMBED.		X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			A. BUILD	ING _		R-	.c.	
		245237	B. WING				7/2018	
NAME OF	PROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE			
COODS	AMADITAN SOCIETY	- REDWOOD FALLS		20	00 SOUTH DEKALB STREET			
GOOD S	AMARITAN SOCIETY	- REDWOOD FALLS		R	EDWOOD FALLS, MN 56283			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 684}	review the facility fassess and provide was identified on the (R7) reviewed for connon-pressure related. Findings include: R7's Admission Rediagnoses including lateral sclerosis (amainly involves the controlling voluntarial identified R7 was resignificant changed dated 2/8/18, identified extensived daily living (ADLs), bladder, and was a During a review of Observation, dated on the "left buttock [centimeter] x 0.25 Observation form and assessment was identified. Review of R7's prodocumentation of the which included, "Famepilex [foam drest [previously identified every 3 days." A fa 3/1/8, identified a com x 0.5 cm blister Cleansed and applications.	ailed to comprehensively interventions when a blister he buttocks for 1 of 1 residents change of condition and	{F 68	84}	response and plan of correction do constitute an admission or agreement the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan correction is prepared and/or exect solely because it is required by the provisions of federal and state law. The purposes of any allegation that center is not in substantial compliant with federal requirements of participating this response and plan of correction constitutes the center! Is allegation compliance in accordance with section 7305 of the State Operation Manual The Interact, wound data collection and procedure has been reviewed 3/20/18. R7 documents were correct and wound data collection was composed on 3/7/18. This practice has the potential to after residents care-planned with the potential scare-planned with the potential scare-planned with the potential deficient practice that may affect other residents and care-plans have updated accordingly. To prevent further potential deficient practice that may affect other residents may affect other residents and communication and documentation breakdown issues. Which will inclusing meeting on 03/28/2018 on communication and documentation breakdown issues. Which will inclusing lementation of completing the reassessment, documentation of a protein faxing the primary care physical family notification, and entering a ninto the communication dashboard. Audits will be done on communication.	he of uted For the nce pation, of tion al. policy on cted appleted fect rential wed for the been at the sk rogress cian, otation		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COME	SURVEY PLETED
						R-	-c
		245237	B. WING			03/0	7/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FALLS			00 SOUTH DEKALB STREET		
				R	REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 684}	Can we use mepile & PRN [as needed] order on 3/2/18, inchealed." R7's Clinican order with a starrt buttock, change of Review of R7's Treas/1/18-3/31/18, indi Mepilex to her right. Review of R7's care identified R7 had a spine, however, lack was identified on the During an interview registered nurse (Rwere responsible for residents with skin process of complet as they did every was tated R7 was not they were not award that she had a blist a.m. RN-B stated p for all residents ever identify any skin condirected to community identified a skin had a skin observativas noted, however progress note and RN-B or RN-A. RN-We should have see be assessing R7's in the start of the start of the skin observatives and the see assessing R7's in the start of the skin observatives and the skin observatives are skin observatives and the skin observatives and the skin observatives and the skin observatives are skin observatives and the skin observatives and the skin observatives are skin observatives.	is, "Refaxed 3/2/18 at 1200. x. Change Q [every] 3 d [days]. The physician signed the licating, "As above. Ok till al Physician Orders included to date of 3/2/18 for Mepilex to every 3 days and as needed. atment Record, dated cated R7 had received buttock on 3/2/18 and 3/5/18. Page plan, last revised on 2/15/18, history of an open area on her ked information that a blister e buttock. If on 3/7/18, at 9:20 a.m. IN)-B and RN-A stated they or completing wound rounds on concerns, and were in the ing wound rounds at that time, yednesday. RN-B and RN-A on their list to see because e of any issues with her skin or er on the buttocks. At 10:20 rogress notes were reviewed ery morning at "stand up," to neerns. Staff were also nicate with RN-A or RN-B if in concern. RN-B stated R7 tion on 2/28/18, and the blister r, was not included in a was not communicated to B stated, "This was missed. en it." RN-B stated they would blister so that they could he cause of the blister and put	{F 6	84}	completion of documentation of ski issues to ensure corresponding pronotes in the resident; s chart and notification of the physician has becompleted timely. Audits will also the completion of the risk assessm communication on the dashboard. will be done by DNS or designee or of the population 1 time weekly for months then every other week for month. Audit results will be reviewed monthly by facility QAPI committee further recommendation.	en include ent and Audits n 10% 2	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY IPLETED
		245237	B. WING				-C 07/2018
	PROVIDER OR SUPPLIER			20	REET ADDRESS, CITY, STATE, ZIP CODE O SOUTH DEKALB STREET EDWOOD FALLS, MN 56283	1 03/	0772010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 684}	On 3/7/18, at 12:4: R7's room. R7 was was removed by R saturated with a yet RN-B identified as identified on the up described the area open, and measur sprayed the area wand dried with gau applied. During an interview and RN-B stated, blister] until you to nurse that noted it and RN-B stated the physician, would be and possibly a new with the dietician. It say it was pressure	age 3 2 p.m. RN-B and RN-A entered solying in bed. Mepilex dressing RN-A and was noted to be ellow substance that RN-A and urine. A dark red area was oper right buttock, and RN-B as flat, soft, not fluid filled, not sed 0.5 cm x 0.25 cm. RN-B with Dermal Wound Cleanser, ze. A Mepilex dressing was NY ON 3/7/18, at 1:05 p.m. RN-A "We did not know about it [R7's lid us. We didn't get a note. The should have told us." RN-A hey would be updating the e calling hospice for direction of mattress, and would consult RN-B stated, "I can't honestly e," indicating the cause could se in her brief or wheelchair	{F 68	34}			
	(DON) was intervied there are too many need to be refined that identified the acharge nurse and on the charge nurse she or RN-A or RN so R7's blister coufurther stated, "No Review of the facil Pressure Ulcer Maincluded, "Promoti	p.m. the director of nursing ewed and stated, "I feel like y steps in the process, they." The DON indicated the nurse area should have notified the it should have been identified se communication sheet, and I-B should have been notified Id have been assessed. DON tification was missed. Period." ity's policy, Wound and anagement, dated 1/17, on of healing, pain prevention of complications is					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	COM	E SURVEY IPLETED
		245237	B. WING			I-C 07/2018
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP COD 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	•	0772010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 684}	extremely importan assessment and do facility's policy, Pres included, "Resident assessments and s maintain skin integr	t, as well as accurate ocumentation. Review of the ssure Ulcers, dated 1/17, s will receive appropriate ervices to promote and ity."	{F 68	34}		
{F 688} SS=D	Increase/Prevent D CFR(s): 483.25(c)(c) §483.25(c) Mobility. §483.25(c)(1) The fresident who enters range of motion dorange of motion unl condition demonstrof motion is unavoid §483.25(c)(2) A resmotion receives apprevent further decives appropriate assistance to maint the maximum practice reduction in mobility. Based on observative review, the facility face of the second secon	ecrease in ROM/Mobility 1)-(3) facility must ensure that a set the facility without limited es not experience reduction in ess the resident's clinical ates that a reduction in range dable; and ident with limited range of propriate treatment and e range of motion and/or to rease in range of motion. ident with limited mobility e services, equipment, and cain or improve mobility with icable independence unless a y is demonstrably unavoidable. NT is not met as evidenced cion, interview, and record ailed to provide restorative esidents (R1, R19) reviewed	{F 68	GSS policy on restorative pro purpose is to provide approprious restorative nursing care to each R1 and R19 Restorative progr	ate ch resident. ams have	3/29/18
		port, printed 3/7/18, identified a iagnoses of, unspecified		been reviewed and care plans 3-21-18 to reflect restorative n therapy recommended progra Resident receiving restorative and their documentation have	eeds of ms. therapies	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245237	B. WING				-C 07/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DEKALB STREET EDWOOD FALLS, MN 56283	1 001	0172010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 688}	dementia without be unspecified osteoal unspecified. R1's comprehensividentified severe consideration and attentified severe consideration and a program dated 1/25 program included discount (ROM) to: both arm extension/ flexion to (knees apart), up at knees-(flex/extension). Interflex current care productified R1 has a intervention to supply wheelchair/Broda constitution and the proposition of the program was being exaluated as the program was being evaluated as the program and the program of the program was being evaluated as the program of the program was being evaluated as the program was being evaluated was the program was being eval	ehavioral disturbance, rthritis, unspecified site, pain e assessment, dated 1/8/18, ignitive impairment. intenance Restorative 5/17, identified a restorative aily passive range of motion is, shoulder, elbows, hands, o both legs, hips-side to side and down (like marches), on). Ian, last revised 2/5/18, need for restorative in hair (chair that allows for eventions included, Nursing range of motion both arms, ands, do extension and and hips, side to side, up and stension and ankles are 10 resp (repetitions) each disched evidence a ROM offered, implemented, and ogram prescribed eport, printed 3/7/18, identified diagnosis of unspecified cified cerebrovascular disease.	{F 68	38}	reviewed and a plan for reeducation staff delivering care to these reside and the completion of documentation been developed and will be completed and will be completed. To prevent further potential deficies practice that may affect other residenter restorative nursing aids have be reeducated on accuracy of charting that were completed. Charting has reviewed for any residents receiving restorative nursing care and training been with restorative aides on charch audits will be completed on residents receiving restorative nur proper documentation. Audits will done by the DNS or designee 1 times week for 2 months then every other for 1 month. Audit results will be remonthly by facility QAPI committee further recommendation.	ents ion has eted by nt dents, been g tasks been ng ng has rting. all sing for be ne a er week eviewed	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION ING			E SURVEY PLETED
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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD E APPROPI	BE	(X5) COMPLETION DATE
{F 688}	indicated R19 has a intervention due to (related to) CVA (ce Interventions identif (exercise bicycle) a x (times) per week, and CGA (care give xwk (times per week R19's Functional M Program, dated 2/6 was to maintain cur Frequency of the reoccur 3-times per walk with cane, gait Scifit level included R19's medical recoambulation and reswere being offered, During interview on asked about the restrey offer the restor but it hasn't been m state the last time was the other day they and didn't want to go The facility 3 ring bin Nursing Documenta available dates of 3 the 3 ring binder was Down the left side or restorative program were the days of the was a corresponding	a need for restorative limited physical mobility R/T crebrovascular accident). Fied: R19 should perform Scifit t level 5 up to 10 minutes 3-5 walking with cane, gait belter assist) up to 100 feet 3-5	{F 68	38}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	, ,	TIPLE CONSTRUCTION NG	CON	TE SURVEY MPLETED
		245237	B. WING			R-C / 07/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		70772016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
{F 688}	3/6/18 were market for 3/1,3/2,3/3, and program recommer per week, however and 3/6 were blank of the document with provided. During interview on nursing assistant (nursing is documed list for each month blank, it means the that date. During interview or registered nurse (If the restorative the stated she had set ring binder. RN-A adocument restorated the page with the resquare on a date in nursing did not occurred or nursing working on the audit was finding blanks restorative nursing stated the blanks is restorative therapy and gave no explain documentation was facility policy titled dated 6/12 identified	r, only the boxes for 3/5/18 and ed by a staff person. The boxes of 3/4 were blank. Restorative endations for R19 was 3-5 times or the box for 3/1,3/2, 3/3,3/4 or 3/5 had an R(refused). A copy was requested but was not an 3/7/18, at 12:10 p.m. the NA)-A stated restorative ented in the 3 ring binder on the an NA-A stated if a square is the restorative was not done for an 3/7/18 at 12:20 p.m. RN)-A, stated they had updated the restorative was not done for an 3/7/18 at 12:20 p.m. RN)-A, stated they had updated the restorative was not done for an 3/7/18 at 12:20 p.m. RN)-A further the documentation in the 3 raiso stated therapy aides in the documentation in the 3 restorative cur that date. In 3/7/18, at 12:30 p.m. the (DON), stated she was dits for restorative nursing and an in the documentation for in the 3 ring binder. The DON in the documentation meant the a was not done on those dates anation as to why the	{F 68	38}		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		245237	B. WING			R-C 07/2018
	PROVIDER OR SUPPLIER	Y - REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP COD 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		0172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 688}	based on individua	age 8 al strengths, needs,and ed in nursing assessments."	{F 68	38}		



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on March 19, 2018.

March 19, 2018

Ms. Haley Amundson, Administrator Good Samaritan Society - Redwood Falls 200 South Dekalb Street Redwood Falls, MN 56283

Re: Project # S5237025

Dear Ms. Amundson:

On March 7, 2018, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 11, 2018.

State licensing orders issued pursuant to the last survey completed on January 11, 2018, found not corrected at the time of this March 7, 2018 revisit and subject to penalty assessment are as follows:

20830 -MN Rule 4658.0520 Subp. 1 Adequate And Proper Nursing Care; General	\$350.00
20895 - MN Rule 4658.0525 Subp. 2.B Rehab - Range Of Motion	\$350.00

The details of the violations noted at the time of this revisit completed on March 7, 2018 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$700.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to , Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, 3333 W Division, #212 St Cloud Mn 56301.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program Minnesota Department of Health

Kamala Fiske Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

Licensing and Certification File cc:

Shellae Dietrich, Licensing and Certification Program

Penalty Assessment Deposit Staff

PRINTED: 03/26/2018 FORM APPROVED

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ R-C B. WING_ 00063 03/07/2018

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY - REDWOOD FAL		TH DEKALB D FALLS, M		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments		{2 000}		
	****ATTENTION*****				
	NH LICENSING CORRECTION ORD)ER			
	In accordance with Minnesota Statute, s 144A.10, this correction order has been pursuant to a survey. If, upon reinspect found that the deficiency or deficiencies herein are not corrected, a fine for each not corrected shall be assessed in accor with a schedule of fines promulgated by the Minnesota Department of Health.	issued ion, it is cited violation rdance			
	Determination of whether a violation has corrected requires compliance with all requirements of the rule provided at the number and MN Rule number indicated When a rule contains several items, failt comply with any of the items will be conslack of compliance. Lack of compliance re-inspection with any item of multi-part result in the assessment of a fine even it that was violated during the initial inspectorrected.	tag below. ure to sidered upon rule will f the item			
	You may request a hearing on any asset that may result from non-compliance wit orders provided that a written request is the Department within 15 days of receip notice of assessment for non-compliance	th these made to t of a			
	INITIAL COMMENTS: An onsite follow-up visit was completed 03/06/2018 and 03/07/2018. During this was determined that the following citatio NOT Corrected.	s visit it			
	The uncorrected citations will remain in will be reviewed at the next onsite visit.	effect and			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

(X6) DATE 03/26/18 Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED		
	00063		B. WING		R-	C 7/2018	
NAME OF	PROVIDER OR SUPPLIER	00063	STDEET AD	<u> </u>	STATE, ZIP CODE	03/0	112010
				TH DEKALB	*		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAL		D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
{2 830}	receive nursing care custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident e and treatment, per supervision based of preferences as ide resident assessmer scribed in parts 4658 ng home resident mpossible unless the attending physicia in in bed or the resident	must resonal and on entified in and 8.0400 and oust be out re is a an that the	{2 830}			3/29/18
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess and provide interventions when a blister was identified on the buttocks for 1 of 1 residents (R7) reviewed for change of condition and non-pressure related skin concerns. Findings include: R7's Admission Record, dated 4/13/17, indicated diagnoses including weakness and amyotrophic lateral sclerosis (a rare neurological disease that mainly involves the nerve cells responsible for controlling voluntary muscle movement) and identified R7 was receiving hospice care. R7's significant change Minimum Data Set (MDS), dated 2/8/18, identified R7 was cognitively intact, required extensive assistance for activities of daily living (ADLs), was incontinent of bowel and			Corrected			

Minnesota Department of Health

PRINTED: 03/26/2018 FORM APPROVED

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00063		B. WING			-C 07/2018	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FAL	200 SOUT	H DEKALB			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	ES / FULL	ID FALLS, M ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{2 830}	•	-	Ole	{2 830}			
	During a review of R Observation, dated on the "left buttock, [centimeter] x 0.25 Observation form w documentation that an assessment was was identified.	2/28/18, identified a " measuring "0.5 cm cm." The rest of the vas blank. There was R7's physician was	n "blister" Skin s no notified or				
	cm x 0.5 cm blister Cleansed and appli like to treat?" The ophysician comment Can we use mepile. & PRN [as needed] order on 3/2/18, indihealed." R7's Clinican order with a starrt buttock, change of Review of R7's Treas/1/18-3/31/18, indimepilex to her right	ne identified blister, of x rec'd [received] ohe sing] to blister rt [right] don the left buttock and the left buttock area on R [right] buttock area on R [right] buttock area on R [right] buttock and an	until 3/2/18 c for ht] buttock c for ht] buttock class a 0.25 ttock. buld you inder at 1200. If 3 d [days] hed the Ok till included wed hed a/5/18. but 2/15/18, on 2/15/18,				
	identified R7 had a spine, however, lac was identified on th	history of an open a ked information that	rea on her				
	During an interview registered nurse (R were responsible for residents with skin of the sk	N)-B and RN-A state or completing wound	ed they rounds on				

Minnesota Department of Health

STATE FORM 6899 KZFT12 If continuation sheet 3 of 9

PRINTED: 03/26/2018 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRU A. BUILDING:	CTION (X3) DATE SURVEY COMPLETED
00063 B. WING	R-C
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP C	·
GOOD SAMARITAN SOCIETY - REDWOOD FAL 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EAC	ROVIDER'S PLAN OF CORRECTION (X5) CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
process of completing wound rounds at that time, as they did every Wednesday. RN-B and RN-A stated R7 was not on their list to see because they were not aware of any issues with her skin or that she had a blister on the buttocks. At 10:20 a.m. RN-B stated progress notes were reviewed for all residents every morning at "stand up," to identify any skin concerns. Staff were also directed to communicate with RN-A or RN-B if they identified a skin concern. RN-B stated R7 had a skin observation on 2/28/18, and the blister was noted, however, was not included in a progress note and was not communicated to RN-B or RN-A. RN-B stated, "This was missed. We should have seen it." RN-B stated they would be assessing R7's blister so that they could attempt to identify the cause of the blister and put interventions in to place. On 3/7/18, at 12:42 p.m. RN-B and RN-A entered R7's room. R7 was lying in bed. Mepilex dressing was removed by RN-A and was noted to be saturated with a yellow substance that RN-A and RN-B identified as urine. A dark red area was identified on the upper right buttock, and RN-B described the area as flat, soft, not fluid filled, not open, and measured 0.5 cm x 0.25 cm. RN-B sprayed the area with Dermal Wound Cleanser, and dried with gauze. A Mepilex dressing was applied. During an interview on 3/7/18, at 1:05 p.m. RN-A and RN-B stated, "We did not know about it [R7's blister] until you told us. We didn't get a note. The nurse that noted it, should have told us." RN-A and RN-B stated they would be updating the physician, would be calling hospice for direction	

Minnesota Department of Health

STATE FORM 6899 KZFT12 If continuation sheet 4 of 9

Minnesota Department of Health

STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00000				R-	.C 7/2018
NAME OF I	PROVIDER OR SUPPLIER	00063	l	STATE, ZIP CODE	03/0	772010
		200 SOUT	H DEKALB	•		
GOOD 3	AMARITAN SOCIETY	- REDWOOD FAL REDWOO	D FALLS, M	N 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
{2 830}	Continued From pa	ige 4	{2 830}			
	have been a crease cushion.	e in her brief or wheelchair				
{2 895}	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion		{2 895}			3/29/18
	Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:					
		th a limited range of motion te treatment and services to				

Minnesota Department of Health

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00063	B. WING		R- 03/0	C 7/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD		STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	H DEKALB			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	D FALLS, M	PROVIDER'S PLAN OF CORRECTION)N	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE
{2 895}	Continued From pa	ge 5	{2 895}			
	increase range of n decrease in range of	notion and to prevent further of motion.				
	by:	ent is not met as evidenced				
	review, the facility fa	on, interview, and record ailed to provide restorative esidents (R1, R19) reviewed ng.		Corrected		
	Findings Include:					
	primary admitting d dementia without be	port, printed 3/7/18, identified a iagnoses of, unspecified ehavioral disturbance, thritis, unspecified site, pain				
	R1's comprehensiv identified severe co	e assessment, dated 1/8/18, gnitive impairment.				
	Program dated 1/25 program included d (ROM) to: both arm extension/ flexion to	intenance Restorative 5/17, identified a restorative aily passive range of motion is, shoulder, elbows, hands, to both legs, hips-side to side and down (like marches), on).				
	identified R1 has a intervention to supp wheelchair/Broda c repositioning). Inter Rehab: #1 Passive shoulders, elbow, h flexion. Both legs a down, knees flex/ex	lan, last revised 2/5/18, need for restorative port midline posture in hair (chair that allows for ventions included, Nursing range of motion both arms, ands, do extension and hips, side to side, up and ctension and ankles				

Minnesota Department of Health

STATE FORM 6899 KZFT12 If continuation sheet 6 of 9

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRU			(X3) DATE SURVEY COMPLETED	
			l A	A. BUILDING: .				
		00063	В	B. WING		03/0	7/2018	
NAME OF	PROVIDER OR SUPPLIER	STRE	EET ADDR	ESS, CITY, S	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI		DEKALB S				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
{2 895}	Continued From pa	age 6	{:	2 895}				
	exercise.							
		d lacked evidence a ROM offered, implemented, an ogram prescribed						
	a primary admitting	eport, printed 3/7/18, ident diagnosis of unspecified cified cerebrovascular dise						
	R19's comprehens identified R19 was	ive assessment, dated 3/5 cognitively intact.	5/18,					
	indicated R19 has a intervention due to (related to) CVA (conterventions idention (exercise bicycle) at (times) per week,	st review date of 2/6/18, a need for restorative limited physical mobility Rerebrovascular accident). fied: R19 should perform at level 5 up to 10 minutes, walking with cane, gait beer assist) up to 100 feet 3-2 k)	Scifit 3-5					
	Program, dated 2/6 was to maintain cul Frequency of the reoccur 3-times per valk with cane, gai	laintenance Restorative 6/18, indicated the overall or rrent level of mobility. estorative program was to week. The program include t belt, and CGA up to 100 l 8 times for 10 minutes.	ed to					
	ambulation and res	ord lacked documentation to storative nursing programs , implemented, and evalua						
	asked about the restor	n 3/7/18, at 12:25 p.m. whe storative program, R19 sta rative program once in aw nuch lately. R19 went on to	ated hile					

Minnesota Department of Health

STATE FORM 6899 KZFT12 If continuation sheet 7 of 9

Minnesota Department of Health

winnesc	ita Department of He	eaim				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI		IPLE CONSTRUCTION		ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDII	NG:		OMPLETED
						R-C
		00063	B. WING _		- (3/07/2018
NAME 05		0.7.0		V 07475 7ID 00D5		
NAME OF	PROVIDER OR SUPPLIER			Y, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	SOUTH DEKAL			
		REI	DWOOD FALLS,	MN 56283		
(X4) ID	-	TEMENT OF DEFICIENCIES	ID		OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		ACTION SHOULD BE TO THE APPROPRIATE	COMPLETE DATE
17.0		,	,,,,	DEFICI	IENCY)	
(2.005)	Cantinuad Francis	7	(2,905)			
{2 895}	Continued From pa	ige /	{2 895}			
	state the last time v	vas 2 weeks ago. R19 sta	ated			
		asked, but was not feeling				
	and didn't want to g	o and have an accident.				
		inder labeled Restorative				
		ation was reviewed for the				
		3/1/18- 3/6/18. The first pa				
		as a page labeled March 2	2018.			
		of the page was a list of				
		o were to receive the				
		n. Across the top of the pa				
		e month 1-31. For each d ng box for each resident.	ay			
		n recommendations for R	21			
		, only the boxes for 3/5/18				
		d by a staff person. The b				
		3/4 were blank. Restorati				
		ndations for R19 was 3-5				
		the box for 3/1,3/2, 3/3,3				
		3/5 had an R(refused). A				
	of the document wa	as requested but was not				
	provided.					
	_	3/7/18, at 12:10 p.m. the				
	•	NA)-A stated restorative				
		nted in the 3 ring binder o				
		NA-A stated if a square is				
	1	restorative was not done	TOT			
	that date.					
	During interview on	3/7/18 at 12:20 p.m.				
		RN)-A, stated they had upo	dated			
		apy care plans. RN-A furti				
		up the documentation in t				
		lso stated therapy aides				
		ve nursing the 3 ring binde	er on			
		esidents names listed. If a				
		blank it means the restor				
	nursing did not occ	ur that date.				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLI IDENTIFICATION NU			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00063		B. WING			-C 07/2018
NAME OF PROVIDE	R OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	, ,	
GOOD SAMARI	AN SOCIETY	- REDWOOD FAL		TH DEKALB			
				D FALLS, M		COORDECTION	0.5
	ACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM.	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{2 895} Contir	ued From pa	ige 8		{2 895}			
During director working was firestored and garded restored documents.	y an interview or of nursing (ag on the aud nding blanks ative nursing the blanks in ative therapy ave no explarmentation was y policy titled 6/12 identificative nursing on individual	on 3/7/18, at 12:30 (DON), stated she wits for restorative nurin the documentation in the 3 ring binder. In the documentation was not done on the action as to why the sonot completed. Restorative nursing d "each resident will care to the extent polystrengths, needs, and in nursing assessred in nursing assessred.	Program receive ossible	{2 090}			

Minnesota Department of Health

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	ARE/MEDICAID CERTIFICATION ARE/MEDICAID CERTIFICATION AT TO BE COMPLETED BY THE STA		ID: KZFT Facility ID: 00063
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245237 2.STATE VENDOR OR MEDICAID NO. (L2) 385318700	3. NAME AND ADDRESS OF FACILITY (L3) GOOD SAMARITAN SOCIETY - R (L4) 200 SOUTH DEKALB STREET (L5) REDWOOD FALLS, MN	EDWOOD FALLS (L6) 56283	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 8. ACCREDITATION STATUS: (L10) 0 Unaccredited	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD 02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/III 04 SNF 08 OPT/SP 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 0 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 43 (L18) 13. Total Certified Beds 43 (L17)	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC X B. Not in Compliance with Program Requirements and/or Applied Waivers:	And/Or Approved Waivers Of 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN5. Life Safety Code * Code: B *	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 43 (L37) (L38) (L39)	ICF IID (L42) (L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
STATE SURVEY AGENCY REMARKS (IF APPLIC A recertification survey was conducted 1/8/18 the the survey, an investigation of complaint #H5237 SURVEYOR SIGNATURE Andrea Schmitz, HFE NE II	rough 1/11/18, and complaint investigation		nd F610 APPROVAL Date:
PART II - TO BE	COMPLETED BY HCFA REGIONAL	L OFFICE OR SINGLE ST	•
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:		ncial Solvency (HCFA-2572) Il Interest Disclosure Stmt (HCFA-1513) :

2. Facility is not Eligit	(L21)			
22. ORIGINAL DATE	23. LTC AGREEMENT	24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING DATE	ENDING DATE	VOLUNTARY 00	INVOLUNTARY
04/14/1981			01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANCTIONS		03-Risk of Involuntary Termination	OTHER
	A. Suspension of Admissions:	_	04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind Suspension Date:	(L44)		00-Active
		(L45)		
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.		30. REMARKS	
	00140			
	(L28)	(L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE			
	(1.32)	(1.33)	DETERMINIATION ADDROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 26, 2018

Ms. Haley Amundson, Administrator Good Samaritan Society - Redwood Falls 200 South Dekalb Street Redwood Falls, MN 56283

RE: Project Number S5237025 and H5237013

Dear Ms. Amundson:

On January 16, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. In addition, at the time of the January 16, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5237013 that was found to be substantiated at F607, F609 and F610.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor St. Cloud B Survey Team Licensing and Certification Program **Health Regulation Division** Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: kathleen.lucas@state.mn.us

Phone: (320) 223-7343 Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 20, 2018, 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 February 20, 2018 the following remedy will be imposed:

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

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.

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 April 11, 2018 (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 July 11, 2018 (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 Health Regulation Division 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 electronic 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.

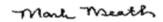
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,



Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

cc: Licensing and Certification File

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY MPLETED
		245237	B. WING			C
	PROVIDER OR SUPPLIER		B. Wille	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	01/	/11/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	Emergency Prepare conducted 01/08/18 recertification surve with the Appendix Requirements.	iance with CMS Appendix Z edness Requirements, was 3 through 01/11/18, during a ey. The facility is in compliance Z Emergency Preparedness	F 00	00		
	through 1/11/18, an also completed at the survey. At the time of complaint #H523	rvey was conducted 1/8/18 d complaint investigation was he time of the standard of the survey, an investigation 7013 was completed and was htiated at F607, F609, and				
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with				
F 561 SS=D	as your allegation of Department's accepenrolled in ePOC, y at the bottom of the form. Your electron be used as verification	·	F 56	51		2/9/18
ABORATOPY	promote and facilitathrough support of not limited to the rig	ermination. e right to and the facility must ate resident self-determination resident choice, including but ahts specified in paragraphs (f) DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

Electronically Signed 02/03/2018

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	` ´сом	E SURVEY PLETED
		245237	B. WING _			C 11/2018
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F 561	activities, schedule waking times), hea care services cons assessments, and applicable provision §483.10(f)(2) The reduces about aspetacility that are sign §483.10(f)(3) The reduces with members of the community activities facility. §483.10(f)(8) The reduced provided prov	resident has a right to choose s (including sleeping and lth care and providers of health istent with his or her interests, plan of care and other ns of this part. resident has a right to make ects of his or her life in the nificant to the resident. resident has a right to interact ne community and participate in its both inside and outside the resident has a right to activities, including social, munity activities that do not ghts of other residents in the NT is not met as evidenced tion, interview, and document failed to identify a resident's uency of shaving for 1 of 2 viewed for activities of daily	F 56	Preparation and execution response and plan of correction is prepared and/s solely because it is required.	ction does not agreement by the facts orth in the che plan of or executed by the	
	(MDS), dated 11/28 physical assist of o including shaving.	nange Minimum Data Set 3/17, indicated R30 required one staff for personal hygiene, R30's Brief Interview for Mental cated a score of 14, indicating intact.		provisions of federal and stathe purposes of any allegatic center is not in substantial cwith federal requirements of this response and plan of constitutes the center's allegatic constitutes.	on that the compliance f participation, orrection	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING			SURVEY PLETED
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F 561	identified R30 requi (activities of daily li identify R30's shaw R30's care plan, darequired staff to co face, arms and hardid not identify R30 shaving. During observation was observed to have an electric raplugged into the wad resser in R30's roclean shaven. R30 assisted with shaving assisted with shaving assisted staff had ne would like to be shaved today and daily. During observation R30's continued to stated staff had ne would like to be shaved today and daily. During observation nursing assistant (shower. After the shaved up." NA-B razor that was local During interview or stated R30 received	age 2 ssessment, dated 12/12/17, aired limited assist with ADL's aving.) The assessment did not aring frequency preference. ated 12/19/17, indicated R30 and hair, identifying can wash after set up. The care plan b's preference for frequency of a on 1/8/18, at 2:50 p.m. R30 ave long gray facial hairs. R30 are long. An electric razor was all and laying on top of the form. R30 stated he liked to be a stated the last time he was are gray facial hair. R30 are gray fa	F 5	compliance in accordant 7305 of the State Operation R30's care plan and preshaving was reviewed a meet his need on 1/11/2 Residents who have the affected by the deficient their care plans reviewed meet their needs. Staff has been reeducated importance and policy are resident preference on To ensure that systemic made that the deficient recur, random observate conducted on shaving puill be completed by DN weekly for 4 weeks ther weeks then every other results will be reviewed QAPI Committee for fur recommendation.	eference for and updated 18. e potential to the practice had and updated and updated and procedures are changes are practices within audits who references. Us or design a 1x weekly the week for 1. monthly by the procest of the procest of the practices within audits who references.	to o be ve had te to res on re Il not ill be Audits iee 2x for 4 Audit	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	COM	E SURVEY IPLETED
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F 561	believed R30 was NA-B stated she of preference for free stated she followe group sheet did not NA-B stated if the shave daily, reside weekly on their shave daily, reside weekly on their shave daily, reside weekly on their shave assisted R30 week, he had facial During interview or registered nurse (I residents are asked shaving preference RN-A stated staff sincluding R30, even shaved. If residents shaving, shaving reare plan. RN-A stated staff sincluding R30, even shaved. If residents shaving, shaving reare plan. RN-A stated staff sincluding R30, even shaved. If residents shaving, shaving reare plan. RN-A stated staff sincluding an interview interim director of should ask resident frequency preference needed plan. The facility's policy 6/14, directed "Anterior out activities necessary service grooming, and per "General Persona"	en asked about shaving, NA-B only shaved on his bath day. Itid not know what R30's quency of shaving was. NA-B d the group sheet and the of direct to shave R30 daily. group sheet did not indicate to ents are shaved one time ower day. NA-B stated when with his shower the previous all stubble as well. In 1/11/18, at 11:35 p.m. RN)-A stated she believed and upon admission about their es, but couldn't say for sure. Should be asking resident's, eryday if they wanted to be atted R30's care plan did not ency of shaving. In or of shaving. In or of shaving the shaving of the shaving of shaving of shaving of shaving of shaving of shaving of the sate of the sate of the shaving of daily living will receive so to maintain good nutrition, as onal and oral hygiene." In Daily Hygiene/Grooming: care e, shaving, applying makeup,	F 5	561			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	` '	TE SURVEY MPLETED
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F 578 SS=D	CFR(s): 483.10(c)(6) The discontinue treatment to participate in exprormulate an advars §483.10(c)(8) Noth construed as the rist the provision of meservices deemed in inappropriate. §483.10(g)(12) The requirements special spart I (Advance (i) These requirements concerning medical or surgical resident's option, for (ii) This includes a facility's policies to and applicable Star (iii) Facilities are pentities to furnish the legally responsible requirements of this (iv) If an adult indivitime of admission a information or artic has executed an amay give advance individual's resident with State Law. (v) The facility is no provide this information or she is able to resident surgical surgica	right to request, refuse, and/or ent, to participate in or refuse perimental research, and to note directive. Ing in this paragraph should be ght of the resident to receive edical treatment or medical nedically unnecessary or e facility must comply with the ified in 42 CFR part 489, e Directives). ents include provisions to written information to all adulting the right to accept or refuse treatment and, at the ormulate an advance directive. written description of the implement advance directives te law. ermitted to contract with other his information but are still for ensuring that the	F 57	8		2/9/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		СОМ	(X3) DATE SURVEY COMPLETED	
		245237	B. WING			C 11/2018	
	PROVIDER OR SUPPLIEF	Y - REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP C 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283			
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F 578	the information to appropriate time. This REQUIREME by: Based on intervie facility failed to en updated to reflect current wishes for received hospice services in the service of the services	the individual directly at the ENT is not met as evidenced w and document review, the sure advance directives were resident participation and 1 or 3 resident (R21) who services in the facility. Change Minimum Data Set, intified no cognitive impairment or receive hospice services. Iders for Life-Sustaining T), signed 11/10/17, indicated the for full treatment and to ion in the event of cardiac or esheet and physician orders, intified his advance directive as, ation/CPR. Patient has not reathing."	F 5	R21 advance directives we 1/9/18 and he has since exp Current residents receiving services have had their advanced directives reviewed and updaneeded add position on who review. Staff will be reeducated on the procedure related to advance be made on new hospice reactimes weekly for 4 weeks the week for 2 months. Audits a reviewed monthly by facility Committee for further recommittee for further recommittee.	bired. hospice anced lated as o did the the policy and ce directives. directives will esidents 1 en every other results will be QAPI		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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F 578	and promote com A facility progress R21's DNR code be changed in his R21's current car a terminal progno failure. The care padvance care pla respect choices." Although R21's ar from "Attempt Re Resuscitate," his record were not un During interview of practical nurse (L code (an emerge in cardiopulmona of CPR), a reside checked pulling un Point Click Care. R21's electronic r pointing to the he "Attempt Resusci stated they also h POLST in the nur the binder to R21 as a full code and During interview of registered nurse of	fort) would be provided. s note, dated 12/8/17, identified status was discussed and would	F 5	578			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 578	usually happened to services. RN-A rep change their advant would be filled out, medical record. RN hospice and got a directive, but didn't aware of the update stated the facility hamedical records, "a POLST and advancharts. During interview or interim director of rused the advance of at the nurse's static medical record, enson file. The IDON adouble checked the prior to updating the reported, in the evelook up a resident's computer in the ele IDON thought the fon hospice and did however, the IDON used pool nurses, where could be poted the charge record, and during would go to social sources (SS)-A static services (SS)-A static service	lege 7 between hospice and social orted if a resident wanted to be directive, a POLST form signed, and scanned into the I-A reported she had called copy of R21's DNR advance think social services was ed advance directive. RN-A ad updated all the residents' a while back," to make sure ce directives were in the directive binder (binder located on) to update every resident suring everyone had a POLST acknowledged she had not at the POLST were current emedical records. She ent of a code, nurses would advance directive on the extronic medical record. The acility nurses knew R21 was n't think they would start CPR; acknowledged the facility who might not know R21, and ential for them to start CPR. oing forward, if a POLST was lity during off hours it would be a nurse to put into the medical business hours, the POLST services first, and then to a would put in the order.	F 5	78				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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F 578	off and/or a copy of when a resident was services, sometimes advance directive as and sometimes the during the discussice either way they nee advance directive we could not enter in the A facility policy entite and Advance Direct "Advance directive resident/healthcare plan meeting to ensome The policy further in condition deteriorate advance directive of family to determine If there is a request directive orders, condition deteriorate advance directive orders, condition determine If there is a request directive orders, condition determine If there is a request directive orders, condition determine If there is a request directive orders, condition determine If there is a request directive orders, condition determine If there is a request directive orders, condition determine If there is a request directive orders, condition determine If there is a request directive orders, and exploit misappropriation of \$483.12(b)(1) Prohineglect, and exploit misappropriation of \$483.12(b)(2) Established to investigate any significant support of the properties of the propert	they need a physician to sign a new POLST. SS-A stated is admitted to hospice is hospice completed the individual give them a copy, facility staff would be present on with hospice. SS-A stated ded a physician order and the would go to nursing, since she ine order. Iteled Advance Care Planning tives, revised 4/16, directed, orders are to be reviewed with decision-maker at each care sure no changes are needed." Instructed, "If a resident's resident and if they wish to make changes. For changes in the advance intact physician for order." Abuse/Neglect Policies 1)-(3) Itility must develop and policies and procedures that: Itility and prevent abuse, ration of residents and resident property, onlish policies and procedures uch allegations, and the training as required at	F 5			2/9/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
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		245237	B. WING _		01/	/11/2018
NAME OF F	PROVIDER OR SUPPLIEF	R		STREET ADDRESS, CITY, STATE, ZIP COD	=	
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000D 0	AMARITAN GOOLT	1 - REDWOOD I ALLO		REDWOOD FALLS, MN 56283		
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				DEFICIENCY)		
F 607	failed to implement policy related to rehours to the state protecting resident investigation for 1 for abuse: Findings include: The facility's policy 11/16, directs if an suspected abuse, measures to prote allegation to a supbe notified immed "If there is an allegexploitation or mist unknown source a property, and/or the it will be reported allegation is made other officials (included and adult protective provides for jurisd in accordance with allegation of emplements of the internal investigation of the internal investigation of the internal investigation of the internal investigation. R18's annual Minimals.	w and record review, the facility at their Abuse and Neglect sporting alleged abuse within 2 agency and related to the form further abuse during of 1 residents (R18) reviewed and Neglect, dated a employee witnesses the employee will take set the resident and report the servisor. The charge nurse will stately and assess the situation. Stately and assess the situation of abuse, neglect, streatment, including injuries of and misappropriation of resident sere is serious bodily injury, than no later than two hours after the set to the administrator, and to uding the state survey agency we services where state law into in long-term care centers) in state law." If this is an object to resident abuse, the emoved from providing direct the suspension pending the results estigation. Another employee to complete the care of the mum Data Set (MDS)	F 60	R18 abuse allegations were re OHFC on 1/3/18. All incidents for the last 3 monbeen reviewed and there were additional abuse allegations the have been reported to OHFC. Staff has been reeducated by abuse and neglect reporting procedure. For 3 months all the location's will be audited to ensure timely to OHFC for suspected abuse allegations. Audit results will be monthly by facility QAPI communitaries further recommendation. Timely reporting of OHFC suspabuse allegations and incident will be Completed 1 times were weeks then every other week for months audits will be completed 1st 2018.	th have no at should 2/1/18 on olicy and incidents reporting neglect e reviewed ittee for oected tes audits kly for 4 or 2	
	required extensive	d 8/25/18, indicated R18 assistance of one staff with lichair for locomotion on the unit.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,			TE SURVEY MPLETED
		245237	B. WING _		01	C / 11/2018
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP OF SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		711/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 607	towards others. R1 Status (BIMS) indic cognitively impaire A facility Suggestion 1/2/18, (time not id assistant (NA)-C w	behavioral symptoms directed 8's Brief Interview for Mental cated a score of 3, severely	F 60	7		
	R18 planted her fe move forward. Nur approached R18 a and coax R18 out room for other resi (NA)-E approached behind R18's (legs up. R18 was not ha agitated. The form not identified) the inursing (IDON) an requirement to repreported the incide	et and wouldn't lift them to sing assistant (NA)-D nd tried to take R18's hand of the dining room to make dents to exit. Nursing assistant d R18. NA-E put his foot) and forcefully lifted R18's feet appy and became more indicated NA-C reported (time ncident to interim director of d mentioned the 2 hour time ort to state to IDON. NA-C also nt (time not identified) to the ensed practical nurse (LPN)-C.				
	incident occurred of 6:00 p.m. NA-C no approximately 2 ho p.m. The report inc	dated 1/2/18, indicated the on 1/2/18 between 5:45 pm and tified IDON of the incident ours later, on 1/2/18 at 7:45 dicated inappropriate use of NA-E) feet to move R18.				
	with NA-C indicate leaving the dining I fold her blanket. N her feet. R18 woulhis foot behind R15	terview document, undated, d R18 planted her feet before coom because she wanted to A-C tried to coax R18 to lift up d not lift up her feet. NA-E put B's legs and pushed them so didn't swing and kick her just				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		245237	B. WING		01	C / 11/2018
	PROVIDER OR SUPPLIE	R Y - REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP (200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		71112010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F 607	p.m. "I know I neereported to (IDON said 'okay' and the on the east." An Incident Reported the incidentified the incident was weareport summary in pending investigated identified NA-E with 4 hours and 45 m abuse allegation. NA-E's time sheet the following day, p.m. and 1/4/18 from 1/2/18, incresidents, includir stated he was not shift on 1/2/18, incresidents, includir stated he was una following day, whe incident. NA-E stated he does not he was going to day the was going to day was assistant reports the was going the was going to day the was going	page 11 cally." Incident occurred around 6 eded to report within 2 hours- so it) at 7:30-7:45 p.m. and she en walked down to do the meds of the state at 11:46 a.m., 18 hours after witnessed by NA-C. Although the endicated NA-E was suspended tion, NA-E's time sheet orked until 10:45 p.m. on 1/2/18, inutes to 5 hours after the initial of the function of the endicated NA-E worked 1/3/18 from 2:15 p.m. to 10:45 from 5 p.m. to 9:00 p.m. The won 1/10/18 at 2:12 p.m. NA-E is suspended, but finished his dependently working with an assisting R18 to bed. NA-E aware of the allegation until the en IDON called to discuss the ated he used his right foot to lift he wheelchair pedals. NA-E of tremember if he told R18 what it is first. NA-E denied kicking went on to say he should have to lift R18's legs up, not his foot. The NA-E denied kicking went on to say he should have to lift R18's legs up, not his foot. The NA-E denied kicking went on to say he should have to lift R18's legs up, not his foot. The NA-E denied kicking went on to say he should have to lift R18's legs up, not his foot. The NA-E denied kicking went on to say he should have to lift R18's legs up, not his foot. The NA-E denied kicking went on to say he should have to lift R18's legs up, not his foot. The NA-E denied kicking went on to say he should have to lift R18's legs up, not his foot.	F6	607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245237	B. WING			C 11/2018
	NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 607	nurses, administrate ability to report to the about the incident rewhen she arrived at 1/3/18, staff (unknown had happened. The had happened and allegation was abust to the state agency allegation should have agency immediately. During an interview interim director of neworking on the flood IDON stated NA-C potential abuse. IDO came in the dining of feet. NA-C did not into IDON. IDON stated then went and spoke his feet under R18 went on to say I could be away. IDON stated National IDON stated notified. "I should have administrator was not the time of the incident incident IDON stated notified."	imediately. SS-A, the floor or, and the IDON all have the state agency. When asked elated to R18, SS-A stated to work on the morning of wn) reported to her something staff could not tell her what it took a while to find out the se. She reported the incident at 11:46 a.m. SS-A stated the ave been reported to the state of the state of the incident at 11:46 a.m. SS-A stated the ave been reported to the state of the incident at 11:46 a.m. SS-A stated the ave been reported to the state of the incident of the incident of the incident	F 6			
			F6	US		2/9/18
	•	i, or improdument, the facility				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		245237	B. WING		C 01/11/2018			
	NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION			
F 609	§483.12(c)(1) Ensi involving abuse, no mistreatment, inclusource and misappare reported imme hours after the allest that cause the alleserious bodily injurted events that cause and do not the administrator officials (including adult protective sefor jurisdiction in loaccordance with Sprocedures. §483.12(c)(4) Repinvestigations to the designated represaccordance with Survey Agency, wiincident, and if the appropriate correct This REQUIREME by: Based on interview failed to report an agency within 2 horeviewed for abuse Findings include: R18's annual Minimals annuals a	ure that all alleged violations eglect, exploitation or uding injuries of unknown propriation of resident property, ediately, but not later than 2 egation is made, if the events gation involve abuse or result in ry, or not later than 24 hours if use the allegation do not involve result in serious bodily injury, to of the facility and to other to the State Survey Agency and rvices where state law provides ong-term care facilities) in tate law through established ort the results of all the administrator or his or her entative and to other officials in tate law, including to the State thin 5 working days of the alleged violation is verified tive action must be taken. ENT is not met as evidenced of a wand record review, the facility allegation of abuse to the state ours for 1 of 1 residents (R18)	F 609	R18 abuse allegations were report OHFC on 1/3/18 Judy Parvin Interior. All incidents for the last 3 month has been reviewed and there were no additional abuse allegations that shave been reported to OHFC. Staff has been reeducated by 2/1/1 abuse and neglect reporting policy procedure. For 3 months all the location's incide will be audited to ensure timely reput to OHFC for suspected abuse/negle	m DNS. live liould 8 on land lents lorting			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
						С	
		245237	B. WING			01/1	11/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	(BIMS) indicated a impaired. R18's care plan, revimpaired cognitive fincluded: to provide cues-stop and returinto other activities agitation. Approach Remove from situal location as needed. A facility Suggestion 1/2/18, (time not ideassistant (NA)-C warde to the TV room R18 planted her fee move forward. Nursapproached R18 ar and coax R18 out croom for other resid (NA)-E approached behind R18's (legs) up. R18 was not ha agitated. The form in not identified) the irnursing (IDON) and requirement to reported the incider next shift nurse, lice An incident report, cincident occurred of 6:00 p.m. NA-C not approximately 2 hop.m. The report ind	Interview for Mental Status score of 3, severely cognitively vised on 12/27/17, identified functions. Interventions R18 with necessary if agitated. Re-direct R18 when showing signs of and speak in a calm manner. Ition and take to alternate on or Concern form, dated entified) indicated nursing as attempting to give R18 a from the dining room, when set and wouldn't lift them to sing assistant (NA)-D and tried to take R18's hand of the dining room to make lents to exit. Nursing assistant R18. NA-E put his foot and forcefully lifted R18's feet and forcefully lifted R18's feet ppy and became more indicated NA-C reported (time incident to interim director of mentioned the 2 hour time out to state to IDON. NA-C also at (time not identified) to the ensed practical nurse (LPN)-C. dated 1/2/18, indicated the in 1/2/18 between 5:45 pm and iffied IDON of the incident urs later, on 1/2/18 at 7:45 incated inappropriate use of IA-E) feet to move R18.	F	609	allegations. Audit results will be revenentably by facility QAPI committee further recommendation. Timely reporting of OHFC suspected abuse allegations and incidences awill be Completed 1 times weekly for weeks then every other week for 2 months audits will be completed by 1st 2018.	for ed udits or 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING	CON	(X3) DATE SURVEY COMPLETED	
		245237	B. WING			C / 11/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 609	A progress note on R18's legs had not difference to lower okay, no distress note and Incident Report identified the incide agency on 1/3/18 at the incident was with a the incident was with Encident was a service director (SS report abuse was a assistant reports to immediately. Allegathe state agency important the floor nurses, and have the ability to row When asked about SS-A stated when smorning of 1/3/18, something had hap her what had happen out the allegation wincident to the state stated the allegation to the state agency. During interview on IDON stated she wevening of 1/2/18. I with concerns of pon NA-C stated NA-E kicked up R18's fee report the incident informed her of the	1/3/18, 1:15 a.m. indicated markings or bruising. No legs. R18 stated she was oted. Resting in bed. Summary, on 1/3/18, nt was reported to the state to 11:46 a.m., 18 hours after thessed by NA-C. 1/10/18, at 1:52 p.m. social s)-A stated the process to sofollows: The nursing the nursing supervisor are to call the administrator attions of abuse are reported to imediately. Along with SS-A, ministrator, and the IDON alleport to the state agency. The incident related to R18, she arrived at work on the staff (unknown) reported to her pened. The staff could not tell ened and it took a while to find as abuse. She reported the agency at 11:46 a.m. SS-A in should have been reported		609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245237	B. WING			C / 11/2018
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALLS				STREET ADDRESS, CITY, STATE, ZIP CO 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		711/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	NA-E said he put hi her feet. IDON wendetermine he kicke agency was not not IDON added the addite allegation at the The facility's policy 11/16, directs if an esuspected abuse, the measures to protect allegation to a superbe notified immedia "If there is an allegation or misting unknown source are property, and/or the it will be reported not allegation is made to other officials (inclusion addult protective provides for jurisdiction accordance with Investigate/Prevent CFR(s): 483.12(c)(3) \$483.12(c)(1) Have violations are thoro	s feet under R18 and lifted up tonto say she could not dher. IDON stated the state ified. "I should have." The ministrator was not notified of time of the incident. Abuse and Neglect, dated employee witnesses he employee will take to the resident and report the envisor. The charge nurse will ately and assess the situation. In a stion of abuse, neglect, reatment, including injuries of an administrator, and to ding the state survey agency to the administrator, and to ding the state survey agency to services where state law stion in long-term care centers) state law. Correct Alleged Violation (2)-(4) Inse to allegations of abuse, and, or mistreatment, the facility of evidence that all alleged ughly investigated. Ent further potential abuse, and, or mistreatment while the rogress.	F 6			2/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
		245237	B. WING			C 11/2018	
	NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALLS			STREET ADDRESS, CITY, STATE, ZIP 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 610	investigations to the designated representations accordance with Survey Agency, wincident, and if the appropriate correct This REQUIREMI by: The facility failed prevent further poinvestigation for 1 for abuse. Findings include: R18's annual Minassessment, date required extensive the use of a wheel R18 had physical towards others. R Status (BIMS) indicognitively impaired cognitively impaired cognitively included: to provide the control of the activitie agitation. Approach Remove from situl location as needed A Suggestion or C (time not identified (NA)-C was attern TV room from the her feet and would have accorded to the control of the contro	he administrator or his or her sentative and to other officials in State law, including to the State vithin 5 working days of the e alleged violation is verified ctive action must be taken. ENT is not met as evidenced to implement interventions to otential abuse during an abuse of 1 residents (R18) reviewed imum Data Set (MDS) at 8/25/17, indicated R18 assistance of one staff with elchair for locomotion on the unit. behavioral symptoms directed at 8's Brief Interview for Mental dicated a score of 3, severely ed. The evised on 12/27/17, identified a functions. Interventions de R18 with necessary urn if agitated. Re-direct R18 s when showing signs of the and speak in a calm manner. Lation and take to alternate	F 6	The policy and procedure reviewed in relation to the involving R18. Staff has be 2/1/18 initiation of appropri interventions during an abuto prevent further potential practice that may affect othe Staff will be reeducated on neglect policy and procedurappropriate interventions to place during an abuse/neg investigation to prevent furthe investigation of suspect allegations and incidences. Completed by DNS or desitime there is an allegation months. Audits results will monthly by facility QAPI confurther recommendation.	incident een educated on ate use allegation. I deficient her residents. the abuse and her regarding to be put into lect her abuse. ventions during ted abuse , will be ignee every for the next 3 be reviewed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245237	B. WING				C 11/2018
	PROVIDER OR SUPPLIEF	Y - REDWOOD FALLS		200	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH DEKALB STREET DWOOD FALLS, MN 56283	<u>, , , , , , , , , , , , , , , , , , , </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 610	tried to take R18's dining room to ma exit. Nursing assis NA-E put his foot forcefully lifted R1 and became more NA-C reported (tir interim director of An incident report incident occurred 6:00 p.m. NA-C no approximately 2 h p.m. The report in nursing assistant An untitled documindicated the interday following the indicated NA-E wand "kicked" them questioning stated R18's feet. An Investigation In with NA-C indicated leaving the dining	shand and coax R18 out of the ake room for other residents to stant (NA)-E approached R18. behind R18's (legs) and 8's feet up. R18 was not happy agitated. The form indicated me not identified) the incident to nursing (IDON). dated 1/2/18, indicated the on 1/2/18 between 5:45 pm and otified IDON of the incident ours later, on 1/2/18 at 7:45 dicated inappropriate use of (NA-E) feet to move R18. Lent of the interview with NA-D, view occurred on 1/3/18, the ncident. The document as needing to move R18's feet out of the way. Upon further INA-E used his foot to move anterview document, undated, and R18 planted her feet before room because she wanted to	F 6	10			
	her feet. R18 wou his foot behind R1 they lifted. "(NA-E lifted them forcefu p.m. "I know I nee reported to (IDON said 'okay' and the on the east."	IA-C tried to coax R18 to lift up ld not lift up her feet. NA-E put 8's legs and pushed them so) didn't swing and kick her just illy." Incident occurred around 6 ded to report within 2 hours- so) at 7:30-7:45 p.m. and she en walked down to do the meds Incident Report Summary member (NA-E) was suspended					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245237	B. WING _		01	C / 11/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		711/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 610	pending investigation identified NA-E wo date of the incident hours after the inition NA-E's time sheet the following day, p.m. and 1/4/18 from Investigation Report indicated the facilitare results were submedays after the incident indicated NA-E was repositioning technological properties and the was not shift on 1/2/18, indirected he was unarefollowing day, when incident. NA-E stated he was unarefollowing day, when incident. NA-E stated he does not he was going to do R18's legs. NA-E was used his hands to buring an interview interim director of the working on the flood IDON stated NA-C potential abuse. ID came in the dining feet. IDON stated sthen went and spohis feet under R18	on, NA-E's time sheet rked until 10:45 p.m. on the t, 4 hours and 45 minutes to 5 al abuse allegation. further identified NA-E worked 1/3/18 from 2:15 p.m. to 10:45 pm 5 p.m. to 9:00 p.m. rt Summary, dated 1/10/18, y's 5-day investigation report itted to the state agency three lent, on 1/5/18. The report is educated on proper	F 61			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245237	B. WING		I	C / 11/2018	
	NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 610	1/2/18 "because I to un-substantiated." told me I should ha away. The facility's policy 11/16, directs the cowill be notified of all and assess the situle employee to reside removed from proversidents. Additional placed on suspensinternal investigation assigned to comple Notice of Bed Hold CFR(s): 483.15(d) (Section 18483.15(d) (19483.15(d)) (19483.	A-E continued to work on nought it was The next day, the consultant ve sent NA-E home right Abuse and Neglect, dated harge nurse or licensed nurse ouse allegations immediately lation. "If this is an allegation of nt abuse, the employee will be iding direct care to all lally, the employee will be ion pending the results of the in. Another employee will be set the care of the resident. Policy Before/Upon Trnsfr	F 6	510		2/9/18	
	facility; (ii) The reserve bed plan, under § 447.4 (iii) The nursing fact bed-hold periods, v paragraph (e)(1) of resident to return; a	I payment policy in the state 0 of this chapter, if any; ility's policies regarding which must be consistent with this section, permitting a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245237	B. WING		O1/11	1/2018
	NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	, , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 625	of this section. §483.15(d)(2) Bed- the time of transfer hospitalization or the facility must provide resident represents specifies the durative described in paragrathis REQUIREMENT by: Based on interview failed to ensure resident (R38) who hospital. Findings include: R38's care plan, day had been admitted with a vertebral fraction of Transidentified R38 plans living facility after the hospital for a bloom and the condition start was filled out by so to the regional Ombod A Discharge Summa R38 had been disclared.	hold notice upon transfer. At of a resident for erapeutic leave, a nursing to the resident and the ative written notice which on of the bed-hold policy raph (d)(1) of this section. NT is not met as evidenced and record review, the facility idents were informed of the residents were informed of the resident to the re	F 625	GSS Sunwood provides a bed hol to all residents upon discharge per policy and procedure. Current residents have the potential effected; any resident discharged with provided a bed hold notice per GSS and procedure on 2/1/18. Staff has been educated on the beautiful policy and procedure. Random audits will be completed to timeliness and completion of bed have the DNS or designee. I times a way 2 months then every other week for month will be. Audit results will be reviewed monthly by facility QAPI committee for further recommendations.	al to be will be S policy d hold on holds by eek for 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
245237	B. WING		C 01/11/2018	
		200 SOUTH DEKALB STREET		
ENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLÉTION	
discharged from the hospital to a SS-A further stated nursing was notifying the resident or resident with bed hold information, and if of then she would come around digive them the bed hold notice. The business office was a back uporther reported the bed hold notice scanned into the medical record, as unable to find evidence a bed provided to R38. From 1/11/18, at 3:25 p.m. the of nursing (IDON) stated a bed digited when a resident was transferred and changed to a different of the Notice of Bed-Hold Policy, dated the Notice of Bed-Hold Policy is resident/financially responsible ission and at the time time of the facility must develop and mprehensive Care Plans the facility must develop and mprehensive person-centered ch resident, consistent with the let forth at §483.10(c)(2) and that includes measurable imeframes to meet a resident's g, and mental and psychosocial dentified in the comprehensive let comprehensive care plan must owing - that are to be furnished to attain			2/9/18	
	IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER: 245237 B. WING ETY - REDWOOD FALLS STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) In page 22 You on 1/11/18, at 2:21 p.m. SS-A discharged from the hospital to a SS-A further stated nursing was notifying the resident or resident with bed hold information, and if of then she would come around digive them the bed hold notice scanned into the medical record, as unable to find evidence a bed provided to R38. You on 1/11/18, at 3:25 p.m. the of nursing (IDON) stated a bed did when a resident was transferred and changed to a different in. Intice of Bed-Hold Policy, dated The Notice of Bed-Hold Policy is resident/financially responsible ission and at the time time of The nent Comprehensive Care Plan (b)(1) Imprehensive Care Plans The facility must develop and Imprehensive person-centered Intich the facility must develop and Intich the facility and Intich th	JERN 245237 JERN STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY PULL DR LSC IDENTIFYING INFORMATION) In page 22 You 1/11/18, at 2:21 p.m. SS-A discharged from the hospital to a SS-A further stated nursing was notifying the resident to resident with bed hold information, and if but then she would come around digive them the bed hold notice. The business office was a back up rither reported the bed hold notice scanned into the medical record, as unable to find evidence a bed provided to R38. You n/11/18, at 3:25 p.m. the of nursing (IDON) stated a bed did when a resident was transferred and changed to a different n. titice of Bed-Hold Policy, dated The Notice of Bed-Hold Policy is resident/financially responsible ission and at the time time of nent Comprehensive Care Plan (b)(1) aprehensive Care Plan (b)(1) aprehensive person-centered ch resident, consistent with the set forth at §483.10(c)(2) and hat includes measurable imeframes to meet a resident's g, and mental and psychosocial dentified in the comprehensive he comprehensive care plan must lowing - that are to be furnished to attain	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245237	B. WING _			C 11/2018	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283			17172010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 656	required under §48 (ii) Any services the under §483.24, §4 provided due to the under §483.10, incomplete the provide as a result recommendations findings of the PAS rationale in the resident's represent (A) The resident's desired outcomes. (B) The resident's future discharge. For the under the resident community was as local contact agenentities, for this puture (C) Discharge plan plan, as appropriate requirements set for section. This REQUIREMED by: Based on interview failed to ensure coincluded medical residents (R22) when the underessary medical findings include:	and psychosocial well-being as 33.24, §483.25 or §483.40; and at would otherwise be required 83.25 or §483.40 but are not be resident's exercise of rights aluding the right to refuse 483.10(c)(6). If services or specialized ces the nursing facility will of PASARR and facility disagrees with the GARR, it must indicate its ident's medical record, with the resident and the antative(s)-goals for admission and preference and potential for facilities must document and the sessed and any referrals to be cies and/or other appropriate repose. The comprehensive care for in accordance with the corth in paragraph (c) of this services were developed for 1 of 5 to were reviewed for	F 65	The policy and procedure hereviewed in relation to the ininvolving R22. R22 care plate on 1/23/18. To prevent further deficient may affect other resident streeducated on the comprehelm and procedure. R22 won 1/23/18 following a discharge of the control of the comprehelm and procedure. R22 won 1/23/18 following a discharge of the control of the comprehelm and procedure. R22 won 1/23/18, upon review of the control of the con	ncident an was updated practice that taff have been nensive care as readmitted narge on		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER (OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO			
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				REDWOOD FALLS, MN 56283			
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impairm was rec MDS fur bowel w admissi 10/18/1' hip surg medicat R22's cr identifie -Lantus morning -Prednis increase taper do -Polyeth twice a c -Tylenol times a -Tramac rating 1- hours as In additi check h bedtime greater units. R22's pl identifie during h 11/15/17 R22's pl indicate - On 10/	eiving thera ther identifith no symp on Care Are 7, indicated ery, using sions. urrent phys d the follow SoloStar S for Diabet sone (stero e blood sug wn to 1 mg ylene Glyc day for con (pain relied day for pain fol (pain re 5 and 2 tal s needed. on, R22's per blood sug noting blo than 200, in mysician co d her Lantuer stay, on 7, due to hig mysician no d the follow 27/17, note	nosis of Diabetes Mellitus, and apy due to a hip fracture. The fied R22 was continent of ptoms of constipation. R22's ea Assessments (CAA), dated I she had pain after her recent scheduled and as needed pain ician orders, dated 1/11/18, ving medications: solulion (insulin) 30 units in the es Mellitus. id medication which can par) 7 mg (milligrams) daily to g for left femur fracture. ol (Miralax laxative) 17 gram stipation. ver) 325 mg 2 tablets three in. liever) 50 mg 1 tablet for pain blets pain rating 6-10 every 6 obysician orders directed to gar before meals and at bod sugars weekly and if increase Lantus insulin by 5 mmunication forms and orders is had been increased twice 10/21/17 and again on gh blood sugars.	F 6	comprehensive care plan co addressed on new admission comprehensive care plan. Random audits of comprehe plans in relation to medical n addressed, will audits 3 com care plans will be completed designee 1 time weekly for 4 every other week for 2 month results will be reviewed mont QAPI committee for further recommendation.	nsive care eeds are prehensive by DNS or weeks then ns. Audit		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		245237	B. WING				C 11/2018
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP CO 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	ODE	017	11/2010
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F 656	further noting she a suppositories. On 12/13/17, note being constipated," medication was ord R22's current care lacked diagnoses, go Diabetes Mellitus wassociated hypergly bowel status with systreatment of post of During interview on registered nurse (R could revise or upd stating they had staweekly with an intershort stay residents usually contained a and noted if a resid she acknowledged the diagnosis and in R22 had not preser admission, but had the pain medication had also mentioned after admission. RN toileting plans and of the care plan, notinmentioned her blad When asked if bow were typically care in the future." RN-A care plan did not act the care plan to add with the pain level a interventions of admissions of a	Iso had used enemas and d R22's, "Biggest complaint is and another laxative ered. plan, last revised 1/3/18, goals, and interventions for her ith Prednisone use and remia (high blood sugar), remptoms of constipation, and	F 6	56			

		IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245237	B. WING				C 11/2018	
	PROVIDER OR SUPPLIER	Y - REDWOOD FALLS		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DEKALB STREET EDWOOD FALLS, MN 56283	,		
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F 656	During interview of interim director of concerns with the not all of the care charting was not gresidents were not stated she had an care plans up to diffurther stated the reviews of the care the facility, further adding quality meading interview of stated the insuling been put on after stated good," noting she been constipated the constipation midically policy ending the pain killers held tried ice packs but a facility policy ending directed, "Each reindividualized, per plan of care that wand timetables directed and timetables directed interview and timetables directed interview of the pain killers held tried ice packs but and timetables directed interview of the pain killers held tried ice packs but and timetables directed interview of the pain killers held tried ice packs but and timetables directed interview of the pain killers held tried ice packs but and timetables directed interview of the pain killers held tried ice packs but and timetables directed interview of the pain killers held tried ice packs but and timetables directed interview of the pain killers held tried ice packs but and timetables directed interview of the pain killers held tried ice packs but and timetables directed interview of the pain killers held tried ice packs but and timetables directed interview of the pain killers held tried ice packs but and timetables directed interview of the pain killers held tried ice packs but and timetables directed interview of the pain killers held tried ice packs but and timetables directed interview of the pain killers held tried ice packs but and timetables directed interview of the pain killers held tried ice packs but and tried ice packs but and timetables directed interview of the pain killers held	monitoring for signs of d to alert the physician. In 1/11/18, at 10:31 a.m. the nursing (IDON) was aware of care plans and charting, noting plans were current, basic etting done, and skilled to being charted on. The IDON hurse working on getting the ate that weekend. The IDON facility was not documenting to noting she had implemented asure questions into the weekly ews, a process they had just orior. In 1/11/18, at 12:35 p.m. R22 was a new medication she had surgery while she was taking rating the hip surgery had es. R22 further stated she had lnisone would help with healing. her bowels were, "Not very gets constipated easily and had the previous day. R22 stated ade her feel uncomfortable. had pain, which could be real up; however, further reported ped a lot. R22 reported she had a didn't think they helped.	Fé	856				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245237	B. WING				C 11/2018
NAME OF PROVIDER OR SUF	PLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SAMARITAN SO	IETY	- REDWOOD FALLS			00 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
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psychosocial further directe completed se assessment.	cal, f and e d the /en c	age 27 functional, spiritual, emotional, educational needs." The policy comprehensive care would be lays after completing the	F 6				
F 684 Quality of Car			F 6	84			2/9/18
applies to all facility resided assessment of that residents accordance was practice, the coare plan, and This REQUIR by: Based on interfailed to assed to the physical for resident (Findings inclusive) R39's Diagnoridentified a programment of the physical for resident (Bleeding from mouth of R39's annual 9/21/17, identified MDS furtility resident to the physical for resident (Findings inclusive)	e is a reatments. B f a receith proceed ith proceed its proceed ith proceed its proceeding its process of the proceeding its proceeding its proceed its proceeding its procedure its proceeding its procedure its proceeding its procedure its proced	fundamental principle that nent and care provided to ased on the comprehensive esident, the facility must ensure ive treatment and care in rofessional standards of rehensive person-centered residents' choices. NT is not met as evidenced w and record review, the facility d provide detailed information ring an episode of acute illness reviewed for death. eport, printed 1/11/18, w admitting diagnosis of morrhage, unspecified gastrointestinal tract either um). mum Data Set (MDS), dated a severe cognitive impairment. Identified R39 had an active entia and gastrointestinal			The eInteract policy and procedure heen reviewed on 2/1/18. R39 expire away on 10/15/17. To prevent further potential deficient practice that may affect other resider Staff will be reeducated on our interapolicy and procedure regarding appropriate notification of the physicia Audits will be done on notification of physician for residents with new illness bruising or open areas and ensure corresponding progress note in the resident's chart and notification of the physician has been timely completed Audits will be done by DNS or design time weekly for 2 months then every week for 1 month. Audit results will be reviewed monthly by facility QAPI committee for further recommendation	ed nts. act ian. sses, e d. nee 1 other oe	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
		245237	B. WING			C / 11/2018	
	PROVIDER OR SUPPLIER	Y - REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP C 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283			
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F 684	contained the follo-order for Protonix reflux, prevent ga gastrointestinal he mg (milligrams) digastrointestinal transport of the man (milligrams) digastrointestinal transport of the man (milligrams) digastrointestinal transport of the man (milligrams) distress, and follo indicated staff, "Morphysical/nonverbadistress, and follo indicated R39 had [related to] hx. [his gastrointestinal transport of the morrhage, nor experience in the morrhage, nor experience in the more movement] more movement] more movement] more movement movements held has no c/o [complete in the movement of the mov	sician orders, printed 1/11/18, bying: ((medication used to treat acid stric ulcers, and prevent emorrhage), dated 1/5/17, for 40 aily for hemorrhage of act. ast review 3/24/17, identified exproblem related to dementia, stood simple direct cues. The dentified R39 had a roblem related to dementia, ficulty expressing herself and onitor/document for al indicators of discomfort or wup as needed." The care pland, "bowel incontinence R/T story] of hemorrhage ace[sic]." The care plan lacked emptoms of gastrointestinal did it indicate R39 received daily note, written by LPN-B as a don 10/14/17, at 9:15 p.m. ent have emesis four times this dark brown and thick at this despresent all four quad ender. Last BM [bowel nedium] noted on 10/12/17. ting to eat at this time. If d/t [due to] vomiting. Resident laints of] pain/discomfort noted	Fé	884			
	movement] md [m Resident not wan Supplements held has no c/o [compl at this time. Resid at this time. Resid	nedium] noted on 10/12/17. ting to eat at this time. I d/t [due to] vomiting. Resident					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED		
		245237	B. WING			C / 11/2018		
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP CO 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	· ·			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 684	a.m. indicated the orgave a telephone of a "Acetaminophen of mg rectally every 6 - "ondansetron HC tablet 4 MG Give 1 as needed for naus Although R39 had 10/14/17, and had p.m., there was no received a compreschange in condition physician being upon a.m. There were not indicate when the vertical to a condansetron HCL to 2:20 a.m. The MAR administered the anondansetron HCL to 2:20 a.m. The MAR administered aceta on 10/15/17, at 3:1 medication was effort in the color dark brown the color d	ders, dated 10/15/17, at 2:00 on-call physician (OCP)-B order for: suppository 650 mg insert 650 hours as needed for fever" L (anti-nausea medication) tablet by mouth every 4 hours sea/vomiting" been having symptoms on vomited four times by 9:15 evidence that the resident hensive assessment due to the dated prior to 10/15/17, at 2:00 to other notes on 10/14/17 to vomiting had started. Iministration Record (MAR), for ensed practical nurse LPN-B inti-nausea medication hablet 4 MG on 10/15/17, at R identified the medication was a further indicated LPN-B iminophen suppository 650 mg 3 a.m. The MAR identified the	F 6	84				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED C	
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	PROVIDER OR SUPPLIER	' - REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP CO 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
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F 684	Although the recornotified of the vom that the physician of gastrointestinal was vomiting brow A facility progress indicated PRN (as ondansetron HCL mausea. R39's MAR indicat scheduled Protoniz on 10/15/17, at 6:00 A facility progress a.m. identified LPN while passing R39' R39's discharge suindicated resident's 10/15/17, at 6:45 a identified, "Disease cognitive, mood or treatments, nursing gastrointestinal her Summary indicated death as demential R39's Certificate of indicated R39's both mortician at 10/15/17 Review of a Community of the commu	d indicated the physician was iting, the record did not indicate was notified of active diagnosis hemorrhage or that resident n, thick emesis. note on 10/15/17, at 3:44 a.m. needed) administration of tablet 4 MG was effective for ed LPN-B administered the tablet delayed release 40 mg, 10 a.m. note, dated 10/15/17, at 7:18 II-A had found R39 expired is morning medication. Jummary, dated 1/15/17, at date and time of death was a.m. Discharge summary erelated to resident functional, behavioral status medical g monitoring, or risk of death. morrhage." The Discharge difinal diagnosis and cause of the Removal, dated 10/15/17, dy was released to the	F 68	34		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245237	B. WING		01	C / 11/2018
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F 684	10/16/17, asking he however, R39 had provided to the atterinformation including gastrointestinal her and did not identify color During interview on registered nurse (Ralicensed practical treatment and foun recall if an investigation of the state of th	ow R39 condition was; already expired. The fax ending physician lacked ag active diagnosis of morrhage, number of emesis, the emesis were brown in a 01/11/18, at 1:05 p.m. RN)-A stated she remembered I nurse had gone to do a d R39 deceased. RN-A did not ation was completed. and/or investigation into R39's a status and death was not received. 11/18, at 3:08 p.m. the interim (IDON) stated R39's death had er coming to the facility. She dent has a change of id expect the resident would be obysician and family notified. If she expected the resident's and nursing interventions to be and that this would be resident's medical record. It when talking to the grant are are action to relay the resident's eckground assessment and alication to relay the resident's		884		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245237	B. WING				C 11/2018
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		20	REET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH DEKALB STREET EDWOOD FALLS, MN 56283	1 017	11/2010
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F 684	the record. The IDC an issue at this fact staff to increase ace education on docur reported an incider investigation was not resident had a character depend on the situate reported there shout into R39's death, exhad thick brown eminterventions should she expected to incomplete follow up phone can administrator and the stated, when there resident not on hos autopsy to family, of if totally unexpected. During interview on stated, "Let me lood I was on call, reside temp, ordered Tyle at his notes, OCP-I recall if he was told emesis, just that Rice reported, "If had dalike a GI bleed." Of nurses," To tell me probably have sent gotten a hemoglobic stated R39 had a hibleed which sure of death if she was verificating a HGB worms and the state of the probably have sent gotten a hemoglobic stated R39 had a hibleed which sure of death if she was verificating a HGB worms.	DN stated documentation was ility, was working with nursing countability, and providing mentation practices. The IDON at report and subsequent of necessarily done when a nege in condition; it would ation. The IDON further all have been an investigation specially since the resident nesis. IDON stated nursing did have been acted upon which clude physician notification, a lit to to the family, the he director of nursing. IDON is an unexpected death of a spice, possibly offering an depending on the scenario and did. In 1/11/18, at 3:49 p.m. OCP-B k at my notes for 10/15. Yeah, lent was vomiting, low grade not and Zofran." While looking B further stated he did not I R39 was having dark brown 39 was vomiting. OCP-B ark brown emesis, sure sounds CP-B stated he expected if dark brown emesis, would her to the ER and at least in (HGB) level." OCP-B further istory of gastrointestinal (GI) ould have contributed to her ery anemic. OCP-B stated,	F6	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 684	come on duty at 6 R39 had a couple was told R39's vit stated, around 6: checked on R39, comfortably, also reported, around moving around in had gone back to change and found she had taken R3 family. LPN-A state call for an order to the mortuary. LPN-A documented R39 in the progress not look for her notes. On 1/16/17, at 10 summary was received no new information. During a telephor p.m. attending phable to view the faction a.m. AP-C sate resident's emes would help in decisince 10/15/17 with physician was not require monitorid determine at what states of the faction of th	6:00 a.m., and she had been told of emesis overnight. LPN-A cal signs had been fine. LPN-A 15 a.m., she and LPN-B had stated she was resting stating the nurses aides had 6:30 a.m., that R39 was seen bed. LPN-A stated at 6:45, she R39's room to do a dressing d R39 deceased. LPN-A stated 39's vital signs and called the ted she called the physician on the release the body to the further stated she would have been discharge summary contained on. 1:42 a.m. a fax of R39 discharge beived from LPN-A, dated discharge summary contained on. 1:45 a.m. a fax of R39 discharge beived from LPN-A, dated discharge summary contained on. 1:46 a.m. a fax of R39 discharge served from LPN-A, dated discharge summary contained on. 1:47 a.m. a fax of R39 discharge beived from LPN-A, dated discharge summary contained on. 1:48 a.m. a fax of R39 discharge served from LPN-A, dated discharge summary contained on.	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245237	B. WING _			C 11/2018
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	_ •	11/2010
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F 684	from a medical doc as well as most rec Continue to monito Change in Conditio	ons, recent progress notes tor/nurse/physicians assistant ent interdisciplinary notes. r the resident and update the n Evaluation as appropriate."	F 68			
	CFR(s): 483.25(b)(§483.25(b) Skin Int §483.25(b)(1) Pres Based on the compresident, the facility (i) A resident receive professional standar pressure ulcers and ulcers unless the indemonstrates that the compressional standar pressure ulcers unless the indemonstrates that the compressional standard professional standard professional standard promote healing, pr	egrity sure ulcers. prehensive assessment of a r must ensure that- res care, consistent with ards of practice, to prevent d does not develop pressure redividual's clinical condition they were unavoidable; and pressure ulcers receives and and services, consistent andards of practice, to revent infection and prevent veloping. NT is not met as evidenced	F 68			2/9/18
	review, the facility f assessment and m for 1 of 2 residents ulcers. Findings include: R28's 12/19/17 adr (MDS) indicated R2 assistance of 2 stat have a pressure ulcer pressure ulcer deve	tion, interview, and document ailed to provide consistent onitoring of a pressure ulcer (R28) reviewed for pressure nission minimum data set 28 required extensive ff for bed mobility. R28 did not ber, but was at risk for elopment. A Brief Interview for ated a score of 6, severe		The policy and procedure has be reviewed in relation to the incide involving R28. To prevent further potential defice practice that may affect other results of the documentation procedure R28. Audits will be completed on dail data collection for completion are measures, completion of audits done by the DNS or designee 1 week for 2 months then every of for 1 month. Audit results will be	cient sidents. nonitoring related to y wound nd wound will be time a ther week	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 686	cognitive impairme R28's Care Plan fo 12/12/17, indicated relieving device in t reducing mattress. turn and reposition A 12/20/17 Wound developed a stage with exposed derm coccyx. Physician r care plan updated. documentation of n ulcer characteristic On 12/20/17 the re- "actual stage 2 pre- medication and treat to the care plan.	r pressure ulcers, initiated interventions of a pressure he chair and pressure The care plan directed staff to the resident every 2 hours. RN Assessment identified R28 2 (partial-thickness skin loss is) pressure ulcer to the notified of pressure ulcer and The assessment lacked neasurements and pressure	F6	886	monthly by facility QAPI committee further recommendation.	for		
	for Arginaid (nutritic healing) two times of dressing order, date a Mepilex border did the coccyx Mepilex present. Area surroform indicated "Meonce every 7 days" measurements and blank. R28's medical reco assessment of the measurements and	onal supplement to promote daily. A wound treatment ed 12/23/17, directed to apply ressing one time every 3 days. Data Collection form indicated dressing was intact. Drainage ounding dressing pink. The asurements-Required at least however, the section for I wound characteristics was						

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F 686	development. A 12/26/17 Wound a coccyx stage "2-(centimeters). Wid measurements about area around o/a (o 5 cm has a sm (sm (right) side of open (superficial tissue, 1/1/17, 1/3/17, and forms revealed meulcer were unchan comprehensive as until 1/5/17, 10 day assessment. A 1/5/17, Wound E the pressure ulcers smaller than previounchanged at 1 cm changed to 90% slappearance and astrings or thick cluit tissue. Although slappearsure ulcer condition of R28's a treatment record (lorder to change the every 3 days. Doci identified a Mepile: The ETAR and med dressing changes During observation registered nurse (F	Data Collection form identified 3" pressure ulcer. Length 3 cm th 1 cm. Open area ove with a pink red circular pen area) witch measures 4 x nall) white area of skin to rt area. 90% epithelialized new pink or shiny). 1 1/4/17 Wound Data Collection easurements of the pressure ged. The record lacked a sessment of the wound bed as after the 12/26/17 Data Collection form identified is length of 2.5 cm, 0.5 cm ous. The width remained in. Wound bed characteristics ough (tissue yellow/white in otheres to the ulcer bed in mps) and 10% epithelialized ough was present, the tinued to be staged at a 2. January 2018 electronic ETAR) indicated the physicians is emplied by the pressure characteristics of the ulcer bed in mps) and 10% epithelialized ough was present, the tinued to be staged at a 2. January 2018 electronic ETAR) indicated the physicians is emplied by the pressing change on 1/4/17. Indical record lacked any further until 1/10/17, 6 days later.	F 68	36		

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F 686	pressure ulcer lack dressing "must have viewable in the beam easurements rer at 2.5 cm x 0.5 cm ulcer "looks very swith red granulation cleansed the press and RN-A placed apressure ulcer as a (NA)-J entered the for the day. During an interview NA-J stated she did R28's bed. During an interview stated the previous supposed to be concounds. It was received being done. RN-A wound round schepressure ulcer assecompleted as they stated a clinical work come to the facility RN-A stated she satisfacility today or ton pressure ulcer. When was 90% slough a CWS-G stated it swould be a stage 3 CWS-S stated the	ked a dressing. RN-A stated the we peeled off." No dressing was d. The pressure ulcer mained unchanged from 1/5/17. RN-B stated the pressure similar to last week" 90% slough in around the edges. RN-B sure ulcer with a wound cleaner a Mepilex dressing over the ordered. Nursing assistant room to assist getting R28 up on 1/10/17, at 1:29 p.m., d not find a wound dressing in a wound dressing in won 1/11/17, at 9:04 a.m. RN-A is director of nursing was impleting weekly wound ently discovered this was not stated last Thursday, a weekly dule was initiated. RN-A stated essments were not being "should have" for R28. RN-A bund specialist (CWS)-G does to advise on pressure ulcers. ent an email to CWS-G on	F 68	6		

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F 686	Mepilex for a least respond to treatment development of slot for treatment change would not have martreatment prior to his tomorrow. During an interview when asked about monitoring pressure nurses (IDON) state one." Staff are to copressure ulcers at a staff were not doing assessments until I wound nurse who witeaching. The IDON	2 weeks, to give it a chance to	F 6	36		
	policy, dated 9/16 in that the Wound Dath nurse's observation from a shift-to shift dressing change. A documentation is review of the press resident experience assessment should Increase/Prevent D CFR(s): 483.25(c)(1) §483.25(c) Mobility §483.25(c)(1) The fresident who enters		F 6	88		2/9/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION		PLETED
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F 688	condition demons of motion is unavous \$483.25(c)(2) A remotion receives a services to increase prevent further de \$483.25(c)(3) A receives appropria assistance to main the maximum pracreduction in mobil This REQUIREMED by: Based on observative review, the facility nursing for 4 of 4 reviewed for mobil affect 17 of 36 reserviewed for	nless the resident's clinical trates that a reduction in range bidable; and resident with limited range of ppropriate treatment and se range of motion and/or to crease in range of motion. resident with limited mobility ate services, equipment, and nation or improve mobility with cticable independence unless a sity is demonstrably unavoidable. ENT is not met as evidenced residents (R17, R19, R7, R1) lity. This had the potential to didents who had therapy orgams. Report, printed 1/11/18, y admitting diagnosis of pain in intertrochanteric fracture left at encounter for closed fracture g, muscle weakness, and	Fé		GSS-Sunwood realizes the importarestorative nursing program. R17, R7 and R1 Restorative programs have been reviewed and care plan updat reflect restorative needs of therapy recommended programs. R7 restor care plan was updated on 2/1/18 dugoing on hospice. R17, 19 and R7 oplan will be updated on 2/5/18. To prevent further potential deficien practice that may affect other reside the restorative programs have been reviewed for residents who have has therapy recommended programs are restorative programs have been up as needed. Audits will be completed on restorar programs. Audits will be done by the or designee 1 time a week for 2 most then every other week for 1 month. results will be reviewed monthly by QAPI committee for further recommendation.	R19, ave ed to rative ue to care at ents, and added tive e DNS on the Audit	

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F 688	R17 needed restor weakness. R17 wil standing tolerance interventions include with resident 3 x[tii wheeled walker], CW/C [wheelchair] t Scifit [a type of exe Seated bilateral leggreen band pull ba [repetitions]each." R17 physician progidentified has pain leg, stated he reall R17's medical recorrestorative nursing implemented, and During observation was sitting in his whis room. No offers observed. During observation self propelled in his towards the dining During interview or therapist (PT)-A starestorative walking	st reviewed 12/27/17, identified ative intervention due to I improve current level of by next review date. Identified ded: "Nursing rehab: Ambulate mes]/day with FWW [four CGA [care giver assist] and of follow PRN [as needed], ercise bike] level 3 PRN, gkick, green band knees apart, ck, 2 x 10 REPS gress note, dated 12/20/17, in hip and radiates down his y does not walk. ord lacked evidence that the program was being offered, evaluated. If on 1/09/18, at 10:03 a.m. R17 heelchair in the hallway outside of ambulation by staff were a on 1/09/18, at 2:00 p.m. R17 is wheelchair down the hallway room. In 1/09/18, at 3:27 p.m. physical ated R17 had been on a program since 4/17. PT-A	F 68	,		
	restorative walking stated since then hambulation due to hip. PT-A stated R apprehension with	program since 4/17. PT-A ne has had a decline in increased pain in his legs and				

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F 688	nursing may change program as needed let physical therapy expect that ambulated documented if refusion of the program as needed let physical therapy expect that ambulated documented if refusion of the program of the	de the frequency of the walking de. Nursing wouldn't necessarily of know that. PT-A stated would atting be offered and sed. 1/09/18, at 3:41 p.m. R17 alked in about two weeks. R17 had not offered ambulation. 1/10/18, at 11:38 a.m. hurse (LPN)-C stated R17 had not program, but today was the wheelchair. LPN-C stated staff at least offer to walk ament resident's refusal. LPC-C n't occurring would be reported no would report to physician, so a up on, so no decline in his l-C stated she reviewed notes and found no documentation ared restorative rehabilitation. 1/11/18, at 8:33 a.m. RN)-A stated when the re not working, R17 probably restorative interventions. RN-A redical record and did not find for goals in his medical record rative program.	F 68	38			

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identified R19 had hypertension and le (paralysis). R19's care plan, late R19 had limited ph history of stroke and of mobility. Interver able to ambulate 7s single point cane do ambulate to meals assist] of one and le behind." Also identified to CVA [cerweakness. Identified should perform Sciup to 10 minutes 2s resistance 150 lbs[[times]week. A physician progresidentified R19 was a cane to walk around hemiparesis. R19's handicapped apart reasonable. R19's progress not continued weight glevel has decrease as he did in the passistance strongers.	an active diagnosis of eft sided hemiparesis st review 12/28/17, indicated ysical mobility related to a d would maintain current level ntions identified: "Ambulation 5'[feet] with CGA, gait belt and aily and PRN. Likes to to tolerance, SBA [stand by pring the w/c [wheelchair] ified, R19 needed restorative limited physical mobility ebrovascular accident] left side ed interventions included: R19 fit[exercise bicycle] at level 5 at imes per week. Leg press pounds]2 x 10 3 x/ ss note, dated 8/17/17, getting around fairly well, used and despite left sided agoal was to look into ment. This will be very e, dated 8/23/17, indicated ain is a concern, his activity d as he does not walk to diner st. e, dated 12/30/17, physical	F6	\$88			
R19's medical reco	ord lacked documentation that					
	PROVIDER OR SUPPLIER AMARITAN SOCIETY SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa identified R19 had a hypertension and le (paralysis). R19's care plan, las R19 had limited ph history of stroke an of mobility. Interver able to ambulate 7 single point cane d ambulate to meals assist] of one and t behind." Also identi intervention due to related to CVA [cer- weakness. Identifies should perform Sci up to 10 minutes 2 resistance 150 lbs[[times]week. A physician progres identified R19 was a cane to walk arou hemiparesis. R19's handicapped aparti reasonable. R19's progress not continued weight g level has decrease as he did in the pas R19's progress not therapy order clarif physical therapy to R19's medical reco	PROVIDER OR SUPPLIER AMARITAN SOCIETY - REDWOOD FALLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 42 identified R19 had an active diagnosis of hypertension and left sided hemiparesis (paralysis). R19's care plan, last review 12/28/17, indicated R19 had limited physical mobility related to a history of stroke and would maintain current level of mobility. Interventions identified: "Ambulation able to ambulate 75'[feet] with CGA, gait belt and single point cane daily and PRN. Likes to ambulate to meals to tolerance, SBA [stand by assist] of one and bring the w/c [wheelchair] behind." Also identified, R19 needed restorative intervention due to limited physical mobility related to CVA [cerebrovascular accident] left side weakness. Identified interventions included: R19 should perform Scifit[exercise bicycle] at level 5 up to 10 minutes 2-3 times per week. Leg press resistance 150 lbs[pounds]2 x 10 3 x/ [times]week. A physician progress note, dated 8/17/17, identified R19 was getting around fairly well, used a cane to walk around despite left sided hemiparesis. R19's goal was to look into handicapped apartment. This will be very	A BUILD 245237 B. WING PROVIDER OR SUPPLIER AMARITAN SOCIETY - REDWOOD FALLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 42 identified R19 had an active diagnosis of hypertension and left sided hemiparesis (paralysis). R19's care plan, last review 12/28/17, indicated R19 had limited physical mobility related to a history of stroke and would maintain current level of mobility. 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R19's progress note, dated 12/30/17, physical therapy order clarification to discharge form physical therapy to SNF[skilled nursing facility].	A BUILDING 245237 B. WING 257 267 267 267 267 267 267 267	PROVIDER OR SUPPLIER AMARITAN SOCIETY - REDWOOD FALLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 42 identified R19 had an active diagnosis of hypertension and left sided hemiparesis (paralysis). R19's care plan, last review 12/28/17, indicated R19 had limited physical mobility related to a history of stroke and would maintain current level of mobility. Interventions identified: "Ambulation able to ambulate 75 [feet] with CGA, gait belt and single point cane daily and PRN. Likes to ambulate to meals to tolerance, SBA [stand by assist] of one and bring the W/c [wheelchair] behind." 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R19's medical record lacked documentation that	AMARITAN SOCIETY - REDWOOD FALLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) Continued From page 42 identified R19 had an active diagnosis of hypertension and left sided hemiparesis (paralysis). R19's care plan, last review 12/28/17, indicated R19 had limited physical mobility related to a history of stroke and would maintain current level of mobility. Interventions identified: "Ambulation able to ambulate 75[feet] with CGA, gait belt and single point cane daily and PRN. Likes to ambulate to meals to tolerance, SBA [stand by assist] of one and bring the w/c [wheelchair] behind." Also identified interventions included: R19 should perform Sciff(exercise bicycle) at level 5 up to 10 minutes 2-3 times per week. Leg press resistance 150 lbs[pounds] x 10 3 x/ [times]week. 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F 688	During interview on stated he hadn't be weeks. R19 further restorative aide stano one else had off. During interview on stated R19 was in a and should be walk he could tolerate. For a stroke and if he was care manager should. The could tolerate in his wheelchair to buring interview on stated R19 ambula LPN-C also stated program, but whose breakfast. LPN-C find in his wheelchair to buring interview on stated when the resumption working, R19 probarestorative intervent electronic medical indocumentation on a conferred or assessed R7's admission Mir 4/9/17, identified no required extensive in her room, and dislower body range of the MDS also identified not reduce the manager of the MDS also identified not required extensive in her room, and dislower body range of the MDS also identified not reduce the manager of the manage	implemented, and evaluated. 1/9/18, at 3:27 p.m. R19 en walking the past couple of stated he had not seen the ff for a couple of weeks and ered to walk him. 1/9/18, at 3:30 p.m. PT-A a restorative nursing programing everyday to breakfast as at 9 had limited mobility due to was not ambulating, the RN ald have been notified. 1/10/18, at 11:31 a.m. LPN-C ted with assist of one staff. R19 had a restorative walking wer got him up can walk him to auther stated R19 was pushed breakfast that morning. 1/11/18, at 8:35 a.m. RN-A storative aides were not ably would not have received tions. RN-A reviewed R19's record and stated there was no restorative programs being	F 68			

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F 688	R7's quarterly MDS she continued to re one staff with mob her room or outsid assessment period PT services during R7's most recent F Summary, dated 1 working with theral extremity strength discharge summar goals of therapy ar skilled therapy intepatient's overall de therefore slowed p therapy goals. Pati will be appropriate intervention once t stable. Ath [sic] this to DC [discharge] t program] to be per maintain therapy g	S, dated 10/18/17, indicated equire extensive assistance of ility, but had not ambulated in e her room during the d, nor had she received OT or the assessment period. Physical Therapy Discharge 0/5/17, indicated R7 had been by on increasing bilateral lower and transfer ability. The ry noted R7 did not meet the ry noted R7 did not me	F6	888			
	recommended, wh walking program. T "maintain current L R7's program inclu	v restorative program was ich replaced R7's previous The overall goal was to, .E [lower extremity] strength." ided using the Scifit bike (type 0 minutes five times a week.					
	identified R7 could her own, noting sh and had noticed gr her hands and feet	ss note, dated 11/14/17, no longer transfer and walk on e was requiring a lift to transfer adually declining strength in t. At that time, R7 had been ogressive neurological					

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	PROVIDER OR SUPPLIER	l		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	1 017	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	dysfunction of her eneurologist. R7's current care pidentified an ADL (arequiring the sit to a for transfers. The care a musculoskeletal adrop and wore a braddress R1 impaired decline, or restoration. R7's medical recommursing program wand evaluated. During observation 3:45 p.m. R7 was corestorative nursing. During observation 11:30 a.m. R7 was no restorative nursing. During observation 12:02 p.m. R7 was no restorative nursing. During observation 12:02 p.m. R7 was no restorative nursing. During interview on stated she felt wea and legs, noting stadidn't do that anym stand lift to transfer seeing a neurologis drop. During interview on the program of t	age 45 extremities," and was to see a clan, last revised 1/3/18, activities of daily living) deficit stand lift and staff assistance are plan also identified R7 had alteration related to left food ace. The care plan did not ed mobility, new neurological ive nursing program. If lacked evidence a restorative as being offered, implemented, so on 1/9/18, from 10:35 a.m. to consistently in her room and no program was provided. If on 1/10/18, from 7:30 a.m. to consistently in her room and ing program was provided. If on 1/11/18, from 7:36 a.m. to consistently in her room and ing program was provided. If 1/9/18, at 10:41 a.m. R7 ker especially in her hands aff used to walk with her, but one and now used the sit to the her. R7 stated she was at for her weakness and foot	F6	888			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
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		245237	B. WING			01/	11/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		2	RETREET ADDRESS, CITY, STATE, ZIP CODE 000 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	stated R7 had had decline very quickly discharged her from something more se R7 to a neurologist discharged from the to walk, and staff us safety. PT-A report home ROM exercis and with a restorati reported recommer were given to the nurse (RN)-A) who chart. PT-A observe would've expected considering R7 had therapy. PT-A state changed to needing would have decline trained in several nurse if the restoration with her while not sure if the restoration the programs. During interview on assistant (NA)-G we program, stating shat one time, but does not considered nurse (R record and acknow restorative nursing)	a very significant functional while in therapy, and she had in therapy thinking there was brious going on and referred. PT-A stated, when R7 was erapy, she was no longer able sed the sit to stand lift for ed she had discharged R7 with ses that R7 could do herself we bike program. PT-A further inded restorative programs urse case manager (registered put them in the electronic ed R7 in her room, stating she a decline in mobility, a rapid decline while in ed, if R7's transfer ability go the full body lift, then she d. PT-A reported she had ursing aides on the restorative on the Scifit bike. PT-A was brative aides were completing as unaware of R7's restorative in was on a walking program easn't walk anymore. 1.1/11/18, at 8:21 a.m. EN)-A reviewed R7's medical ledged she did not have a	F	688			
	severe cognitive im Alzheimer's demen	pairment with a diagnosis of tia. The MDS also identified ive assistance to total					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l .		NSTRUCTION	СОМ	E SURVEY PLETED
		245237	B. WING				C 11/2018
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		200 S	ET ADDRESS, CITY, STATE, ZIP CODE OUTH DEKALB STREET NOOD FALLS, MN 56283	1 017	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	dependence of two identify any upper of R1's most recent C Discharge Summa had been assessed left hand tightness, time was, "Patient of left resting hand overnight in order to therapy discharge biting and hitting; high plan/instructions in nursing splinting profacility] where pt [pitermROM [range with added focus of the property	o staff with mobility, but did not or lower body ROM limitations. Occupational Therapy ry, dated 8/11/17, indicated R1 d for a left hand splint due to The goal of therapy at the will have increased tolerance splint to 8 hours during day or to prevent contractures." The indicated R1 had behaviors of lowever, the discharge cluded, "Discharged to to rogram at SNF [skilled nursing atient] will reside long of motion] program in place on hand ROM." Inance Restorative Programs R1, and identified the following: or restorative program was the overall goal was to, "Prevent and support midline posture in ogram included daily passive	F 6	888			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245237	B. WING				C 11/2018
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	R1's medical recorprogram was being evaluated. During observation assistant (NA)-F ather room and transchair (type of wheek were observed durobserved to be cleprovided by NA-F odirectly after observant of a restorative aided by the restorative aided by the restorative aided by the restorative aided by the restorative binder for R1's RO for August stating the comprehensive." Oprogram from Janucurrent. OT-A observational comprehensive."	d lacked evidence a ROM g offered, implemented, and on 1/10/18, at 9:09 nursing and NA-G brought R1 back to aftered her from her Broda elchair) into bed. No behaviors ing transfer. R1's hands were niched in fists. No ROM was or NA-G. When interviewed vation, NA-F stated she was rative program for R1 stating, in here," and NA-G stated R1 ROM program; however, only es completed ROM. In 1/10/18, at 11:38 pist (OT)-A stated she had for a decline in ROM in R1 left she had discharged R1 to a contractures prevention. OT-A ve recommendations were en to the director of nursing rapy also kept a copy in their OT-A looked in the restorative M program, couldn't find one the binder, "Isn't all OT-A looked at R1's ROM uary and stating it would still be erved R1's hands, which were	F6	\$88	,		
	to open R1's hands in ROM. OT-A reporestorative aide, which	as lying in bed. OT-A was able s, stating there was no decline orted NA-I was a trained no consistently completed owever, OT-A further reported NA-I, "For a while."					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	СОМ	E SURVEY PLETED
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	PROVIDER OR SUPPLIER	Y - REDWOOD FALLS		200	REET ADDRESS, CITY, STATE, ZIP CODE D SOUTH DEKALB STREET EDWOOD FALLS, MN 56283	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	During interview o registered nurse (I record and acknown restorative ROM programs, interview of interim director of for documentation programs, stated, further stated restoplan to implement any formal restoral IDON reported a whad been pulled of to staffing issues. It is facility was in the passistants to compute the facility had two NA-H. LPN-A state working; however, NA-I was on vacated the facility who had equipment. During interview of stated there were NA-H. NA-G state went through the restorative aid and would get pull stated they werended.	n 1/11/18, at 8:21 a.m. RN)-A reviewed R1's medical wledged she did not have a	F6	588			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	COM	
		245237	B. WING				C 11/2018
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		200 S	ET ADDRESS, CITY, STATE, ZIP CODE OUTH DEKALB STREET NOOD FALLS, MN 56283	1 017	11/2010
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F 688	completed restoration NA-H were gone or re-iterated that they do the restorative possible of the restoration of the restoration of the walking stated, when the rapprecommendations, ended up on her dedesk to put into the RN-A went on to stain the time she had all recommendation reported the restoration pulled to the floor, but them being pulled or reported the facility for completing and programs, further reall staff doing the pile of the restoration of the possible of the possible of the restoration of th	ve programs when NA-I and pulled to the floor, NA-G were the only ones trained to rograms. NA-I were available during the t. g schedule, reviewed for the /13/18, identified neither NA-I 1/7/18, 1/10/18, and 1/11/18. 1/11/18, at 8:21 a.m. RN-A, e facility since August, stated ormal restorative programs umenting on the program, the formed, and did not have which resident's progress was ated NA-I and NA-H were the ed to use the restorative e rest of the staff, "We do g, but not the machines." RN-A by wrote restorative some of the recommendations esk and some on the DON's electronic medical record. The electronic medical record are there had been four DON's been there, so was not sure if as were entered. RN-A ative aides were still being out it was getting better with one to two days less. RN-A was working on the process evaluating the restorative eporting ideally they would like rograms. RN-A acknowledged, as restorative programs	F6	88			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	СОМІ	E SURVEY PLETED
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	PROVIDER OR SUPPLIER	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 695 SS=D	A facility policy entit dated 6/12, directed restorative nursing based on individual problems as define. The restorative carresidents nursing c directed the goal of to maintain indeper Respiratory/Trache CFR(s): 483.25(i) § 483.25(i) Respirat tracheostomy care. The facility must enneeds respiratory care and tracheal scare, consistent wit practice, the compresare plan, the resid and 483.65 of this stand 4	cled Restorative Nursing Care, d., "Each resident will receive care to the extent possible, strengths, needs and d in nursing assessments. e will be outlined in the are plan." The policy further restorative nursing would be adence and prevent decline. ostomy Care and Suctioning and tracheal suctioning. Eaure that a resident who are, including tracheostomy uctioning, is provided such h professional standards of rehensive person-centered ents' goals and preferences, subpart. NT is not met as evidenced ation, interview, and document ailed to ensure oxygen consistently monitored for 1 of reviewed for oxygen.	F 6		rtance to lone on a eeds record stent ent idents, ve been needs vill be ure	2/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
			A. BUILDI	<u> </u>	l ,	c l	
		245237	B. WING		l	11/2018	
NAME OF	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP CO			
GOODS	AMARITAN SOCIET	Y - REDWOOD FALLS		200 SOUTH DEKALB STREET			
00000	AMARITAN GOOILT	1 - REDWOOD I ALEG		REDWOOD FALLS, MN 56283			
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F 695	Continued From p R238's medication and treatment adr 1/18, lacked docu monitoring. R238's care plan, assess for shortne (appearance of a the skin). The care oxygen use and in use or non-compli On 1/6/18, at 1:39 identified R238 wa Oxygen saturation On 1/7/18, at 1:02 indicated R238 wa via nasal cannula. 98%. A progress note d indicated oxygen a cannula. Alert. Ab A progress note d indicated R238 wa known. Uses Oxygennula. R 238's re	age 52 n administration record (MAR) ninistration record (TAR), for mentation of oxygen use or dated 1/6/18, directed to ess of breath and cyanosis blue or purple discoloration of e plan lacked identification of sterventions related to oxygen	F 6	DEFICIENCY)	the EMR, S or 2 months nonth. cted to one weekly. e DNS or 2 months nonth Audit		
	indicated R238 ha Regular, easy res During observatio	ated 1/9/18, at 6:47 a.m. ad O2 at 2L via nasal cannula. pirations. n on 1/9/18, at 11:15 a.m. R238 An oxygen concentrator					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	СОМ	E SURVEY IPLETED
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	PROVIDER OR SUPPLIER	- REDWOOD FALLS		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	<u>, , , , , , , , , , , , , , , , , , , </u>	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 695	located next to the off. The nasal cannithe concentrator waroom. The oxygen asked when the ox "Oh, when the nurs R238 stated he did times. R238 was not date. A progress note, daindicated R238 was Will use call light for During observation was sitting on the seating lunch. R238 R238's medical recan oxygen saturatic determine if R238's physicians order or documentation of the record from accommentation of the record from accommentation of Fubing. During observation was sleeping in because on and set at 2 receiving oxygen. To on the floor next to short of breath. On 1/10/18, at 9:06 identified an oxyge via nasal cannula.	head of the bed was turned aula, which was connected to as laying on the recliner in the tubing was not dated. When ygen was used, R238 replied, he pokes her head in here." take the oxygen tubing off at bot short of breath. The oxygen ed. ated 1/9/18, at 11:47 a.m. as alert, oriented, and pleasant.	F6	\$95			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245237	B. WING				C 11/2018	
	PROVIDER OR SUPPLIER	I		200 SOUTH	DRESS, CITY, STATE, ZIP CODE DEKALB STREET D FALLS, MN 56283	1 01/	11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EA	PROVIDER'S PLAN OF CORREC' ACH CORRECTIVE ACTION SHO SS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 695	R238 was sitting in his feet elevated. Ton, and R238 was cannula at 2L/min. shortness of breath especially today." Fishort of breath earl administration, R23 tubing." "If I could fit on." Oxygen tubing interview on licensed practical in concentrators are uportable oxygen tar resident's room. LF at 2 liters. R238's oxyobtain daily oxygen stated R238 would tubing off. When thoxygen cannula bathat day, she had pR238 after finding in nurse changes all of "tubing Tuesday." I changed. Tubing Tubing was not chart the facility for a wR238's tubing should build in the facility for a wR238's tubing should build bui	the recliner in his room with the oxygen concentrator was receiving oxygen via nasal When asked if he experienced at R238 replied, "Yeah, R238 went on to say he was ier. When asked about oxygen 88 stated he, "Loses the ind the darn thing, I would put any continued to be undated." 1/10/18, at 11:34 a.m. aurse (LPN)-A stated oxygen used in resident rooms and ask are used outside of the PN-A stated R238 used oxygen oxygen saturations needed to be when asked how staff a saturations readings. LPN-A sometimes take his oxygen at happened, staff put the ck on. LPN-A stated earlier but the oxygen cannula back on toff. LPN-A stated the day oxygen tubing weekly on The tubing is dated when uesday was on 1/9/18. R238's anged, as R238 had not resided week on 1/9/19. LPN-A stated ald be dated, but was not. 1/11/18, at 11:35 a.m. and the resided week on 1/9/19. LPN-A stated ald be dated, but was not. 1/11/18, at 11:35 a.m. and the R238's oxygen least once daily. Oxygen documented on the MAR or R238's MAR/TAR record did	F6	95				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245237	B. WING _		01	C / 11/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		711/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 695	administration. The monitoring of oxygmonitoring on 1/8/use, as well as integrated as a well as integrated as well as include oxygen the non-compliance. During interview or interim director of resident had an orwere to monitor the each shift and as a to obtain an oxyger resident was found tubing. Oxygen us care plan. All oxygreplaced weekly. The facility's policy Nasal Cannula, Fa 10/17, identified the administration. The physicians order. Oxygen anxiety, cyanosis, on continuous oxygen care every eight he tolerance of oxygen symptoms. Disposichanged weekly, oxygen weekly.	entation of oxygen e record was inconsistent with len saturations levels, missing 18 and 1/9/18. R238's oxygen erventions, should be on the lated R238's care plan did not erapy or interventions related to on 1/11/18, at 12:34 p.m. the later for continuous oxygen, staff e oxygen saturations levels lineeded. Additionally, staff were on saturation reading when a dot have removed the oxygen e was to be addressed on the len tubing should be dated and of Oxygen Administration with lace Mask or Face Tent, dated len process included: verify observe for signs of lota, dyspnea, confusion, land restlessness. For resident line gen therapy, give oral, nasal lours. Observe resident for lotant therapy and for any adverse listed equipment should be lor according to manufactures line and linitials.	F 69	95			
	Document on TAR items are changed started, type of ad time when oxygen resident's reaction	or eAdmin note when these I. Record when oxygen therapy ministration used, flow rate and tanks are changed. Document and tolerance to therapy. Topriate on the eMAR and TAR					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		245237	B. WING			C 11/2018
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	<u>, </u>	11,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 695 F 730 SS=D	Continued From parand on the progress Nurse Aide Peform CFR(s): 483.35(d)(7) Regular The facility must confevery nurse aide months, and must peducation based or reviews. In-service requirements of §4. This REQUIREMENT by: Based on interview facility failed to coma nurse aide at least of 3 nursing aides (Findings include: A personnel file review revealed a hire data lacked a performant During an interview human resource disperformance evaluation.	ge 56 s note in the MAR or TAR. Review-12 hr/yr In-Service 7) Ilar in-service education. Implete a performance review at least once every 12 provide regular in-service in the outcome of these training must comply with the 83.95(g). NT is not met as evidenced of and document review, the inplete a performance review of st once every 12 months for 1 NA)-C reviewed. In the personnel file in the control of the	F 695	Nursing aide –C performance revicompleted on 1/31/18. To prevent further potential deficier practice that may affect other nursiassistants we will be utilizing the neperformance management process schedule developed by the Good Samaritan Society for evaluations. was educated on the new staff evaluations are developed by the Good Samaritan Society for evaluations. Was educated on the new staff evaluation was educated on the new staff evaluation.	ew was nt ing ew s with a Staff iluation t to eview e by the d by ed	2/9/18
	interim director of n assistants are to ha evaluations. Typica department head a assistants who are evaluations. IDON	on 1/11/18, at 3:02 p.m. the sursing (IDON) stated nursing ave yearly performance lly human resources gives the monthly list of nursing due for performance stated she has been at the and has not received any		monthly by facility QAPI committee further recommendation.	· for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245237	B. WING		01	C / 11/2018	
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		711/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE	
F 730	dated 12/17, direct employees at least and document the Drug Regimen Rev CFR(s): 483.45(c)(\$483.45(c)(1) The Must be reviewed a licensed pharmacis \$483.45(c)(2) This of the resident's medical direct and these reports regularities to the facility's medical direct and these reports regularities in drug that meets the (d) of this section for (ii) Any irregularities during this review reparate, written resident and these reports required the control of the section for the control of th	Performance Management, ed managers to meet with annually to formally review entire year's performance. view, Report Irregular, Act On 1)(2)(4)(5) egimen Review. drug regimen of each resident at least once a month by a st. review must include a review edical chart. pharmacist must report any attending physician and the rector and director of nursing, must be acted upon. Elude, but are not limited to, any excriteria set forth in paragraph or an unnecessary drug. It is noted by the pharmacist must be documented on a export that is sent to the		730 756		2/9/18	
	director and director minimum, the reside and the irregularity (iii) The attending president's medical irregularity has been action has been tall be no change in the	a and the facility's medical or of nursing and lists, at a lent's name, the relevant drug, the pharmacist identified. Only sician must document in the record that the identified on reviewed and what, if any, seen to address it. If there is to be medication, the attending ocument his or her rationale in cal record.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
			A. BOILDII			С	
		245237	B. WING_			11/2018	
NAME OF F	PROVIDER OR SUPPLIEF	२		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
COODS	AMADITAN COCIET	V DEDWOOD FALLS		200 SOUTH DEKALB STREET			
GOOD S	AWARITAN SUCIET	Y - REDWOOD FALLS		REDWOOD FALLS, MN 56283			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE 'ROPRIATE	COMPLETION DATE	
F 756	Continued From p	page 58	F 7	56			
	maintain policies	e facility must develop and and procedures for the monthly					
		ew that include, but are not mes for the different steps in					
		teps the pharmacist must take entifies an irregularity that					
	requires urgent ac	ction to protect the resident.					
	This REQUIREME by:	ENT is not met as evidenced					
	Based on intervie	ew and document review, the		Policy and procedure has bee			
		sure the consulting pharmacist orted medication irregularities		related to pharmacist documer relation to R22 and R1. Their F			
		of resident specific target		have been reviewed by the cor			
	behaviors for anti-	-psychotic and anti-anxiety		pharmacist for irregularities rel			
		of 5 residents (R22, R1) and		psychotropic use. The DNS ar			
		ring for psychotropic		physician have been notified of			
		e attending physician and the		irregularities R22, R5, R13 and			
		g for 5 of 5 residents (R22, R23,		been reviewed for unnecessar			
	medications.	ewed for unnecessary		medications. R23 expired on 7 To prevent further potential def			
	medications.			practice current residents who			
	Findings include:			receiving psychotropic medical behaviors and side effects have	tions, target		
	R22's admission I	Minimum Data Set (MDS), dated		reviewed by the consultant pha			
		d a moderate cognitive		with findings given to the DNS			
	impairment and h	ad been admitted to the facility		physician. The pharmacist has	been		
		re. The MDS further identified		reeducated on expectations re	ated to		
		-anxiety and anti-depressant		appropriate monthly review rela			
		's admission Care Area		psychotropic medications, targ	et		
), dated 10/18/17, indicated she		behaviors and side effects.			
		depressant and as needed		Audits of consultant pharmacy			
		cations which would be reviewed		be completed on residents rec			
	during rounds.			psychotropic medications for n irregularities as related to targe			
	R22's current nhy	sician orders, dated 1/11/18,		and side effect monitoring, any			
		wing medications:		recommendation communicati			
		ety) 0.25 mg (milligram) three		physician and DNS. Audits will			
	times a day for an			the DNS or designee after the	•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245237	B. WING _			C / 11/2018	
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZI 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 5628	P CODE	11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 756	-Wellbutrin SR (and morning and at bed-Remeron (anti-del depression) R22's current care identified she received and the rece	ti-depressant) 150 mg every ditime for anxiety disorder pressant) 7.5 mg daily for plan, last revised 1/3/18, wed anti-anxiety medication and anti-depressant medication on, noting a goal for R22 to be exts. The care plan indicated "Monitor [R22] condition ractice guidelines or clinical ce," and, "Consult with care provider, etc. to consider with clinically appropriate." Imacy Reviews, reviewed from ntified the following: ted R22 was a, "New resident." amade indicating no 2/22/17 entries were blank, plarities. In 1/11/18, at 9:19 a.m. RN)-A stated the facility was enting target behaviors and ing. RN-A reviewed R22's dacknowledged it lacked target	F 75	pharmacist does their motime a month for 3 month will be reviewed monthly committee for further recommittee for further recommittee.	s. Audit results by facility QAPI		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		245237	B. WING				11/2018	
	PROVIDER OR SUPPLIER	- REDWOOD FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283			,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE	
F 756	contained the follow-Zoloft dated 10/18 -Zyprexa dated 8/9 behavioral disturbal R1's current care plidentified R1 was or goal to be free side adverse side effects medication use. No interventions includ snack, approach in offer her personal it R1's Monthly Pharm 12/22/17, contained -On 9/27/17, was sifew months back. R23's annual MDS, received anti-depreannual CAA, dated anti-depressant medepression and the on rounds. The CA depression, identify energy for one day. R23's current physical identified the follow -duloxetine HCL (ar depression and anxions)	dications. ian orders, printed 1/11/18, ving: 8/17, 75 mg, for depression 8/17, 2.5 mg for dementia with noce lan, last revised 1/2/18, n an anti-depressant with a effects, free of discomfort or s from antipsychotic in pharmacological ed redirect, offer a drink or a positive smiling manner, tems, (bunny, baby or dog). Inacy Reviews, from 12/16 to d the following: tarted on low dose Zyprexa a dated 9/6/17, identified she ssant medications. R23's 9/6/17, identified she received dication for a history of medications were reviewed A indicated R23 had minimal ring she felt tired and had little cian orders, dated 1/11/18, ing medications: nti-depressant) 60 mg daily for	F 7	756				
	R23's current care	plan, last revised 1/2/18,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245237	B. WING				C 11/2018
	PROVIDER OR SUPPLIER	I		200	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH DEKALB STREET DWOOD FALLS, MN 56283	1 017	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)) BE	(X5) COMPLETION DATE
F 756	identified she recei medication related for R23 to be free or plan indicated intercondition based on clinical standards or pharmacy, health or dosage reduction with the reconsulting Pfrom 2/17 to 12/17, pharmacist request medication. There consulting pharmacist effect monitoring for the above the medication aide (The consulting interview on medication aide (The consulting stollar the consulting to look for Zyalso stated they trie interventions like or combative to give helped to soothe he encouraged staff to re-approach and middle the consulting interview on stated she didn't see documented in R1's medical reconsulting to look for Zyalso stated they trie interventions like or combative to give helped to soothe he encouraged staff to re-approach and middle the seed of the consulting interview on stated she didn't see documented in R1's medical reconsulting the pharmacy and the seed of the consulting interview on stated she didn't see documented in R1's medical reconsulting the plantage of the consulting the plantage of the	ved anti-depressant to depression, noting a goal of adverse effects. The care ventions were, "Monitor [R23] clinical practice guidelines or f practice," and, "Consult with are provider, etc. to consider vith clinically appropriate." harmacist Reviews, reviewed identified on 2/20/17, the ted to taper R23's fluoxetine was no indication the cist had identified the lack of ing. and lacked side effect anti-depressant medications. and 1/10/18, at 1:53 p.m. trained MA)-A stated R1 was on cation, and she would look for ming, that means the big yprexa, mortality rate." TMA-A and non pharmacological ine on one, if grabbing, biting, the her a stuffed animal, which is and if she continued, take a step back and anintain calm environment.	F	756			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		245237	B. WING			01/	11/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DEKALB STREET EDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	p.m. the consulting focused on a difference of the process of the	pharmacist (CP) stated she ent topic each month for the state topic each, "Ya know they say the notes will say resident is coming out to dining room stated the behaviors were not a medications the resident was at in some of her facilities, she viors, but not at this facility. CP and any concerns with the stations. When asked about ng, CP reported she used to consents, which would list the state of appetite, but further reported em in about two years. CP ped her mind to look for them, as herself a note to look the	F	756			
	as severely cognitive CAA, dated 2/18/17 Sertraline (anti-deposition R5's quarterly MDS verbal behavioral services MDS further indicated to the control of t	s, dated 11/15/17, identified ymptoms towards others. The ted R5 received antipsychotic					
	1/18/17- Cymbalta milligrams (mg) dai	entified the following: (anti-depressant) 60 (ly for depressive episodes. (anti-psychotic) 100 mg daily for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245237	B. WING _		01	C / 11/2018	
	PROVIDER OR SUPPLIER	7 - REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	CODE	711/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 756	(anti-depressant) & R5's care plan, las R5 received antips depressive disorder Monitor for behavious danger to the residual danger to the residual danger to depressive disorder to depressive disorder danger to the residual danger to the residual danger to the residual danger to depressive danger	disorder. anti-depressant Sertraline 50 mg daily for depression. It reviewed 5/18/17 identified sychotic medication related to er. "Black Box Warning." oral symptoms that present a dent and others. Updated antidepressant medication ion. "Monitor (R5's) condition oractice guidelines or clinical ice related to use of consult with pharmacy, health onsider dose reduction when ite. history documentation identifies document every shift for the haviors. Trouble falling or eling bed about self, moving or dgeting, states life is not worth harm self, being short	F 75	,			
	R13's annual MDS was severely cogn dated 2/18/17, ide antidepressant me	or side effect monitoring. 6, dated 2/17/17, identified R13 itively impaired. R13's CAA, ntified R13 used an edication. OS, dated 11/15/17, identified					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245237	B. WING				C 11/2018
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	1 011	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	R13 receives antiparantidepressant med 8/9/17- Seroquel (a mouth one time dai 11/27/17-Zoloft 75 depression 12/5/17-Ativan 0.5 disorder. R13's care plan incomplete and the p	sychotic, antianxiety, and dication. Evealed the following: Intipsychotic medication) by ly for dementia with behaviors. In many one time daily for many one time daily for anxiety luded the following: Indication in Monitor Clinical standards of practice. In Indication in Indicatio	F 7	756			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	<u> </u>	2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 756	During an interview registered nurse (R any official docume about side effect m A policy on psychot was requested but	or side effect monitoring. on 1/11/18, at 11:35 a.m., N)-A stated "we don't have entation on that" when asked onitoring for R5 and R13. ropic medication monitoring	F 75			2/9/18	
SS=D	CFR(s): 483.45(d)(§483.45(d) Unnece Each resident's dru unnecessary drugs drug when used- §483.45(d)(1) In ex duplicate drug thera §483.45(d)(2) For ex §483.45(d)(3) Wither §483.45(d)(4) Wither use; or	and the second s				2,67,16	
	stated in paragraph section. This REQUIREMED by: Based on observat	combinations of the reasons as (d)(1) through (5) of this NT is not met as evidenced tion, interview, and document ailed to monitor bruising and		The policy and procedure has to reviewed in relation to the incide			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 757	notify the coumage of anticoagulant the reviewed for unnership include: R19's Diagnosis Fidentified a prima Unspecified seques cerebrovascular of R19's quarterly M11/20/17, identified MDS further identified and identified and identified included the following for	lin clinic of possible side effect herapy for 1 of 2 residents (R19) ecessary medications. Report, printed 1/11/18, ry admitting diagnosis of elae of unspecified disease, inimum Data Set (MDS), dated do no cognitive impairment. The tified R19 had an active rtension, hemiparesis, seizure sy. Psician orders, printed 1/11/18, owing: 16/2018, dated 1/9/18. 2.5 mg (milligrams) every 2/4/17, for cerebrovascular every Sunday, Tuesday, rsday, Friday and Saturday, recrebrovascular disease. The tablet daily, dated 3/9/15, ovascular disease. Parmacy Reviews, reviewed from 17, contained a note on 6/23/14 in 5/22/15 INR 2.2, and a note on	F 7	757	involving R19 with side effect monitimplemented. To prevent further potential deficient practice that could affect other residence who are on Coumadin therapy. States been reeducated to implement daily effect monitoring and to report irregularities to the physician. Audits will be completed on side efficient monitoring of residents who are curton Coumadin, also any irregularities reported to primary care physician. will be done by the DNS or designed time a week for 2 months then ever week for 1 month. Audit results will reviewed monthly by facility QAPI committee for further recommendations.	t dents ff has y side fect rently s Audits e 1 ry other be	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	' - REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP O 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		711/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 757	Continued From pa	age 67	F 7	57		
	vomiting, diarrhea, bruising, blurred vi loss of appetite, su status, significant o signs." R19's Skin Observ 1/19, identified the					
	was noted on R19 -On 1/1/18, no bru conditions observed -On 1/9/18, at 9:51 measured 4 cm (cobserved and was room. The back of stages of healing. related to the medibruising in differen	ising observed and no skin				
	bruising was noted back of both upper approximately 3-4 shades of dark pur protectors on both	n on 1/8/18, at 3:45 p.m. large labove the elbow and on the arms. The bruising was inches in diameter, in various the in color. R19 had sleeve forearms covering to the elbow over the upper arms where the elocated.				
	stated he got bruis coumadin, stating bruise. He further s about side effects them know if there wore sleeve protect	es on his arms from the any little bump caused a stated the nurses told him and what to watch for; he let was bruising. R19 stated he ctors and tried to be careful. these bruise are from				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		TE SURVEY MPLETED C
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	PROVIDER OR SUPPLIER	' - REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP CO 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 757	looked at them. A facility progress p.m. indicated com "resident had INR this time will reche Although R19 was bruising on arms a indication the physibruising. During interview or medication aide (T Coumadin, and the scabs. TMA-A repradministration recesside effects to look R19 reported or not go to the charge of the progress notes aware of any bruis stated R19 had a k would have checked During an interview licensed practical reports areas, any blunched the progress of the charge of the progress notes aware of the progress not	er." R19 thought the nurse note, dated 1/9/18, at 12:18 nunication to physican, 1.9, no Coumadin changes at ck INR 1/16/18." identified on 1/9/18 as having nd elbow there is is no ican was notified of the n 1/10/18, at 8:28 a.m. trained MA)-A stated R19 was on ey checked for any bruising or orted, on the medication ord (MAR), there was a list of a for. TMA-A further reported if officed any bruising, she would urse, and would document it in a. TMA-A stated she wasn't ing for R19. TMA-A further oath on Monday and the nurse ed for any bruising then. I on 1/10/18, at 11:37 a.m. Inurse (LPN)-C stated she inursing assistants to report any eeding, or any major bruising. would get it reported to the ed would also document the orther stated R19 wears the	F 75	57		
	was a weekly skin	assessment for anticoagulant ing. Nursing would address				

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETION DATE
y skin tears documented on the heet. Serious bruising would be ysican. RN-A observed R19's knowledging his weekly skin ed documentation and bruising. itled Pro Time: Measuring alues, dated 9/12, identified the brease recognition of potential did proper dosing of brapy, to decrease reporting and physican or health care Psychotropic Meds/PRN Use (3)(e)(1)-(5) otropic Drugs. bychotropic drug is any drug that the associated with mental phavior. These drugs include, to, drugs in the following t; and ehensive assessment of a	F 7	57		2/9/18
idents who have not used are not given these drugs tion is necessary to treat a as diagnosed and documented drd;				
	245237 A - REDWOOD FALLS ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) age 69 y skin tears documented on the heet. Serious bruising would be ysican. RN-A observed R19's cknowledging his weekly skin ed documentation and bruising. bitled Pro Time: Measuring alues, dated 9/12, identified the brease recognition of potential and proper dosing of berapy, to decrease reporting and physican or health care Psychotropic Meds/PRN Use (3)(e)(1)-(5) botropic Drugs.	245237 RY - REDWOOD FALLS ATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) age 69 y skin tears documented on the heet. Serious bruising would be yisican. RN-A observed R19's cknowledging his weekly skin ed documentation and oruising. iitled Pro Time: Measuring alues, dated 9/12, identified the crease recognition of potential and proper dosing of erapy, to decrease reporting ing physican or health care Psychotropic Meds/PRN Use (3)(e)(1)-(5) otropic Drugs. Sychotropic drug is any drug that ties associated with mental havior. These drugs include, to, drugs in the following at; and rehensive assessment of a cymust ensure that— idents who have not used are not given these drugs tion is necessary to treat a as diagnosed and documented ard;	Z45237 B. WING STREET ADDRESS, CITY, STATE, ZIP COL 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283 ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY PULL LISC IDENTIFYING INFORMATION) Age 69 Ye skin tears documented on the heet. Serious bruising would be ysican. RN-A observed R19's cknowledging his weekly skin ed documentation and orusising. Aitied Pro Time: Measuring alues, dated 9/12, identified the crease recognition of potential dropper dosing of grapy, to decrease reporting ng physican or health care Psychotropic Meds/PRN Use (3)(e)(1)-(5) Atropic Drugs. Sychotropic drug is any drug that ties associated with mental havior. These drugs include, to, drugs in the following att; The didents who have not used a gare not given these drugs tion is necessary to treat a as diagnosed and documented rid;	245237 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283 ATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION SUBJECT ON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) age 69 P. Skin tears documented on the heet. Serious bruising would be ysican. RN-A observed R19's knowledging his weekly skin ed documentation and oruising. ittled Pro Time: Measuring flues, dated 9/12, identified the prease recognition of potential drypoper dosing of grapy, to decrease reporting flues, dated 9/12, identified the prease recognition of potential drypoper dosing of grapy, to decrease reporting flues, dated with mental havior. These drugs include, to, drugs in the following t; and the following the following the same of the proper doses are not given these drugs tion is necessary to treat a as diagnosed and documented rd;

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	СОМ	E SURVEY PLETED
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	PROVIDER OR SUPPLIER	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	CODE	11/2010
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F 758	Continued From pa	age 70	F 75	58		
	drugs receive grad behavioral interven contraindicated, in drugs;	ual dose reductions, and itions, unless clinically an effort to discontinue these				
	psychotropic drugs unless that medica	dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented d; and				
	are limited to 14 da §483.45(e)(5), if th prescribing practition appropriate for the beyond 14 days, he rationale in the res	I orders for psychotropic drugs ays. Except as provided in e attending physician or oner believes that it is PRN order to be extended e or she should document their ident's medical record and on for the PRN order.				
	drugs are limited to renewed unless the prescribing practition the appropriatenes	I orders for anti-psychotic of 14 days and cannot be e attending physician or oner evaluates the resident for s of that medication. NT is not met as evidenced				
	Based on observareview, the facility to monitored for target (R22, R1) and faile and educated on the psychotropic use p	rior to initiation for 5 of 5 3, R1, R5 and R13) reviewed		GSS-Sunwood realizes the monitor target behaviors, someonitoring and to provide the risk and benefits of psymedication for residents repsychotropic medication. Obeen updated for target be non-pharmacological interpand R22. The policy and pinitiation of psychotropic medications of psychotropic medications.	side effect education on ychotropic eceiving Care plan have ehavior and eventions for R1 rocedure on	
	J	linimum Data Set (MDS), dated		been reviewed for resident 23, 1, 5 and 13. Resident I	number 22,	

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
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		245237	B. WING			01/1	1/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
	CLIMMAN DV CTA	TEMENT OF DEFICIENCIES			T		0.15
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F 758	impairment and had due to a hip fracture R22 received anti-amedications. R22's Assessment(CAA), used a daily anti-deanti-anxiety medical during rounds. R22's hospital disclusion of the second of th	a moderate cognitive d been admitted to the facility de. The MDS further identified anxiety and anti-depressant admission Care Area dated 10/18/17, indicated she pressant and as needed ations which would be reviewed that the facility with am (anti-anxiety medication) as needed with indications anxiety. R22's discharge orders opion (anti-depressant) 150 mg of anxiety with depression. The property of the facility with an indication fax, dated 11/2/17, and facility with depression (anti-depressant) and been changed scheduled three times a day. The physician would evaluate at the facility of the facili	F 7	758	expired on 1/26/18. To prevent further potential deficien practice that may affect other reside with monitoring of target behaviors, has been reeducated on 2/1/18 for monitoring target behaviors, side ef and notification of risk and benefits psychotropic medication use reside representatives. Facility will be mor target behaviors by auditing the car related to non-pharmacological interventions. Audit care plans for target behavior side effects for any resident receiving psychotropic medications that they non-pharmacological intervention. A will be done by the DNS or designe time a week for 1 months then ever week for 2 month. To prevent further potential deficient practice due to failed monitoring for effects and education on the risk/be of psychotropic use prior to initiation Facility will audit this by using the "permission for use of psychotropic medications" (GSS #478 form) of residents who are on psychotropic medication with appropriate interve To monitor the side effects we will use abnormal involuntary movement so (AIMs) per facility protocol. Side effective them, to be monitored daily Audit will be done on GSS #478 of a new orders on psychotropic medication for the side effects we will a subnormal involuntary movement so (AIMs) per facility protocol. Side effective them, to be monitored daily Audit will be done on GSS #478 of a new orders on psychotropic medication for the side effects we will a subnormal involuntary movement so (AIMs) per facility protocol. Side effective them, to be monitored daily Audit will be done on GSS #478 of a new orders on psychotropic medication for the side effects we order on psychotropic medication for the side effects we order on psychotropic medication for the side effects we order on psychotropic medication for the side effects we order on psychotropic medication for the side effects we order on psychotropic medication for the side effects we order on psychotropic medication for the side effects we will use the subnormal subnormal subnormal subnormal subnormal subnor	ents Staff fects, of ent ifects, of ent itoring e plan s and ng have a Audits e 1 ry other it side enefits n. intions. use the ale fects of en ho any ations	
	identified she receive	plan, last revised 1/3/18, ved anti-anxiety medication nd anti-depressant medication			for residents before initiation of the medication and on the daily assess and scheduled AIMS assessment.		

	T OF DEFICIENCIES OF CORRECTION	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLET		PLETED			
		245237	B. WING			1	C 11/2018
	PROVIDER OR SUPPLIE	R TY - REDWOOD FALLS		200	REET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH DEKALB STREET EDWOOD FALLS, MN 56283		
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F 758	related to depress free of adverse er interventions were based on clinical standards of prace pharmacy, health dosage reduction. Although R22's a scheduled and ar was added, R22's behaviors for anxichanges. Further lacked non-pharmanxiety and side of anti-anxiety and side of anti-anxiety and a R22's medical reducated on the red	sion, noting a goal for R22 to be ffects. The care plan indicated e, "Monitor [R22] condition practice guidelines or clinical ctice," and, "Consult with a care provider, etc. to consider with clinically appropriate." Ilprazolam was changed to nother psychotropic medication is medical record lacked target ciety justifying the medication more, R22's medical record nacological approaches to effects monitoring for the anti-depressant medications. Cord lacked evidence she was risks/benefits of psychotropics. In on 1/10/18, at 8:05 a.m. R22 therapy. R22 was conversing and did not display anxiety or on on 1/10/18, at 2:25 p.m. R22 g with therapy. R22 did not side effects.	F 7		will be done by the DNS or design time a week for 2 months then evel week for 1 month. Audit results wereviewed monthly by facility QAPI committee for further recommend	ery other vill be l	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	keeping her busy we therapy. TMA-A staneeded, they docur giving it in the admit chart whether or not Xanax was schedul behaviors and effect documented in R22 stated she didn't this behaviors. TMA-A sin the, "Black box we every medication. To warning meant therefor. TMA-A stated if she would alert the having any side effect remors. During interview on stated her anxiety, she was on a little phelped. R22 furtherefor anxiety at home feeling depressed; home. R22 denied medications. R22 drisks/benefits prior is if they give you to [staff] never told means on some psychotronered anti-depressant medications. R23's annual MDS, received anti-depressant medications. R23's annual MDS, received anti-depressant medications.	behaviors as much anymore, ith occupational and physical ted, when the Xanax was as nented R22's behaviors when nistration note, and would also t if was effective. Now that the ed, TMA-A thought the	F	758			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
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F 758	R23's current physicentified the follow-duloxetine HCL (adepression and an-Trazadone (anti-disleep) R23's current care identified she recemedication related for R23 to be free explan indicated intercondition based or clinical standards or pharmacy, health of dosage reduction with R23's medical recomonitoring for the R23's medical recomonitoring for the R23's medical recomonitoring for the R23's medical recomonitoring observation was transferred into stand lift. No siden R1's quarterly MD3 severe cognitive in diagnoses of Alzhed depression, and pseudoption and pseudoption in the right of the R1's current physic contained the following depression and pseudoption in the right of the R1's current physic contained the following depression and pseudoption in the right of the R1's current physic contained the following depression and pseudoption in the right of the R1's current physic contained the following depression and pseudoption in the right of the R1's current physic contained the following depression and pseudoption in the right of the R1's current physic contained the following depression and pseudoption in the right of the R1's current physic contained the following depression and pseudoption in the R1's current physic contained the following depression and pseudoption in the R1's current physic contained the following depression and pseudoption in the R1's current physic contained the following depression and pseudoption in the R1's current physic contained the following depression and pseudoption in the R1's current physic contained the following depression and pseudoption in the R1's current physic contained the following depression and pseudoption in the R1's current physic contained the following depression and pseudoption in the R1's current physic contained the following depression and pseudoption in the R1's current physic contained the following depression and pseudoption in the R1's current physic contained the following depression and pseudoption in the R1's current physic contained the following	cician orders, dated 1/11/18, wing medications: anti-depressant) 60 mg daily for xiety epressant) 100 mg daily for plan, last revised 1/2/18, ived anti-depressant to depression, noting a goal of adverse effects. The care eventions were, "Monitor [R23] in clinical practice guidelines or of practice," and, "Consult with care provider, etc. to consider with clinically appropriate." ord lacked side effect anti-depressant medications. ord lacked evidence she was saks/benefits of psychotropics. In on 1/10/18, at 8:49 a.m. R23 to her wheelchair using the sit e effects were observed. So dated 9/29/17, identified a appairment and had active elimers dementia, aphasia, sychotic disorder. The MDS 1 received antipsychotic and dications. Cian orders, printed 1/11/18, wing:	F 75	8		
	contained the follor-Zoloft (anti-depression -Zyprexa (anti-psyd					

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F 758	identified R1 was on with the goal to be interventions were care provider to combine when clinically app. Warning-depression also identified R1 I dementia. Intervent necessary to prote others. Hitting, kick positive manner. R1's facility progresidentified R1's datu Wellbutrin (anti-de 6/21/7, and was stoedtime. A facility progress R1 was difficult to falling asleep with feeding as resident R1's physician not has some end stage communicative, but Some of the psychological stage of the psychological provides the p	plan, last revised 1/2/18, on anti-depressant medication, free of any side effects. The consult with pharmacy, health phasider medication alterations propriate, BLACK BOX on medications. The careplant had behaviors related to ations included intervene as cot the rights and safety of king biting, apraxia, and see note, dated 6/15/17, ghter was notified that pressant) was discontinued on arted on Zyprexa 2.5 mg at a note, dated 9/4/17, identified arouse for lunch, barely ate, food in her mouth. Ceased that at risk for aspiration. The dementia, really is not too at its aggressive towards others. The pressive towards others are greater to the pressive towards others. The pressive towards others are greater to the pressive towards others. The pressive towards others are greater to the pressive towards others. The pressive towards others are greater to the pressive towards others. The pressive towards others are greater to the pressive towards others. The pressive towards others are greater to the pressive towards others. The pressive towards others are greater to the pressive towards others. The pressive towards others are greater to the pressive towards others. The pressive towards others are greater to the pressive towards others. The pressive towards others are greater to the pressive towards others. The pressive towards others are greater to the pressive towards others. The pressive towards others are greater to the pressive towards others. The pressive towards others are greater to the pressive towards others. The pressive towards others are greater to the pressive towards others. The pressive towards others are greater to the pressive towards others. The pressive towards others are greater to the pressive towards others. The pressive towards others are greater to the pressive towards others.	F 75	58		
	sitting up in a Brod TV lounge area, of R1 did not display During observation	n on 1/09/18, at 10:07 a.m. R1 la chair (type of wheelchair) in their residents were talking, and behaviors. n on 1/09/18, at 12:17 p.m. R1 in dining room with staff				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	CODE	71112010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 758	assistance; R1 did During interview or medication aide (T antipsychotic medieffects, she would warning", which medicath, associated also stated R1 was she would look at it. TMA-A stated if she would let the nurse. During an interview registered nurse (F target behaviors or R1's medical record. Although R1's medical record. Include Zyprexa, a record lacked door monitoring. R1's medications were greatly some severely cognitic care area assessmindicated the use of anti-depressant. R5's quarterly MDS verbal behavioral some severely cognitic care area assessmindicated the use of anti-depressant. R5's quarterly mDS verbal behavioral some severely cognitic care area assessmindicated the use of anti-depressant.	not display behaviors. 1/10/18, at 1:53 p.m. trained MA)-A stated R1 was on cation. TMA-A stated, for side look for the, "Black box eant there were big things. like with the medication. TMA-A salso on Zoloft for depression; negative mood and crying. e observed any behaviors, she know. 1/2 on 1/11/18, at 8:44 a.m. RN)-A stated she didn't see any side effect monitoring listed in id. 2/3 dications were changed to anti-psychotic, R1's medical amentation of target behavior redical record also lacked side and evidence that the attipsychotic and antidepressant give prior to use. 2/3 dated 2/17/17, identified R5 vely impaired. R5's admission nent (CAA), dated 2/18/17, of sertraline (anti-Depressant) 3/4 dated 11/15/17, identified symptoms towards others. The ted R5 received antipsychotic	F 75	8		

F 758 Continued From page 77 milligrams (mg) daily for depressive episodes. 9/30/17-Seroquel (anti-psychotic) 100 mg daily for major depressive disorder. 1/8/18-Additional anti-depressant sertraline (anti-depressant) 50 mg daily for depression. R5's care plan, last reviewed 5/18/17 identified R5 received antipsychotic medication related to depressive disorder. "Black Box Warning."		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		PLE CONSTRUCTION G		E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALLS (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 758 Continued From page 77 milligrams (mg) daily for depressive episodes. 9/30/17-Seroquel (anti-depressant) 50 mg daily for depression. R5's care plan, last reviewed 5/18/17 identified R5 received antipsychotic medication related to depressive disorder. "Black Box Warning." STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 758 F 758 F 758 STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 758 F 758 F 758 F 758			245237	B. WING				
(X4) ID PREFIX TAG CONTINUED FROM INTERPRETATION TO BE PROVIDER'S PLAN OF CORRECTION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 758 Continued From page 77 milligrams (mg) daily for depressive episodes. 9/30/17-Seroquel (anti-psychotic) 100 mg daily for major depressive disorder. 1/8/18-Additional anti-depressant sertraline (anti-depressant) 50 mg daily for depression. R5's care plan, last reviewed 5/18/17 identified R5 received antipsychotic medication related to depressive disorder. "Black Box Warning."	NAME OF I	PROVIDER OR SUPPLIER		' 		STREET ADDRESS, CITY, STATE, ZIP CODE	1 017	11/2010
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 758 Continued From page 77 milligrams (mg) daily for depressive episodes. 9/30/17-Seroquel (anti-psychotic) 100 mg daily for major depressive disorder. 1/8/18-Additional anti-depressant sertraline (anti-depressant) 50 mg daily for depression. R5's care plan, last reviewed 5/18/17 identified R5 received antipsychotic medication related to depressive disorder. "Black Box Warning."	GOOD S	AMARITAN SOCIETY	- REDWOOD FALLS					
milligrams (mg) daily for depressive episodes. 9/30/17-Seroquel (anti-psychotic) 100 mg daily for major depressive disorder. 1/8/18-Additional anti-depressant sertraline (anti-depressant) 50 mg daily for depression. R5's care plan, last reviewed 5/18/17 identified R5 received antipsychotic medication related to depressive disorder. "Black Box Warning."	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
Monitor for behavioral symptoms that present a danger to the resident and others. Updated 1/2/18 resident on antidepressant medication related to depression. "Monitor (R5's) condition based on clinical practice guidelines or clinical standards of practice related to use of antidepressants. Consult with pharmacy, health care provider to consider dose reduction when clinically appropriate. During observations on 1/10/17, 7:14 a.m. R5 was sitting in a wheelchair in the dining room awaiting breakfast. R5 was pleasant, calm, talking with another resident at the table. During an interview on 1/11/18, at 12:57 p.m. R5 was sitting in the TV area. R5 stated "I'm kind of blue." R5 was aware he takes medication for "feeling blue" and stated "sometimes" they help. R5 was smiling during the conversation. R5's point of care history documentation identifies staff monitor and document every shift for the following target behaviors. Trouble falling or staying asleep, feeling bed about self, moving or speaking slowly, fidgeting, states life is not work living, attempts to harm self, being short tempered. Although staff monitored R5's mood. R5's	F 758	milligrams (mg) dai 9/30/17-Seroquel (imajor depressive di 1/8/18-Additional at (anti-depressant) 5 R5's care plan, last R5 received antipsi depressive disorde Monitor for behavior danger to the resid 1/2/18 resident on a related to depressive based on clinical proposition of the provider to conclinically appropriate During observation was sitting in a whomal awaiting breakfast. Talking with another During an interview was sitting in the Tiblue." R5 was await "feeling blue" and sitting breakfast. Talking with another R5's point of care in staff monitor and diffullowing target behaving asleep, fee speaking slowly, ficiliving, attempts to intempered.	illy for depressive episodes. anti-psychotic) 100 mg daily for lisorder. nti-depressant sertraline 0 mg daily for depression. It reviewed 5/18/17 identified ychotic medication related to r. "Black Box Warning." oral symptoms that present a ent and others. Updated antidepressant medication on. "Monitor (R5's) condition ractice guidelines or clinical ce related to use of onsult with pharmacy, health insider dose reduction when see. Is on 1/10/17, 7:14 a.m. R5 eelchair in the dining room R5 was pleasant, calm, resident at the table. If on 1/11/18, at 12:57 p.m. R5 or an entire and others in the dining room R5 was pleasant, calm, resident at the table. If on 1/11/18, at 12:57 p.m. R5 or an entire and others in the dining room related "sometimes" they help. In the conversation. Inistory documentation identifies occument every shift for the naviors. Trouble falling or ling bed about self, moving or digeting, states life is not work narm self, being short	F 7	'58			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTR AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			СОМ	E SURVEY PLETED			
		245237	B. WING				C 11/2018
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DEKALB STREET EDWOOD FALLS, MN 56283	1 017	11/2010
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F 758	risk/benefits of psy Additionally, the remonitoring of the p R13's annual MDS was severely cogn dated 2/18/17, ider antidepressant me R13's quarterly ME R13 receives antipantidepressant me Physician orders re 8/9/17- Seroquel (a mouth one time da 11/27/17-Zoloft 75 depression 12/5/17-Ativan 0.5 disorder. R13's care plan inc 1/2/18 -on antipsyc condition based on Attempt non-pharm redirections, offerir blanket. 1/2/18- on antidepressed on clinical swith pharmacy, hear consider dosage reappropriate. 1/3/18-antianxiety based on clinical sinterventions for m resident separated When calling/yellin	ked education on the chotropic medication. cord lacked side effect sychotropic medication. ditively impaired. R13's CAA, nified R13 used an dication. S, dated 11/15/17, identified R13 eychotic, antianxiety, and dication. S, dated 11/15/17, identified sychotic, antianxiety, and dication. evealed the following: antipsychotic medication) by ily for dementia with behaviors. mg one time daily for mg one time daily for anxiety cluded the following: chotic medication. Monitor a clinical standards of practice. nacological intervention mg snacks, blue comfort ressant. Monitor condition tandards of practice. Consult alth care provider, etc. to eduction when clinically medication. monitor condition tandards of practice. ood also included to keep from (R18) when agitated.	F 7	758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245237	B. WING			l l	C 11/2018
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	1 01/	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 758	personal items and TV. During observation R13 in a loud voice Nursing assistant (I with R13. R13 was approached R13 and R13's point of care identified staff monfor the target behave. Although staff monfor the target behave additionally, the reconstruction of the personal	assist to bathroom. Offer the s on 1/10/18 at 12:37 p.m. repeatedly said "help." NA)-E responded and spoke quiet. At 12:46 p.m. NA-B and assisted R13 to an activity. history documentation itor and document every shift	F 7	758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		711/2010	
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F 758	work in progress, a behaviors screening behaviors. SS-A reformat at their last (IDT), but hadn't gramonitoring, such a and associated be consents for psychological programs. The sident spaces of the program of the program. The IDO see the program of the program of the program. The IDO see the program of the program. The IDO see the program of the pr	ated behavior monitoring was a and they were working on their ing to target and monitor reported they had started a new interdisciplinary team meeting one into great detail regarding is a looking at the diagnosis haviors. SS-A stated if notropics are done, they would be medical record under "SS-A further stated the reviewed at care conferences is on admission. SS-A stated ogress notes about staff going in 1/11/18, at 10:31 a.m. the nursing (IDON) stated the lat the facility was lacking and a concern. The IDON stated Monday to start to address the N reported she would like to consist of what medications the lat specific behaviors the ly having and how often, and one every quarter. The IDON	F 75	8			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 758	was scanned into "	age 81 he consent, then the consent Resident Spaces." CP further t seen them in about two	F 7	58		
F 838 SS=F	was requested but Facility Assessmen	nt	F 8	38		2/9/18
	facility-wide assess resources are necessare necessare necessare mediand emergencies. update that assess least annually. The update this assess facility plans for, ar substantial modific	onduct and document a sment to determine what essary to care for its residents a both day-to-day operations. The facility must review and sment, as necessary, and at a facility must also review and ment whenever there is, or the my change that would require a ation to any part of this acility assessment must				
	including, but not li (i) Both the numbe resident capacity; (ii) The care requir considering the typ physical and cogni and other pertinent that population; (iii) The staff comp provide the level at resident population (iv) The physical et	r of residents and the facility's ed by the resident population es of diseases, conditions, tive disabilities, overall acuity, t facts that are present within etencies that are necessary to nd types of care needed for the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIEI	₹ Y - REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP C 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 838	(v) Any ethnic, cui may potentially af facility, including, food and nutrition §483.70(e)(2) The but not limited to, (i) All buildings an and vehicles; (ii) Equipment (medicial) Services provipharmacy, and specific (v) All personnel, employees and the contract), and volueducation and/or related to resident (v) Contracts, me or other agreemes services or equipment or other agreemes services or equipment information with one §483.70(e)(3) A facommunity-based all-hazards approach this REQUIREMI by: Based on interviet facility failed to coassessment of the effective plan was	y to care for this population; and ltural, or religious factors that fect the care provided by the but not limited to, activities and services. It facility's resources, including d/or other physical structures edical and non- medical); ided, such as physical therapy, recific rehabilitation therapies; including managers, staff (both rose who provide services under unteers, as well as their training and any competencies t care; morandums of understanding, ints with third parties to provide ment to the facility during both is and emergencies; and action technology resources, for electronically managing and electronically sharing ther organizations.	F8	GSS-Sunwood realizes the have a comprehensive facilito ensure the effective plan to maintain the highest pracall 36 residents. The facility assessment has reviewed and updated to income	ity assessment was in place tical care for been		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY IPLETED
			A. BUILDI	NG		c
		245237	B. WING		1	11/2018
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMADITAN SOCIETY	- REDWOOD FALLS		200 SOUTH DEKALB STREET		
GOOD 3	AWARITAN SOCIETT	- REDWOOD FALLS		REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOOK CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 838	p.m. when asked to facility assessment copy of Imported D Data, undated. Durithe administrator s facility for approxing facility assessment previous administrational previous and implementational previous (See F66) -Care of a residents and implementational previous (See F66) -Care of residents (See F66) -Lack of target behamonitoring for psycomological previous administrational previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F66) -Lack of target behamonitoring for psycomological previous (See F	the facility on 1/8/17, at 1:44 to provide a copy of the current to the administrator provided a demographics and Census ring the entrance conference, tated she had been at the nately one week, noting the to had been completed by the ator. The re-certification survey to 1/11/18, quality of care and is were identified regarding the station of restorative nursing	F 8	documentation of the resident and assessment to identify star contracted staff competencies education, facility resources in pharmacy and contracted thera services, structural resources a management and communicat between electronic medical reconstructor to ensure the deficient practice reoccur, the facility assessment updated annually as per regular Ongoing facility assessment recoviewed monthly by facility QA committee for further recommendations.	ff and and cluding apy and the cords. de does not t will be tion. sults will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245237	B. WING _		01	C / 11/2018
	PROVIDER OR SUPPLIER	Y - REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 838	the needs and star care for their resididentification of all pool staff noting the competencies need addition, the facilitidentification of the pharmacy and corprovided, equipmed The assessment landeress the manabetween their electick Care and Resulting interview of interim director of not participated in assessment, and addressed. The ID she had worked of interdisciplinary. The purpose of a facility's strength quality standards a aware of what is proncerns, and to be emergency situation.	ents. The assessment lacked personnel including contracted personnel including contracted personnel including contracted per education and eded to provide care. In y assessment lacked a facility's resources including paracted therapy services and, and structural resources. Eacked information regarding technology (HIM) and did not gement and communication tronic medical records i.e. Point asident Spaces. In 1/11/18, at 10:31 a.m. the nursing (IDON) stated she had making the current facility could not comment on what it DON stated facility assessments in the past were the IDON further stated the cy assessment was to address as and weakness, achieve the set forth for ourselves, to be otentially out there for the able to function in an on.	F 83	8		
	11/17, identified the assessment was to care for residentified the compincluding but not lipopulation and carcondition, physical employee competers.	itled Facility Assessment, dated e purpose of the facility of determine resources needed to competently. The policy conents of the assessment, mited to, the resident re required by disease, and cognitive abilities, encies, and services, including nacy services, provided by the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		245237	B. WING			l	C 11/2018
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	, <u> </u>	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 838	Continued From pa	ge 85	F8	338			
	facility. Infection Prevention CFR(s): 483.80(a)(F 8	380			2/9/18
	infection prevention designed to provide comfortable enviror	stablish and maintain an and control program as a safe, sanitary and anent and to help prevent the cansmission of communicable					
	program. The facility must es	n prevention and control stablish an infection prevention n (IPCP) that must include, at owing elements:					
	reporting, investiga and communicable staff, volunteers, via providing services u arrangement based	d upon the facility assessment ng to §483.70(e) and following					
	procedures for the but are not limited to (i) A system of survice possible communications before the persons in the facility (ii) When and to who communicable diserreported;	eillance designed to identify able diseases or ey can spread to other					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C		
		245237	B. WING _			_ 11/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP COD 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	to be followed to provide the content with resident with resident contact with resident contact with resident contact will transm (vi)The hand hygie by staff involved in §483.80(a)(4) A sylidentified under the corrective actions to \$483.80(e) Linens. Personnel must ha transport linens so infection. §483.80(f) Annual The facility will contact will transm (vi)The hand hygie by staff involved in §483.80(e) Linens. Personnel must ha transport linens so infection.	revent spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility oyees with a communicable I skin lesions from direct ints or their food, if direct it the disease; and ne procedures to be followed direct resident contact. Istem for recording incidents a facility's IPCP and the caken by the facility. Indle, store, process, and as to prevent the spread of review. Induct an annual review of its heir program, as necessary. Note that is a serie of the contact is not met as evidenced to, interview, and document	F 88	GSS-Sunwood realizes the im have proper hand hygiene and for resident's personal care. P procedure on hand hygiene arwas reviewed in regards with r number 17. To prevent further potential de practice with hand hygiene and	d glove use olicy and nd gloving resident	

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NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
00000	**************************************	, DEDWOOD 54110		2	00 SOUTH DEKALB STREET		
GOOD SA	AMARITAN SOCIETY	- REDWOOD FALLS		R	REDWOOD FALLS, MN 56283		
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F 880	R17's quarterly Mir 11/17/17, indicated required staff assis daily living), and ware R17's current physicontained the followinit/GM (units per buttocks two times). During observation nurses assistant (Noused hand sanitized NA-A went into the grabbed several was ink. NA-A walked door, and picked undisposable wipes, the wet washclothes side of R17's bed. was pulling the con NA-A opened R17' over onto his right brief, a large former observed between fold. NA-A picked upulling some out, a fold using his right soiled wipes into the NA-A using the soiled wipes gluteal fold. NA-A discard soiled wipes gluteal fold. NA-A discard soiled wipes pulled the soiled brit into a ball, and di NA-A then used his pick up a wet wash	nimum Data Set (MDS), dated I R17 was cognitively intact, stance for all ADLs (activities of as always incontinent of bowel. ician orders, printed 1/11/18, wing: Nystatin Cream 100000 gram) apply to groin and	F 8	380	that may affect other residents duri personal resident care. Staff was reeducated on hand hygiene at an Staff meeting on 1/16/18. Learning online education on hand hygiene was completed by January by 1/31/18. Random audits will be completed on observations of staff on hand hygiene during personal care of residents. A will be done by the DNS or designed times a week for 2 months then ewe other week for 1 month. Audit result be reviewed monthly be facility QAI committee for further recommendations.	All center was on ene Audits ee 1 ery lts will	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	COMPLETED	
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	PROVIDER OR SUPPLIER	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP COE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		7.1.1.20.10	
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F 880	applied the cream soiled gloved right gloved hand, place bottom, picked up washed off R17's g soiled gloved right groin. NA-A used open the bedside obody lotion, and aplegs. NA-A then went int soiled gloves; how hands. NA-A donne shirt and pants from R17 to put on pant gloved hands to as the bed. NA-A then put a transfer belt a R17 to stand up. Wup R17 pants. NA-bag, tied it, and pu NA-A then doffed the garbage can. Nahads. NA-A made then picked up gar NA-A carried the sedown the hallway to reached into his possible to be she walked out of the gloves and didn't change gloves and didn't change gloves and change gloves and controlled the sedown were applied the sedown were applied to the sedown were sedown we	container of cream, and to R17's coccyx using his hand. NA-A, using the soiled a clean brief under R17 a clean wet wash cloth, and groin. NA-A continued to use hand to apply cream to R17's the soiled gloved right hand to drawer, picked up a bottle of oplied lotion to R17's back and to bathroom and removed ever, NA-A did not wash his ed clean gloves, picked out m R17's closet, and assisted and shoes. NA-A used his esist R17 to a sitting position on assisted R17 to put shirt on, around R17 waist, and assisted while standing up, NA-A pulled A picked up the soiled laundry to tit on the floor by garbage can, the gloves and placed them in IA-A again did not wash his explores and soiled linen bag, boiled linen and trash bags to the soiled linen room. NA-A bocket and used hand sanitizer of the soiled linen room. 1.1/10/18, at 9:05 a.m. NA-A essed up." NA-A stated he es until after the cream and NA-A stated he forgot to I wash his hands after cleaning A further stated, "Sadly, that's	F 88	30			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	- REDWOOD FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
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F 880	Continued From pa	nge 89	F 880			
F 881 SS=F	director of nursing was for staff to follo procedures, meaning washing hands as a control program a minimum, the follows the includes antibiosystem to monitor at the full program a minimum, the follows.	ey was requested but not chip Program 3) In prevention and control stablish an infection prevention in (IPCP) that must include, at owing elements: Intibiotic stewardship program otic use protocols and a	F 88′	GSS-Sunwood realizes the important have a process in place for antibiotic review in order to determine appropria indications, dosage, duration, and tren	ate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LTIPLE CONSTRUCTION DING		E SURVEY IPLETED
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALLS				STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 881	Continued From paresistance. This has residents who residents include: During review of the program on 1/10/1 registered nurse (Fourmentation that program was identified program lacked program lacked program lacked program lacked program also signs and sympton appropriate antibio patterns identified. Monthly Infection Corresponding Morth Infections, reviewed the following: -April: one urinary identified and treat was taken prior to symptoms were lising.	age 90 ad the potential to affect all 36 ded in the facility. The facility's infection control 8, at 1:15 p.m. with the RN)-B, the facility lacked t an antibiotic stewardship ified. The infection control botocols for prescribing before antibiotic use and antibiotic use by physicians. lacked protocols for review of his, labs, determination of tic use and reporting of any Control Report and hithly Report of Resident d from 4/17 to 12/17, indicated tract infection (UTI) was ed with antibiotic. No culture initiating antibiotic and no ted. ere identified. All were cultured	F 88°	DEFICIENCY)	Policy relation to cient esidents d ing all , ing symptoms is been ing facility's iss. inotic in, dose, c use and in Sor onths then Audit	
	growing the same had antibiotic chan treatmentJuly: five UTI's we and treated with ar results were not lis the antibiotics had -August: three UTI cultured and treate one culture result were not the same continued.	ntibiotics, with two residents organism and two residents ges during the course of the identified. All were cultured ntibiotics; however, two culture ted. There was no indication been reviewed. Its were identified. All were ad with antibiotics; however, was not listed and two had no there was no indication the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C		
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALLS				STREET ADDRESS, CITY, STATE, ZIP CO 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283	•			
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F 881	with antibiotic. The antibiotic had beer october: three UT treated with antibiothospital and one wroom; there was no obtained. The third with antibiotics; ho listed. There was no isted. There was no ibeen reviewed. November: one Utreated with antibiotic and there was no ibeen reviewed. December: two Utreated with antibiotic culture. Neither UT was no indication treviewed. During interview or and the interim direacknowledged the with antibiotic stewnew to the infection process of learning antibiotic stewards stated the facility the notice stewardship, and shack to fellow physically in the facility the notice stewardship, and shack to fellow physically in the facility the notice stewardship, and shack to fellow physically in the facility the notice stewardship, and shack to fellow physically in the facility the notice stewardship, and shack to fellow physically in the facility the notice stewardship, and shack to fellow physically in the facility the notice stewardship, and shack to fellow physically in the facility the notice stewardship, and shack to fellow physically in the facility providers result prior to initial document a reason prior. A facility policy entities the facility policy entitled the facility policy entitled the facility policy entitled the facility is the facility in the facility in the facility is the facility is the facility in the facility is the facility in	n reviewed. ITI was identified and treated re was no indication the	F 8	81				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 881	treatment of infection events associated values instructed each cern November 2017.	hip Plan was to, "Optimize the ons while reducing the adverse with antibiotic use." The policy of the would have a plan by	F 8	81		
F 883 SS=D	CFR(s): 483.80(d)(§483.80(d) Influenze immunizations §483.80(d)(1) Influe policies and proced (i) Before offering the each resident or the receives education potential side effect (ii) Each resident is immunization October annually, unless the contraindicated or the timmunized during the timmunized during the contraindicated or the timmunized during the timmunized during the timmunization or dictimmunization or dictimmunization due to refusal.	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization due to medical contraindications or		83		2/9/18
	must develop polici that-	es and procedures to ensure				

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION ING	COM	(X3) DATE SURVEY COMPLETED	
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F 883	(i) Before offering immunization, each representative received phenefits and poter immunization; (ii) Each resident immunization, unleading to the medically contrain already been immunization, unleading to the resident of the has the opportunit (iv) The resident's documentation the following: (A) That the reside was provided educand potential side immunization; and (B) That the reside pheumococcal impunication of this REQUIREME by: Based on intervie failed to ensure refreceived pheumococcal contraindication of the pheumococcal impunities and the pheumococcal impunities and the pheumococcal impunities and the pheumococcal impunities and the facility of the pheumococcal impunities and the pheumococcal impuniti	the pneumococcal the resident or the resident's eives education regarding the nitial side effects of the soffered a pneumococcal ess the immunization is dicated or the resident has unized; or the resident's representative by to refuse immunization; and medical record includes at indicates, at a minimum, the ent or resident's representative cation regarding the benefits effects of pneumococcal lent either received the munization or did not receive Immunization due to medical or refusal. ENT is not met as evidenced we and record review, the facility sidents were offered and coccal (PPSV23 and PCV13) of 5 residents (R23, R2) who lity.	F8	GSS-Sunwood realizes the offer and receive pneumocoand PCV13) vaccination for Policy and procedure were received to the practice that may affect othe regarding pneumococcal vacfacility reviewed records to deligibility for pneumococcal it those eligible will have conseand offered the vaccine if deadmitted residents records were recorded to the regarding pneumococcal vacfacility reviewed records to deligibility for pneumococcal it those eligible will have conseand offered the vaccine if deadmitted residents records were recorded to the recorded to the vaccine if deadmitted residents records were recorded to the vaccine if deadmitted residents records were recorded to the vaccine if deadmitted residents records were recorded to the vaccine if deadmitted residents records were recorded to the vaccine if deadmitted residents recorded to the vaccine if the vacc	ccal (PPSV23 residents. eviewed for and PPSV23 number 23 3. deficient er residents ecinations letermine their mmunization ent obtained esired. Newly		

AND PLAN OF CORRECTION IDENTIFICATIO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
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GOOD S	AMARITAN SOCIET	Y - REDWOOD FALLS		200 SOUTH DEKALB STREET REDWOOD FALLS, MN 5628	3		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 883	PCV13 pneumood R2's most recent identified he was Review of R2's C 1/9/18, indicated pneumococcal varecord lacked ind PPSV23 pneumo During interview or registered nurse or infection control in the residents who pneumococcal varecord interim director of aware pneumococconcern, further sidirector who had begun to work on IDON reported the looking for vaccing gaps in their vaccing stated she had up residents who we stated they were	quarterly MDS, dated 10/4/17, 74 years old. linical-Immunizations, printed he received PCV13 accine on 1/4/17. R23's medical ication as to whether the coccal vaccine was offered. In 1/10/18, at 1:15 p.m. (RN)-B stated he was new in the ole and had made a report of estill needed the series of accinations. In 1/11/18, at 10:31 a.m. the finursing (IDON) stated she was ccal vaccinations were a stating the interim nursing been there prior to her had updating the vaccinations. The efacility had faxed the clinics eations in order to fill in some cination histories. The IDON odated some, but there were still are missed. The IDON further in the process of getting	F8	reviewed and if eligible, the offered the PPSV 23 and vaccines, orders will be greceived then the vaccine administered as ordered. Audits will be completed a charts looking for consent administration or refusal for PCV13. Audits will be dorn designee 1 time weekly for every other week for 1 may results will be reviewed may QAPI committee for further recommendation.	PCV 13 gotten, consents es will be on random t and for PPSV23 and he by the DNS or or 2 months then onth. Audits honthly by facility		
	of pneumococcal PCV13 or PPSV2 be entering them weekend. During interview or registered nurse (vaccination concerns)	al to administer the second dose vaccinations, whether that be 23, and had a nurse who would into the medical records that on 1/11/18, at 4:28 p.m. (RN)-B was aware of the ern and stated they were him access to MIIC (Minnesota					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
	245237		B. WING			C 01/11/2018		
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALLS				200	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH DEKALB STREET DWOOD FALLS, MN 56283	1 017	11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 883	The facility's policy Residents, dated 9/ recommended that administered in ser	mation Connection) so he had presidents' vaccination history. entitled Immunization for	F8	883				

F9237026

PRINTED: 02/05/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 245237 B. WING 01/16/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 SOUTH DEKALB STREET **GOOD SAMARITAN SOCIETY - REDWOOD FALLS REDWOOD FALLS, MN 56283** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society Redwood Falls was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145

Electronically Signed

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

02/03/2018

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.

TITLE

PRINTED: 02/05/2018 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01				COMPLETED		
	245237		B. WING			01/16/2018			
	PROVIDER OR SUPPLIER	- REDWOOD FALLS		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DEKALB STREET EDWOOD FALLS, MN 56283				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
K 000	and Angela.Kappenmar <mailto:angela.kap 1.="" 2.="" 43="" a="" actual,="" addition.="" and="" be="" beds="" building="" capacity="" codeficiency="" comprevent="" corrorridors="" deficit="" department="" description="" detection="" determined="" facility="" fire="" following="" for="" fully="" good="" has="" in="" info="" is="" mus="" not="" notifical="" of="" or="" original="" plan="" processors="" reoccurred="" responsible="" samaritan="" scone-story="" sprinkler="" survey.<="" td="" the="" time="" to="" vocorrect="" vois="" which="" with=""><td>tate.mn.us itney@state.mn.us> in@state.mn.us ppenman@state.mn.us> RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. If title of the person rection and monitoring to ence of the deficiency. ociety Redwood Falls is a with no basement. The facility is protected, and was if Type II(000) construction. g was constructed in 1962, ons in 1966 and 1975. The alarm system with smoke ridors and spaces open to the monitored for automatic fire tion. The facility has a a and had a census of 34 at 42 CFR, Subpart 483.70(a) is</td><td>KO</td><td>000</td><td></td><td></td><td></td></mailto:angela.kap>	tate.mn.us itney@state.mn.us> in@state.mn.us ppenman@state.mn.us> RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. If title of the person rection and monitoring to ence of the deficiency. ociety Redwood Falls is a with no basement. The facility is protected, and was if Type II(000) construction. g was constructed in 1962, ons in 1966 and 1975. The alarm system with smoke ridors and spaces open to the monitored for automatic fire tion. The facility has a a and had a census of 34 at 42 CFR, Subpart 483.70(a) is	KO	000					

Facility ID: 00063

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALLS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283 PROVIDER'S PLAN OF CORRECTION		
GOOD SAMARITAN SOCIETY - REDWOOD FALLS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283 D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	01/16/2018	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE		
	(X5) COMPLETION DATE	
K 372 K 372 Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls construction that meet the requirements of NFPA 101 - 2012 edition, Sections 19-3.7.3 and 8.6.7.1. (1). This deficient practice could affect 25 of 43 residents by allowing smoke to propagate from one smoke compartment to another. Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for	2/9/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245237	B. WING_		01/	16/2018
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALLS				STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 372	in REMARKS. Findings include: On facility tour betwon 01/16/2018, a power wall above the layismoke barrier. NOTE: All smoke between the smoke barrier.	veen 10:00 AM and 1:00 PM enetration was observed in the n ceiling at the southwest earriers in the Facility need to ure there are no penetrations	K 37	72		
	These deficient pra Facility Maintenand Gas Equipment - Q CFR(s): NFPA 101 Gas Equipment - Q Personnel Personnel concern	ectices were verified by the see Director. Equalifications and Training equalifications and Training of ed with the application,	K 92	26		2/9/18
	cylinders are traine provide continuing guidelines and usar serviced only by permaintenance and of 11.5.2.1 (NFPA 99) This REQUIREMENT of the services of the	andling of medical gases and d on the risk. Facilities education, including safety ge requirements. Equipment is a resonnel trained in the operation of equipment. NT is not met as evidenced Qualifications and Training of ed with the application, andling of medical gases and d on the risk. Facilities education, including safety		Gss-Sunwood staff developmer contacted northwest respiratory, be sending out training material our facility has a trained person medical gases and cylinders. The proposed completion date is Ma	they will so then nel on the ne	

LAND BLAN OF CORDECTION L'ADENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
245237		B. WING			01/16/2018		
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FALLS		200	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH DEKALB STREET DWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE
K 926	serviced only by permaintenance and of 11.5.2.1 (NFPA 99) effect 43 of 43 residents of 43 resi	ge requirements. Equipment is rsonnel trained in the peration of equipment. This deficient practive could dents. DE: ion and documentation 00 AM and 1:00 PM on rentation could not be located if that handle gas cylinders ty training guidelines and s of gas cylinders. ice was verified by the Facility	K 92		2018. Dean Wilson is in charge of monitoring to prevent a reoccurrent the deficiency.	ce of	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 26, 2018

Ms. Haley Amundson, Administrator Good Samaritan Society - Redwood Falls 200 South Dekalb Street Redwood Falls, MN 56283

Re: State Nursing Home Licensing Orders - Project Number S5237025 and H5237013

Dear Ms. Amundson:

The above facility was surveyed on January 8, 2018 through January 11, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5237013. that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

Good Samaritan Society - Redwood Falls January 26, 2018 Page 2

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathleen Lucas at (320) 223-7343 or email: kathleen.lucas@state.mn.us.

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

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

Please feel free to call me with any questions.

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 Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

cc: Licensing and Certification File

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION i:		(X3) DATE SURVEY COMPLETED		
		00000	B. WING			C	
		00063	B. WIIVO		01/	11/2018	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FAL	ET ADDRESS, CITY,	STREET			
		RED	WOOD FALLS, N	IN 56283			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000				
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issue y. If, upon reinspection, it iency or deficiencies cited ected, a fine for each violatible assessed in accordancines promulgated by rule cartment of Health.	d is ion e				
	Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.						
	that may result from orders provided tha the Department with	hearing on any assessment n non-compliance with the ta written request is made thin 15 days of receipt of a nt for non-compliance.	se				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electroning nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfore licensing orders are	th				

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 02/03/18

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00063		B. WING			C 11/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FAL	200 SOUT	DRESS, CITY, S TH DEKALB : D FALLS, M			
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2 000	Department of Hearyou electronically, is necessary for State neter the word "corn text. You must then State licensure proceed of the Minnesota Department's staff, the following correct Please indicate in your correction that you and identify the date. In addition, a completed at the tin An investigation of completed. The corn at a licensing order. Minnesota Department he State Licensing federal software. The assigned to Minneson Nursing Homes. The assigned tag in column entitled "ID statute/rule out of completed of the Torrection order. The findings which are in after the statement, evidence by." Follow	Althorders being substantial Although no plan of late Statutes/Rules, prected" in the box avaindicate in the electroess, under the header date your orders welectronically submitting and of Health. 1/11/18, surveyors of visited the above protion orders are issued our electronic plan of have reviewed these when they will be of the licensing substantial was not substantial to the licensing in the lic	correction olease vailable for ronic ding vill be ng to the of this covider and ed. of e orders, completed. as also urvey. B was stantiated umenting using en eles for the testatute et as indings	2 000			

Minnesota Department of Health

STATE FORM 6899 KZFT11 If continuation sheet 2 of 53

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY
,	o. oo.u.20		A. BUILDING:			
		00063	B. WING		01/1	1/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD ΕΔΙ	TH DEKALB DD FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ige 2	2 000			
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC	ARD THE HEADING OF THE N WHICH STATES, IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF TE STATUTES/RULES.				
2 560	MN Rule 4658.040 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			2/9/18
	Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).					
	by: Based on interview failed to ensure cor included medical ne	ent is not met as evidenced and record review, the facility apprehensive care plans which eeds were developed for 1 of 5 o were reviewed for cations.		Corrected		
	Findings include:					
	10/18/17, identified impairment, a diagi	inimum Data Set (MDS), dated a moderate cognitive nosis of Diabetes Mellitus, and apy due to a hip fracture. The				

Minnesota Department of Health

STATE FORM 6899 KZFT11 If continuation sheet 3 of 53

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NI		` ′	E CONSTRUCTION		E SURVEY PLETED
		00063		B. WING			C 11/2018
	PROVIDER OR SUPPLIER	- REDWOOD FAL	200 SOUT	DRESS, CITY, S TH DEKALB S DD FALLS, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 560	MDS further identification bowel with no sympadmission Care Are 10/18/17, indicated hip surgery, using symedications. R22's current physical identified the follow -Lantus SoloStar Symorning for Diabeter -Prednisone (steroical increase blood sugataper down to 1 mg -Polyethylene Glycotwice a day for consumers a day for pair -Tramadol (pain relievatimes a day for pair -Tramadol (pain relievating 1-5 and 2 tab hours as needed. In addition, R22's purchase ther blood sugataper than 200, in units. R22's physician considentified her Lanture admission of the consumers in the consumer	ied R22 was contined by the storms of constipations and assessments (CA she had pain after head and as new the scheduled (Miralax laxative) and (Miralax laxative) astipation. In the scheduled and as new the scheduled and	n. R22's AA), dated her recent eeded pain I/11/18, units in the can b) daily to ure. 17 gram s three et for pain o every 6 cted to and at and if lin by 5 and orders ed twice	2 560	DEI IOIEINO I		
	R22's physician not indicated the follow - On 10/27/17, note bowel movements a further noting she a suppositories.	tes were reviewed a	ase in her ⁄liralax, as and				

Minnesota Department of Health

STATE FORM 6899 KZFT11 If continuation sheet 4 of 53

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00063		B. WING			C 11/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS CITY S	STATE, ZIP CODE	1 0	
				H DEKALB			
GOOD S	AMARITAN SOCIETY	- REDWOOD FAL		D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 4		2 560			
2 560	being constipated," medication was ord R22's current care placked diagnoses, go Diabetes Mellitus wassociated hypergly bowel status with systreatment of post op During interview on registered nurse (R could revise or updastating they had staweekly with an intershort stay residents usually contained a and noted if a reside she acknowledged the diagnosis and in R22 had not presenadmission, but had the pain medication had also mentioned after admission. RN toileting plans and of the care plan, noting mentioned her blad When asked if bow were typically care plans.	and another laxative ered. plan, last revised 1/3 poals, and interventifith Prednisone use a predict of the prednisone use and prednisone use an	3/18, ons for her and sugar), ation, and n. he nurses rther plans DT) for are plan res Mellitus nowever, as missing eported n on his due to 22's family ssues resident ere put on hly atus. stipation rted, "It will	2 560			
	in the future." RN-A care plan did not ad the care plan to add with the pain level a interventions of adn ordered, offering alt repositioning, and n increased pain and	further acknowledge dress pain; she would ress a goal to be confirmed from the function of the	ed R22's uld expect omfortable ng with the ons as e pack or of n.				

Minnesota Department of Health

STATE FORM 6899 KZFT11 If continuation sheet 5 of 53

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			;
		00063	B. WING		1	1/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	H DEKALB D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	interim director of reconcerns with the constipation marked when she got uthe pain killers help tried ice packs but had a wind a further stated the fareviews of the care the facility, further radding quality mea IDT care plan reviews tarted the week properties that the week properties that the insulin where the prediction of the predi	nursing (IDON) was aware of care plans and charting, noting plans were current, basic etting done, and skilled being charted on. The IDON curse working on getting the steet that weekend. The IDON acility was not documenting plans prior to her coming to noting she had implemented sure questions into the weekly ws, a process they had just rior. 1.1/11/18, at 12:35 p.m. R22 was a new medication she had surgery while she was taking ating the hip surgery had wis. R22 further stated she had hisone would help with healing, her bowels were, "Not very gets constipated easily and had ne previous day. R22 stated and pain, which could be real up; however, further reported bed a lot. R22 reported she had didn't think they helped.	2 560			

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00063	B. WING		01/1	1/2018	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	TH DEKALB D FALLS, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 560	Continued From pa	nge 6	2 560				
2 830	director of nursing educate staff to derincludes appropriat all identified care nauditing could be eongoing and effectito resident care neutron to the end of the end	R CORRECTION: Twenty One 0 Subp. 1 Adequate and	2 830			2/9/18	
	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced						
	by: Based on observat review, the facility f	ion, interview, and document ailed to ensure oxygen consistently monitored for 1 of		Corrected			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY
						5
		00063	B. WING		01/1	11/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	TH DEKALB DD FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 7	2 830			
	1 residents (R238)	reviewed for oxygen.				
	Findings include:					
		eport indicated, on 1/4/18, enza due to unidentified other respiratory				
	order, dated 1/5/18	sicians orders identified an , for " O2 (oxygen) to keep eater than 90% (percent)."				
	and treatment adm	administration record (MAR) inistration record (TAR), for nentation of oxygen use or				
	R238's care plan, dated 1/6/18, directed to assess for shortness of breath and cyanosis (appearance of a blue or purple discoloration of the skin). The care plan lacked identification of oxygen use and interventions related to oxygen use or non-compliance.					
	identified R238 was	p.m. vital sign documentation s on oxygen (lacked flow rate). 96% via nasal cannula.				
	indicated R238 was	p.m. vial sign documentation s on oxygen (lacked flow rate) R238's oxygen saturation was				
	indicated oxygen a	ted 1/7/18, at 11:30 a.m. t 2 liters (liters/min) via nasal e to make needs known.				
ı		ted 1/8/18, at 12:03 p.m. s alert and able to make needs				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00063		B. WING			C 11/2018
	PROVIDER OR SUPPLIER	- REDWOOD FAL	200 SOUT	DRESS, CITY, S TH DEKALB : D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	known. Uses Oxyge cannula. R 238's m documentation of a 1/8/18. A progress note data indicated R238 had Regular, easy respin During observation was laying in bed. A located next to the loff. The nasal cannuthe concentrator was room. The oxygen to asked when the oxygen to asked when the oxygen to asked when the nurs R238 stated he didutimes. R238 was not ubing was not date. A progress note, daindicated R238 was Will use call light for During observation was sitting on the seating lunch. R238. R238's medical recan oxygen saturation determine if R238's physicians order on documentation of the record from addocumentation of Rubing.	en at 2 L (liters) via redial record lacked noxygen saturation at d. 1/9/18, at 6:47 at O2 at 2L via nasal or rations. on 1/9/18, at 11:15 at Oxygen concentrated of the bed was ula, which was connected as laying on the reclinations was used, R23 e pokes her head in take the oxygen tubort short of breath. The d.	level on .m. cannula. a.m. R238 ator turned ected to ner in the I. When 8 replied, here." ing off at ne oxygen a.m. pleasant. p.m. R238 endently kygen. atation of g to 90% per lacked f oxygen. cked kygen a.m. R238	2 830			

Minnesota Department of Health

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:			LLTLD
		00063	B. WING			C 11/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
COOD S	AMARITAN SOCIETY	REDWOOD FAL 200 SOU	TH DEKALB	STREET		
GOOD 3	AWARITAN SOCIETY	REDWOOD FAL REDWOO	DD FALLS, M	N 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	age 9	2 830			
	was on and set at 2 receiving oxygen.	2L, however; R238 was not The nasal cannula was laying the bed. R238 did not appear				
		a.m. vital sign documentation n saturation of 96%. Oxygen				
	R238 was sitting in his feet elevated. Ton, and R238 was cannula at 2L/min. shortness of breath especially today." Fishort of breath earl administration, R23 tubing." "If I could f	on 1/10/18, at 11:28 a.m. the recliner in his room with the oxygen concentrator was receiving oxygen via nasal When asked if he experienced n, R238 replied, "Yeah, R238 went on to say he was lier. When asked about oxygen as stated he, "Loses the ind the darn thing, I would put ng continued to be undated.				
	licensed practical nation concentrators are uportable oxygen tail resident's room. LF at 2 liters. R238's obe kept above 90% monitor R238's oxyobtain daily oxygen stated R238 would tubing off. When thoxygen cannula bathat day, she had preceded the result of the result	n 1/10/18, at 11:34 a.m. nurse (LPN)-A stated oxygen used in resident rooms and nks are used outside of the PN-A stated R238 used oxygen oxygen saturations needed to b. When asked how staff ygen, LPN-A replied that staff a saturations readings. LPN-A sometimes take his oxygen tat happened, staff put the ck on. LPN-A stated earlier out the oxygen cannula back on toff. LPN-A stated the day oxygen tubing weekly on The tubing is dated when uesday was on 1/9/18. R238's nged, as R238 had not resided week on 1/9/19. LPN-A stated				

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE : COMPL	
			A. BUILDING.		C	
		00063	B. WING			, 1/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	TH DEKALB : DD FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	 age 10	2 830			
	R238's tubing shou	ıld be dated, but was not.				
	registered nurse (R order directed to ke 90%. Staff were to saturation levels at administration was TAR. RN-A stated F not contain docume administration. The monitoring of oxyge monitoring on 1/8/1 use, as well as inte care plan. RN-A stainclude oxygen their non-compliance.	e record was inconsistent with en saturations levels, missing 18 and 1/9/18. R238's oxygen erventions, should be on the ated R238's care plan did not rapy or interventions related to				
	interim director of n resident had an ord were to monitor the each shift and as n to obtain an oxyger resident was found tubing. Oxygen use	n 1/11/18, at 12:34 p.m. the nursing (IDON) stated when a der for continuous oxygen, staff e oxygen saturations levels eeded. Additionally, staff were n saturation reading when a to have removed the oxygen e was to be addressed on the en tubing should be dated and				
	Nasal Cannula, Factorial Nasal Cannula, Factorial National Nationa	Oxygen Administration with ce Mask or Face Tent, dated e procedure for oxygen e process included: verify Observe for signs of ia, dyspnea, confusion, and restlessness. For resident gen therapy, give oral. nasal ours. Observe resident for a therapy and for any adverse able equipment should be				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY PLETED		
		00063		B. WING			C 11/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FAL	200 SOUT	DRESS, CITY, S TH DEKALB D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 830	changed weekly, or instructions, and managed weekly, or instructions, and managed. Items are changed. Started, type of admitted time when oxygen to resident's reaction and on the progress.	r according to manufarked with date and or eAdmin note when Record when oxygeninistration used, flowanks are changed. Eand tolerance to therepriate on the MAR or so that the marked in the MAR or the marked in the MAR or the marked in the ma	initials. In these In therapy In therapy In therapy In therapy In therapy In therapy In the and In	2 830			
	Director of Nursing review and revise p regarding the assest documentation of a DON or designee c policies and proced to ensure complain could review and regarding oxygen u monitoring oxygen compliance with oxygen with oxy	THOD OF CORRECT (DON) or designee of colices and procedure sament, monitoring, a change of condition ould educate staff or lures, and audit residuce. The DON or desivise policies and prose, edcuate staff on levels, and audit for gyen order.	could es and The the lent charts gnee ocedure				
2 895	MN Rule 4658.0528 Motion Subp. 2. Range of that is directed towa through positioning implemented and motion comprehensive resof nursing services	motion. A supportive and prevention of defeand range of motion naintained. Based or ident assessment, the must coordinate the ursing care plan whice	e program ormities must be n the ne director	2 895			2/9/18

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00063		B. WING			C 11/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAL		TH DEKALB			
				D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 12		2 895			
	provides that:						
	receives appropriat	h a limited range of it e treatment and serv notion and to preven of motion.	ices to				
	by: Based on observati review, the facility fa nursing for 4 of 4 re reviewed for mobilit	ent is not met as evi on, interview, and re ailed to provide resto esidents (R17, R19, I y. This had the pote dents who had theral grams.	cord orative R7, R1) ntial to		Corrected		
	Findings Include:						
	identified a primary left hip, displaced ir femur, subsequent	eport, printed 1/11/18 admitting diagnosis ntertrochanteric fract encounter for closed , muscle weakness,	of pain in ure left I fracture				
	11/17/17, identified	imum Data Set (MD no cognitive impairn tance for ambulation	nent and				
	Program dated 4/14	aintenance Restorat 4/17, identified exerc x/wk [five times a we	ise and				
	R17 needed restora weakness. R17 will standing tolerance interventions includ	st reviewed 12/27/17 ative intervention due improve current leve by next review date. ed: "Nursing rehab: nes]/day with FWW [e to el of Identified Ambulate				

Minnesota Department of Health

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00063		B. WING			C 11/2018
	PROVIDER OR SUPPLIER	- REDWOOD FAL	200 SOUT	DRESS, CITY, S TH DEKALB : D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 895	wheeled walker], C W/C [wheelchair] to Scifit [a type of exe Seated bilateral leg green band pull bac [repetitions]each." R17 physician prog identified has pain i leg, stated he really R17's medical reco restorative nursing implemented, and of During observation was sitting in his wh his room. No offers observed. During observation self propelled in his towards the dining of During interview on therapist (PT)-A sta restorative walking stated since then he ambulation due to in hip. PT-A stated R1 apprehension with p ambulation. PT-A s nursing may chang program as needed let physical therapy expect that ambula documented if refus	GA [care giver assist] of follow PRN [as need recise bike] level 3 PR kick, green band kneed, 2 x 10 REPS ress note, dated 12/2 n hip and radiates do redoes not walk. rd lacked evidence the program was being devaluated. on 1/09/18, at 10:03 neelchair in the hallward of ambulation by stated and the room. 1/09/18, at 3:27 p.m. ted R17 had been or program since 4/17. The has had a decline in the hall was a decline in the room. 7 had increased pain in his land the reduced with residents res	ded], iN, ees apart, 20/17, own his nat the offered, a.m. R17 ay outside ff were b.m. R17 c hallway c physical n a PT-A n legs and ed efusal, e walking ecessarily ed would	2 895			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				71. BOILDING.			c
		00063		B. WING			11/2018
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAL		TH DEKALB D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 895	Continued From pa	ige 14		2 895			
	further stated staff	had not offered ambu	ulation.				
	licensed practical na restorative walkin observed mainly in she would expect severyday and docu stated if walking isr to charge nurse whit could be followed ability to walk. LPN back to 12/20/17 at R17 had been offer During interview on registered nurse (R restorative aides ar would not receive reviewed R17's me	a 1/10/18, at 11:38 a.r. urse (LPN)-C stated by program, but today the wheelchair. LPN taff at least offer to we ment resident's refus o would report to phy up on, so no decline -C stated she reviewed found no document red restorative rehability. A stated when the enot working, R17 prestorative intervention dical record and did or goals in his medical rative program.	R17 had / was -C stated valk sal. LPC-C e reported / sician, so e in his ed notes ntation bilitation.				
	•						
	no cognitive impair identified R19 had	S, dated 11/20/17, id ment. The MDS furth an active diagnosis o eft sided hemiparesis	er of				
	R19 had limited phy history of stroke an of mobility. Interver	st review 12/28/17, in ysical mobility related d would maintain cur ntions identified: "Aml 5'[feet] with CGA, gai	to a rent level bulation				

Minnesota Department of Health

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MAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALL (A) ID PREERI (EACH DEPICIENCY MUST BE PRECEDED BY PLUL PREERI PREERI (EACH DEPICIENCY MUST BE PRECEDED BY PLUL PREERI PREERI (EACH DEPICIENCY MUST BE PRECEDED BY PLUL PREERI PREERI (EACH DEPICIENCY MUST BE PRECEDED BY PLUL PREERI PREERI (EACH DEPICIENCY MUST BE PRECEDED BY PLUL PREERI PREERI (EACH DEPICIENCY MUST BE PRECEDED BY PLUL PREERI PREERI PREERI (EACH DEPICIENCY MUST BE PRECEDED BY PLUL PREERI PREERI PREERI PROVIDERS PLAN OF CORRECTION PREERI PREERI PREERI PREERI PREERI PROVIDERS PLAN OF CORRECTION PREERI PREERI PREERI PREERI PREERI PROVIDERS PLAN OF CORRECTION PREERI PROVIDERS PLAN OF CORRECTION PREERI PREERI PREERI PREERI PREERI PROVIDERS PLAN OF CORRECTION PREERI PREERI PREERI PREERI PREERI PROVIDERS PLAN OF CORRECTION PREERI PREERI PREERI PREERI PREERI PROVIDERS PLAN OF CORRECTION PREERI PREERI PREERI PREERI PREERI PROVIDERS PLAN OF CORRECTION PREERI PREERI PREERI PREERI PREERI PROVIDERS PLAN OF CORRECTION PREERI PREERI PREERI PREERI PREERI PROVIDERS PLAN OF CORRECTION PREERI PREERI PREERI PREERI PREERI PROVIDERS PLAN OF CORRECTION PREERI PREERI PREERI PREERI PREERI PROVIDERS PREERI PROVIDERS PREERI PROVIDERS PREERI PROVIDERS PREERI PROVIDERS PLAN OF CORRECTION PREERI PREERI PREERI PREERI PREERI PROVIDERS PREERI PROVIDERS PREERI PROVIDERS PREERI PROVIDERS PREERI PROVIDERS PREERI PROVIDERS PLAN OF CORRECTION PREERI PREERI PROVIDERS PLAN OF CORRECTION PREERI PREERI PREERI PROVIDERS PLAN OF CORRECTION PREERI PREERI PREERI PREERI PROVIDERS PREERI PROVIDERS PREERI PREERI PROVIDERS PLAN OF CORRECTION PREERI PREERI		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION N		` ′	E CONSTRUCTION		SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - REDWOOD FALL (XA) ID (XA) ID (PA) ID (71. BOILDING.			c
COOD SAMARITAN SOCIETY - REDWOOD FAL CACH DEPCIENCE CRACH DEFICIENCY MUST BE PRECEDED BY FULL FREE CROSS-REFERENCED TO THE APPROPRIATE DATE PROVIDENS PLAN OF CORRECTION (EACH CORRECTIVE ACTION HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE PROVIDENS PLAN OF CORRECTIVE ACTION HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE			00063		B. WING			
REDWOOD FALLS, MN 56283 CALL CA	NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 895 Continued From page 15 single point cane daily and PRN. Likes to ambulate to meals to tolerance, SBA [stand by assist] of one and bring the w/c [wheelchair] behind." Also identified, R19 needed restorative intervention due to limited physical mobility related to CVA [cerebrovascular accident] left side weakness. Identified interventions included: R19 should perform Scifft[exercise bicycle] at level 5 up to 10 minutes 2-3 times per week. Leg press resistance 150 lbs[pounds]2 x 10 3 x/ [times]week. A physician progress note, dated 8/17/17, identified R19 was getting around fairly well, used a cane to walk around despite left sided hemiparesis. R19's goal was to look into handicapped apartment. This will be very reasonable. R19's progress note, dated 8/23/17, indicated continued weight gain is a concern, his activity level has decreased as he does not walk to diner as he did in the past. R19's progress note, dated 12/30/17, physical therapy order clarification to discharge form physical therapy to SNF[skilled nursing facility]. R19's medical record lacked documentation that ambulation and restorative nursing programs were being offered, implemented, and evaluated. During interview on 1/9/18, at 3:27 p.m. R19 stated he hadnot seen the restorative aids eaff for a couple of weeks. R19 further stated he had not seen the restorative aids eaff for a couple of weeks and	GOOD S	AMARITAN SOCIETY	- REDWOOD FAL					
single point cane daily and PRN. Likes to ambulate to meals to tolerance, SBA [stand by assist] of one and bring the wic [wheelchair] behind." Also identified, R19 needed restorative intervention due to limited physical mobility related to CVA [cerebrovascular accident] left side weakness. Identified interventions included: R19 should perform Sciffigexercise bicycle] at level 5 up to 10 minutes 2-3 times per week. Leg press resistance 150 lbs[pounds]2 x 10 3 x/ [times]week. A physician progress note, dated 8/17/17, identified R19 was getting around fairly well, used a cane to walk around despite left sided hemiparesis. R19's goal was to look into handicapped apartment. This will be very reasonable. R19's progress note, dated 8/23/17, indicated continued weight gain is a concern, his activity level has decreased as he does not walk to diner as he did in the past. R19's progress note, dated 12/30/17, physical therapy order clarification to discharge form physical therapy to SNF[skilled nursing facility]. R19's medical record lacked documentation that ambulation and restorative nursing programs were being offered, implemented, and evaluated. During interview on 1/9/18, at 3:27 p.m. R19 stated he hadn't been walking the past couple of weeks. R19 further stated he had not seen the restorative aide staff for a couple of weeks and	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY	Y FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
During interview on 1/9/18, at 3:30 p.m. PT-A	2 895	single point cane da ambulate to meals assist] of one and behind." Also identi intervention due to related to CVA [cere weakness. Identifies should perform Sci up to 10 minutes 2-resistance 150 lbs[[times]week. A physician progresidentified R19 was a cane to walk around hemiparesis. R19's handicapped apartire asonable. R19's progress not continued weight galevel has decrease as he did in the passible. R19's progress not the rapy order clarifiphysical therapy to R19's medical recombulation and residential weeks. R19 further restorative aide stano one else had off	aily and PRN. Likes to tolerance, SBA [storing the w/c [wheeld fied, R19 needed relimited physical mode brovascular accide and interventions included interventions and states are also as times per week. Lipounds [2 x 10 3 x/states are also as note, dated 8/17/states are also as note, dated 8/17/states are also as note in the pounds are also as note in the pounds are also as note in the pounds are also as a concern, his das he does not was ast. The pounds [2 x 10 3 x/states are also as note in the pounds are also as note in the pounds are also as a concern, his das he does not was ast. The pounds [2 x 10 3 x/states are also as a concern, his das he does not was ast. The pounds [2 x 10 3 x/states are also as a concern, his das he does not was ast. The pounds [2 x 10 3 x/states are also as a concern, his das he does not was ast. The pounds [2 x 10 3 x/states are also as a concern, his das he does not was ast. The pounds [2 x 10 3 x/states are also as a concern, his das he does not was ast. The pounds [2 x 10 3 x/states are also as a concern, his das he does not was ast. The pounds [2 x 10 3 x/states are also as a concern, his das he does not was ast. The pounds [2 x 10 3 x/states are also as a concern, his das he does not was ast. The pounds [2 x 10 3 x/states are also as a concern, his das he does not was as a concern, his das he does not was as a concern, his das he does not was as a concern, his das he does not was as a concern, his das he does not was as a concern, his das he does not was a concern, his das he does not wa	tand by chair] storative bility nt] left side ided: R19 at level 5 eg press 17, well, used door, well, used activity lik to diner facility]. cation that grams evaluated. R19 couple of een the eks and	2 895			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FAL	200 SOUT	DRESS, CITY, S TH DEKALB : D FALLS, M		•	2 2
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM.	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 895	and should be walk he could tolerate. R a stroke and if he w care manager should be used to be care manager should	ing everyday to break 19 had limited mobilizes not ambulating, to a solution of the limited mobilizes and ambulating, to a solution of the limited materials and the limited materials are storative and the limited materials are storative and stated the limited materials are storative programs of the limited materials. In the limited materials are storative programs of the limited materials are storative programs	lity due to the RN d. m. LPN-C e staff. re walking walk him to as pushed ling. n. RN-A not received d R19's ere was no being PS), dated nt, aff to walk per or rations.	2 895			
	R7's quarterly MDS she continued to re one staff with mobil her room or outside assessment period.	y (OT) and physical dated 10/18/17, incomplete extensive assisty, but had not ambe her room during the nor had she receive the assessment per	dicated stance of ulated in e ed OT or				
	Summary, dated 10	hysical Therapy Disc 0/5/17, indicated R7 on increasing bilat	had been				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00063	B. WING			1/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	TH DEKALB : DD FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	discharge summary goals of therapy and skilled therapy interpatient's overall deterfore slowed putherapy goals. Patie will be appropriate intervention once the stable. Ath [sic] this to DC [discharge] to program] to be performaintain therapy goals. Functional Maintent were reviewed for Formaintain therapy goals. The stable of the stable	and transfer ability. The y noted R7 did not meet the id, "Patient is discharged from evention at this time due to cline in health status and rogress towards functional ent referred to neurologist and for further skilled therapy ne patient is more medically at time the patient is appropriate to RNP [restorative nursing formed on a daily basis to	2 895			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
					С	
	00063				01/11	/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COOD C	AMADITAN COCIETY	DEDWOOD FAL 200 SOUT	H DEKALB	STREET		
GOOD SAMARITAN SOCIETY - REDWOOD FAL REDWO			D FALLS, M	N 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 18	2 895			
	nursing program wa and evaluated.	d lacked evidence a restorative as being offered, implemented, s on 1/9/18, from 10:35 a.m. to				
	3:45 p.m. R7 was c	consistently in her room and no program was provided.				
	11:30 a.m. R7 was	s on 1/10/18, from 7:30 a.m. to consistently in her room and ng program was provided.				
	12:02 p.m. R7 was	s on 1/11/18, from 7:36 a.m. to consistently in her room and ng program was provided.				
	During interview on 1/9/18, at 10:41 a.m. R7 stated she felt weaker especially in her hands and legs, noting staff used to walk with her, but didn't do that anymore and now used the sit to stand lift to transfer her. R7 stated she was seeing a neurologist for her weakness and foot drop.					
	therapist (PT)-A state October due to new stated R7 had had decline very quickly discharged her from something more se R7 to a neurologist discharged from the to walk, and staff us safety. PT-A reported home ROM exercise and with a restoration reported recommend in the state of	1/9/18, at 3:02 p.m. physical ated she had seen R7 in a conset right foot drop. PT-A a very significant functional a while in therapy, and she had an therapy thinking there was brious going on and referred a PT-A stated, when R7 was erapy, she was no longer able sed the sit to stand lift for ed she had discharged R7 with ses that R7 could do herself we bike program. PT-A further anded restorative programs urse case manager (registered				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C			E CONSTRUCTION	(X3) DATE	SURVEY
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		00063		B. WING			C I 1/2018
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GOOD SAM	MARITAN SOCIETY	- REDWOOD FAI		H DEKALB : D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
r covociti c	chart. PT-A observed would've expected a considering R7 had herapy. PT-A state changed to needing would have declined in several nickes, further report aide with her while work are if the restored he programs. During interview on assistant (NA)-G was program, stating shat one time, but does a condition of the programs of the program	put them in the electrored R7 in her room, statical decline in mobility, a rapid decline while ind, if R7's transfer ability, the full body lift, then so d. PT-A reported she haursing aides on the resting R7 needed a restore on the Scifit bike. PT-A rative aides were comparting R7 at 9:30 a.m. not as unaware of R7's reste was on a walking proper walk anymore. 1/11/18, at 8:21 a.m. N)-A reviewed R7's meledged she did not have	ing she in / she ad torative rative was pleting torative agram edical e a sis of tified did not tations. Atted R1 ue to the rance day or "The iors of	2 895			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:				
		00063		B. WING		I	C 11/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FAL	200 SOUT	DRESS, CITY, S TH DEKALB : D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 895	nursing splinting profacility] where pt [patermROM [range with added focus or Functional Maintens were reviewed for F-On 1/25/17, a new recommended. The joint contractures a wheelchair." R1 pro ROM to both arms a-On 8/4/17, a change was recommended "decrease risk of cowas changed to incesplint at night. R1's current care plidentified an ADL deand identified the nointervention to supply wheelchair," however addressed intervention to supply wheelchair, however addressed intervention and transition assistant (NA)-F and her room and transition a	ogram at SNF [skille atient] will reside long of motion] program in hand ROM." ance Restorative Program at a coverall goal was to a coverall goal was to and support midline program included daily and both legs. The overall goal was to a contractures." R1's program included the contractures. The program included the contractures of the restorative and support midline posture in the standard program includes the left of the coverall goal was contractures. The program include wearing the left of the coverall goal was contractured in the coverance of the nursing rehalt the standard program. It is a contractured in the coverance of	ograms e following: was , "Prevent oosture in passive program as to, ogram t hand 18, assistance in ofood. The mobility, ROM ed, and nursing back to Broda	2 895	DEFICIENC	2Y)	
	were observed duri observed to be clen provided by NA-F o directly after observ	Ichair) into bed. No bed ing transfer. R1's had inched in fists. No RC r NA-G. When intervation, NA-F stated stative program for R	nds were OM was viewed she was				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION N		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
				A. BOILDING.			С
		00063		B. WING			11/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI		H DEKALB			
	AMARTAN GOGILTT	- REDWOOD I AL	REDWOO	D FALLS, M	N 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 21		2 895			
	was currently on a I the restorative aide	s completed ROM.					
	hand. OT-A stated s ROM program for c stated the restorative written up and given (DON), stating thera restorative binder. Obinder for R1's ROM for August stating the comprehensive." Of	pist (OT)-A stated she for a decline in ROM she had discharged contractures prevent by recommendations in to the director of napy also kept a copy OT-A looked in the rown program, couldn't ne binder, "Isn't all T-A looked at R1's Fary and stating it worved R1's hands, whas lying in bed. OT-A stating there was roted NA-I was a train to consistently compowever, OT-A further	In R1 left R1 to a ion. OT-A s were ursing in their estorative find one ROM ould still be nich were was able no decline ned bleted				
	During interview on registered nurse (R record and acknowl restorative ROM pro	ledged she did not h	medical				
		ursing (IDON), when restorative nursing You won't find any." rative programs were but they currently dive programs in place ille ago the restorative tof their restorative.	n asked ig The IDON e in their d not have e. The ive aides roles due				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM		, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY
				A. BOILDING.			
		00063		B. WING			11/2018
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI		H DEKALB D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 895	facility was in the prassistants to complete practical nurse (LP) binder with resident the facility had two NA-H. LPN-A state working; however, NA-I was on vacatic completed restorationally two who had be equipment. During interview on stated there were the NA-H. NA-G stated went through the restorative aide and would get pulles stated they weren't depended on how had had been developed on the restorative process of the restoration process of the restorative process of the restoration process of the r	rocess of training nursilete the restorative products of 1/10/18, at 8:14 a.m. N)-A stated therapy hats' restorative program restorative aides, NAdusually one of them that was NA-H's day on. When asked who ive programs when NAPN-A reported they were trained on the restorative training. NAs also helped out on the day on. When asked who ive programs when NAS also helped out on the day were the only two pulled everyday, just ousy they were. NA-Gon. When asked who ive programs when NAS pulled to the floor, NAS were the only ones to programs.	licensed ad a ns and land was off and A-I and ere the storative NA-G NA-I and o who -G stated he floor . NA-G stated A-I and arined to arined to uring the for the ner NA-I 1/11/18. RN-A, stated	2 895			

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLII		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NU	JIVIDER.	A. BUILDING:		COIVIF	PLETED
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NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	200 SOUT	H DEKALB	STREET		
	AMARITAN GOOLIT	- KEDWOOD I AL	REDWOO	D FALLS, M	N 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 23		2 895			
	formal programs in evaluated. RN-A state only two aides train equipment, while the some of the walking stated, when therap recommendations, ended up on her dedesk to put into the RN-A went on to stain the time she had all recommendation reported the restoration pulled to the floor, but them being pulled or reported the facility for completing and programs, further reall staff doing the programs.	some of the recomness and some on the electronic medical rate there had been for been there, so was as were entered. RN ative aides were still out it was getting betone to two days less, was working on the evaluating the restore eporting ideally they rograms. RN-A ackness restorative programs.	gress was were the ative Ve do nes." RN-A nendations DON's ecord. our DON's not sure if -A being ter with RN-A process rative would like owledged,				
	A facility policy entit dated 6/12, directed restorative nursing based on individual problems as define The restorative care residents nursing of directed the goal of to maintain indeper SUGGESTED MET The Director of Nur ensure residents will identified and providents.	led Restorative Nursid, "Each resident will care to the extent postrengths, needs and in nursing assessment will be outlined in the plan." The policy restorative nursing and ance and prevent of the control of the con	receive ossible, and ments. he further would be decline. TION: nee could are to prevent				

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abilities. The DON or designee could give

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED
		00000			0444	
		00063			01/1	1/2018
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, \$ TH DEKALB	STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - REDWOOD FAI			D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 24	2 895			
	education and perfo compliance with res	orm audits to ensure storative programs.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
2 900	MN Rule 4658.0529 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			2/9/18
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	rho has pressure sores y treatment and services to revent infection, and prevent yeloping.				
	by: Based on observati review, the facility for assessment and m	ent is not met as evidenced ion, interview, and document ailed to provide consistent onitoring of a pressure ulcer (R28) reviewed for pressure		Corrected		
	Findings include:					
		nission minimum data set 28 required extensive				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(3) DATE SURVEY COMPLETED			
		00063		B. WING			C 01/11/2018	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FAL	200 SOUT	DRESS, CITY, S TH DEKALB : D FALLS, M				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 900	have a pressure ulder pressure ulcer developmental Status indicated relieving device in the reducing mattress. Turn and reposition of the A 12/20/17 Wound developed a stage of with exposed dermic coccyx. Physician in care plan updated. documentation of mulcer characteristics on 12/20/17 the result and the care plan. R28's physician or developed a stage of the care plan. R28's physician or developed a stage of the care plan. R28's physician or developed a stage of the care plan. R28's physician or developed a stage of the care plan.	of for bed mobility. Rater, but was at risk for belopment. A Brief Interest at a score of 6, sent. The pressure ulcers, inition interventions of a proper the chair and pressure the resident every 2 and the resident every 2 and the pressure ulcer to notified of pressure unteressure unteressure unteressure unteressurements and pressurements and pressurements and pressurements and pressure was at risk pressurements and pressurements and pressure was at risk pressurements and pressurements and pressurements and pressurements.	tiated ressure re ed staff to hours. httified R28 skin loss the licer and ressure ressure dated to ressure ressure dated to ressure ressure dated to ressure dated to ressure ressure	2 900				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE S COMPL			SURVEY PLETED			
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	PROVIDER OR SUPPLIER	- REDWOOD FAL	200 SOUT	DRESS, CITY, S TH DEKALB : D FALLS, M				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 900	(centimeters). Widti measurements abo area around o/a (op 5 cm has a sm (sm (right) side of open (superficial tissue, r 1/1/17, 1/3/17, and forms revealed meaulcer were unchange comprehensive assuntil 1/5/17, 10 days assessment. A 1/5/17, Wound Dathe pressure ulcers smaller than previounchanged at 1 cm changed to 90% sld appearance and adstrings or thick clumtissue. Although slopressure ulcer continuous A review of R28's Jatreatment record (Eorder to change the every 3 days. Docuidentified a Mepilex The ETAR and meddressing changes under the every and the	pressure ulcers characteristics of the state of the state of the pressure ulcer. Let have with a pink red core area) witch mean all) white area of sk area. 90% epithelianew pink or shiny). 1/4/17 Wound Data assurements of the pressurements of the pressurements of the pressurement of the wous after the 12/26/17 at Collection form in length of 2.5 cm, 0. us. The width remains. Wound bed characters to the ulcer be pressured to the ulcer be pressured to be staged at anuary 2018 electron (TAR) indicated the elementation on the Endressing change or dical record lacked antil 1/10/17, 6 days intil 1/10/17, 6 days are sure and staged at a staged and are considered the staged and are considered t	fter in identified ength 3 cm ircular sures 4 x in to rt lized Collection ressure end a and bed dentified 5 cm ned cteristics white in edialized in elialized in elialized in en at a 2. nic physicians ssing FAR in 1/4/17. any further later.	2 900				
	During observations	s on 1/10/17, at 8:43	3 a.m.,					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMF			SURVEY LETED
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				1 01/1	1/2016
NAME OF PROVIDER OR SUPPLIE		TH DEKALB	STATE, ZIP CODE		
GOOD SAMARITAN SOCIET	Y - REDWOOD FAI	D FALLS, M			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
room to re-assess pressure ulcer lad dressing "must haviewable in the best measurements reat 2.5 cm x 0.5 cm ulcer "looks very with red granulatic cleansed the presand RN-A placed pressure ulcer as (NA)-J entered the for the day. During an interviewable of the previous supposed to be consumed to the complete of the day. Wound round schippessure ulcer as completed as the stated a clinical wable of the facility RN-A stated she stated a clinical wable of the facility today or to pressure ulcer. Was 90% slough a CWS-G stated it stated a stated it stated a stated it stated and stated a clinical wable of the facility today or to pressure ulcer. Was 90% slough a CWS-G stated it stated a stated it stated a stated it stated a stated it stated and stated a stated at stated and stated a stated at stated and stated a stated at stated and stated at stated and stated a stated at stated and stated at stated at stated at stated and stated at st	RN)-A and RN-B entered R28's the pressure ulcer. R28's ked a dressing. RN-A stated the twe peeled off." No dressing was d. The pressure ulcer mained unchanged from 1/5/17 n. RN-B stated the pressure similar to last week" 90% slough on around the edges. RN-B sure ulcer with a wound cleaner a Mepilex dressing over the ordered. Nursing assistant e room to assist getting R28 up w on 1/10/17, at 1:29 p.m., id not find a wound dressing in w on 1/11/17, at 9:04 a.m. RN-A s director of nursing was empleting weekly wound ently discovered this was not stated last Thursday, a weekly edule was initiated. RN-A stated sessments were not being a "should have" for R28. RN-A cound specialist (CWS)-G does by to advise on pressure ulcers. Seent an email to CWS-G on	2 900			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		SURVEY PLETED		
				A. BUILDING:			_
		00063		B. WING			C I1/2018
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	GOOD SAMARITAN SOCIETY - REDWOOD FAI				STREET N 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 900	new and likes to sta Mepilex for a least respond to treatmed development of slo for treatment chang would not have matreatment prior to homorrow. During an interview when asked about monitoring pressure nurses (IDON) statione." Staff are to opressure ulcers at staff were not doing assessments until I wound nurse who would treat the Wound Painconsistent. The facility's Pressipolicy, dated 9/16 in that the Wound Danurse's observation from a shift-to shift dressing change. A documentation is review of the pressipesident experience.	ay with the initial treatr 2 weeks, to give it a c	p.m. sing and rector of was ss The le a some and re idelines mended ects the wounds each de a e a n	2 900			

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY LETED		
7.1.12.1.27.11	0. 00.11.120.10.1	.52	32. t.:	A. BUILDING:			
		00063		B. WING		01/1	1/2018
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI		H DEKALB D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	SUGGESTED MET The director of nurs all residents at risk they are receiving t treatment/services from developing an pressure ulcers. To designee, could could delivery of care; to services are impler pressure ulcer deve	THOD OF CORRECTI sing or designee, could for pressure ulcers to he necessary to prevent pressure ul d to promote healing on the director of nursing on the director of nursing on the director of nursing on the director appropriate can be nented; to reduce the	d review assure cers of or of the re and risk for	2 900			
21375	Program Subpart 1. Infection home must establist control program desanitary environme This MN Requirements by: Based on observation review, the facility for the recommendations for the subsection of the subse	ent is not met as evid	nursing ection fe and enced eument glove or rocess , and his had	21375	Corrected		2/9/18

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
							С	
		00063		B. WING			01/11/2018	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-		
				H DEKALB				
GOOD S	AMARITAN SOCIETY	- REDWOOD FAL		D FALLS, M				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIE	ES .	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		' MUST BE PRECEDED BY SC IDENTIFYING INFORM		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLÉTE DATE	
21375	Continued From pa	ge 30		21375				
	required staff assist daily living), and was R17's current physicontained the follow unit/GM (units per gobuttocks two times) During observation nurses assistant (Nused hand sanitizer NA-A went into the grabbed several was sink. NA-A walked to door, and picked up disposable wipes, at the wet washcloths, side of R17's bed. Now was pulling the cow NA-A opened R17's over onto his right so brief, a large former observed between fold. NA-A picked up ulling some out, and fold using his right goiled wipes into the NA-A using the soile several more wipes gluteal fold. NA-A u discard soiled wipes	R17 was cognitively tance for all ADLs (as always incontinent cian orders, printed wing: Nystatin Creamyram) apply to groin daily for redness. on 1/10/18, at 8:32 A)-A entered R17's and donned clean bath room, turned on the complete of the control of the contr	rintact, activities of t of bowel. 1/11/18, a 100000 and a.m. room, gloves. n water, nem at the ble, opened ckage of A-A placed pes on 17 that he ed yes. 7 to turn open the nent) was gluteal pes, R17 gluteal blaced de of bed. It to pull out the off R17 hand to a. NA-A					
	NA-A then used his	scarded it in the tras soiled gloved right l cloth and washed of	hand to					
		ced the soiled wash						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
			7. BOLEDINO.		C	
		00063	B. WING			1/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	TH DEKALB : DD FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21375	plastic bag. NA-A the drawer, picked up applied the cream is soiled gloved right gloved hand, place bottom, picked up a washed off R17's g soiled gloved right groin. NA-A used topen the bedside obody lotion, and aplegs. NA-A then went into soiled gloves; howe hands. NA-A donne shirt and pants from R17 to put on pants gloved hands to as the bed. NA-A then put a transfer belt a R17 to stand up. Wup R17 pants. NA-bag, tied it, and put NA-A then doffed the garbage can. Nands. NA-A made then picked up garl NA-A carried the sodown the hallway to reached into his poas he walked out or buring interview or stated, "Yeah, I medidn't change gloves and change gloves and carried gloves and change gloves and change gloves and carried gloves and carried gloves and change gloves and carried gloves gloves and carried gloves gloves and carried gloves gloves and gloves gloves gloves and gloves gloves gloves gloves gloves and gloves gl	nen opened the bedside container of cream, and to R17's coccyx using his hand. NA-A, using the soiled d a clean brief under R17 a clean wet wash cloth, and troin. NA-A continued to use hand to apply cream to R17's he soiled gloved right hand to trawer, picked up a bottle of plied lotion to R17's back and to bathroom and removed ever, NA-A did not wash his ed clean gloves, picked out in R17's closet, and assisted and shoes. NA-A used his sist R17 to a sitting position on assisted R17 to put shirt on, around R17 waist, and assisted A picked up the soiled laundry it on the floor by garbage can. In a gloves and placed them in IA-A again did not wash his R17's bed using both hands, bage bag and soiled linen bag. In the soiled linen room. NA-A cket and used hand sanitizer of the soiled linen room. 1 1/10/18, at 9:05 a.m. NA-A seed up." NA-A stated he se until after the cream and the soiled linen room. 2 1/10/18, at 9:05 a.m. NA-A seed up." NA-A stated he forgot to wash his hands after cleaning a further stated, "Sadly, that's further stated, "Sadly, that's	21375			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SU COMPLET					
		00063		B. WING			C 11/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	·	
GOOD S	AMARITAN SOCIETY	- REDWOOD FAL		H DEKALB			
0.0.15	CLIMANA DV CTA	TEMENT OF DEFICIENCIE		D FALLS, M		CORRECTION	0.45)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21375	Continued From pa	ge 32		21375			
	director of nursing (was for staff to follo procedures, meanir washing hands as of During interview on registered nurse (R infection control, sta and was in the proceducation for staff r with the hand saniti change gloves. RN- the information at the	1/11/18, at 4:28 p.m N)-B, who was in chated he was new to the ess of forming hand regarding "foaming in zer and when they no B stated he hoped the next nurses meet anned on doing audi	nectation and arge of he role hygiene and out," eed to o present ing. RN-B				
	Hand hygiene policy received.	y was requested but	not				
	program on 1/10/18 registered nurse (R documentation that program was identif program lacked pro antibiotics, criteria t periodic review of a The program also to signs and symptom	hip e facility's infection c g, at 1:15 p.m. with th N)-B, the facility lack an antibiotic steward fied. The infection co tocols for prescribin pefore antibiotic use ntibiotic use by physicacked protocols for r s, labs, determination ic use and reporting	ne ded dship ontrol g and icians. eview of on of				
	Infections, reviewed the following:	ontrol Report and thly Report of Resident from 4/17 to 12/17, to the infection (UTI) we control of the control	indicated				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP			SURVEY LETED
					C	
		00063	B. WING		01/1	1/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMADITAN SOCIETY	PEDWOOD FAL 200 SOUT	H DEKALB	STREET		
GOOD SAMARITAN SOCIETY - REDWOOD FAL REDWOO			D FALLS, M	N 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ige 33	21375			
213/5	identified and treate was taken prior to i symptoms were list -May: five UTI's we and treated with an growing the same of had antibiotic change treatment. -July: five UTI's we and treated with an results were not list the antibiotics had I-August: three UTI's cultured and treated one culture result we symptoms listed. The antibiotics had been -September: one U with antibiotic had been -October: three UT treated with antibiotic hospital and one we room; there was no obtained. The third with antibiotics; how listed. There was no been reviewed. -November: one U treated with antibiotic and there was no in been reviewed. -December: two UT treated with antibiotic culture. Neither UT was no indication the reviewed.	ed with antibiotic. No culture nitiating antibiotic and no red. re identified. All were cultured tibiotics, with two residents organism and two residents ges during the course of re identified. All were cultured tibiotics; however, two culture red. There was no indication been reviewed. Is were identified. All were d with antibiotics; however, was not listed and two had no here was no indication the reviewed. I's were identified and treated re was no indication the reviewed. I's were identified. All were tics. One was admitted to the resident of the endication cultures were utility and treated rever, no symptoms were or indication the antibiotics had I'l was identified, cultured, and tics. No symptoms were listed indication the antibiotic had I's were identified. Both were tics; however, only one had a listed symptoms and there and antibiotics had been	213/5			
	reviewed. During interview on	ne antibiotics had been 1/11/18, at 4:28 p.m. RN-B ector of nursing (IDON)				

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STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP		
7 IND 1 L7 IIV	OF CONTRECTION	BENTI TOATTON NOMBER.	A. BUILDING:			
		00063	B. WING		01/1) 1/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAL	OUTH DEKALB			
		REDW	OOD FALLS, M	N 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 34	21375			
	with antibiotic steware new to the infection process of learning antibiotic stewardsh stated the facility's it to the facility the nestewardship, and so back to fellow physic reported they were staff and providers result prior to initiatid document a reason prior.	were aware of the concernardship. RN-B stated he was control role and was in the the requirements for the hip program. RN-B further medical director was coming at week to discuss antibiotic to he could bring the programicians and providers. RN-B in the process of educating to obtain and wait for a cultuing antibiotics for UTI's, and if antibiotics were initiated	g : n			
	A facility policy entitled Antibiotic Stewardship, revised 10/17, directed the purpose of an Antibiotic Stewardship Plan was to, "Optimize the treatment of infections while reducing the adverse events associated with antibiotic use." The policy instructed each center would have a plan by November 2017.		se			
	Suggested Method of Correction: The director of nursing (DON) or designee could review and re-inforce policy and procedures regarding hand hygiene and glove use. The DON or designee could audit for compliance with cares. The DON or designee could develop a system for reviewing antibiotics to ensure appropriate cultures are performed prior to intiation.		d N			
	Time Period for Cor	rrection: Twenty one (21) da	ys.			
21530	MN Rule 4658.1310) A.B.C Drug Regimen Revi	ew 21530			2/9/18
	A. The drug regim	en of each resident must be				

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PRINTED: 02/12/2018 FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		D WING		C	
	00063	B. WING		01/1	1/2018
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY -	· REDWOOD FAI	TH DEKALB : DD FALLS, MI			
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
currently licensed by This review must be Appendix N of the S Surveyor Procedure Requirements in Lor the Department of H Health Care Financi This standard is incavailable through the system. It is not sub B. The pharmaci irregularities to the dand the attending ph must be acted upon physician visit, or so pharmacist. For pur upon' means the acreport and the signir of nursing services a C. If the attendim with the pharmacist' not provide adequate pharmacist believes being adversely afferefer the matter to the fithe medical director physician. If the me the attending physic justification for the ophysician does not omust be referred for assessment and asset by part 4658.0070. The medical director	onthly by a pharmacist of the Board of Pharmacy. It done in accordance with tate Operations Manual, as for Pharmaceutical Service ing-Term Care, published by dealth and Human Services, ing Administration, April 1992. Corporated by reference. It is the Minitex interlibrary loan object to frequent change. Coist must report any director of nursing services in the time of the next coner, if indicated by the proses of this part, "acted deptance or rejection of the ingor initialing by the director and the attending physician. In the resident's quality of life is exted, the pharmacist must be medical director for review or is not the attending change the order, the matter of the attending physician is the consulting pharmacist or the consulting pharmacist or the consulting pharmacist or directly to the quality of directly to the quality or directly to t	21530			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
				A. BOILDING.			:
		00063		B. WING			1/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAL		H DEKALB D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM.	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	Continued From pa	nge 36		21530			
	This MN Requirem	ent is not met as ev	idenced				
	by: Based on interview facility failed to ensidentified and reporrelated to the lack obehaviors for anti-pmedications for 2 oside effect monitori medications to the director of nursing fR1, R5 R13) review medications.	and document revieure the consulting plote the consulting plote medication irregof resident specific to any control and anti-any f 5 residents (R22, F	ew, the narmacist ularities arget exiety R1) and		Corrected		
	Findings include:						
	10/18/17, identified impairment and had due to a hip fracture R22 received anti-amedications. R22's Assessment(CAA), used a daily anti-definition of the second sec	linimum Data Set (M a moderate cognitived d been admitted to the. The MDS further in anxiety and anti-depression Care Area, dated 10/18/17, indepressant and as new ations which would be	he facility dentified ressant a icated she				
	identified the follow -Xanax (anti-anxiet times a day for anx -Wellbutrin SR (ant morning and at bed	y) 0.25 mg (milligran	n) three g every order				
	identified she received related to anxiety a	plan, last revised 1/3 ved anti-anxiety med nd anti-depressant r on, noting a goal for	dication nedication				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY		
				A. BOILDING.			
		00063		B. WING			11/2018
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAL		H DEKALB D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETE DATE
21530	Continued From pa	nge 37		21530			
	interventions were, based on clinical pr standards of practic pharmacy, health c	ects. The care plan in "Monitor [R22] condi- ractice guidelines or coe," and, "Consult with are provider, etc. to could appropria	tion clinical h consider				
	10/17 to 12/17, idel -on 10/16/17 denot No other entry was irregularity.	rmacy Reviews, revientified the following: ed R22 was a, "New made indicating no 2/22/17 entries were larities.	resident."				
	R22's medical reco	ord lacked target beha fect monitoring.	viors for				
	During interview on 1/11/18, at 9:19 a.m. registered nurse (RN)-A stated the facility was working on implementing target behaviors and side effect monitoring. RN-A reviewed R22's medical record and acknowledged it lacked target behaviors and side effect monitoring.		y was rs and 22's				
	severe cognitive im diagnoses of Alzhe depression, and ps	5, dated 9/29/17, iden pairment and had actimers dementia, aphaychotic disorder. The 1 received antipsychodications.	tive asia, MDS				
	contained the follow -Zoloft dated 10/18	3/17, 75 mg, for depre 3/17, 2.5 mg for deme	ession				
		lan, last revised 1/2/1 n an anti-depressant					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00063		B. WING			C 11/2018
	PROVIDER OR SUPPLIER	- REDWOOD FAL	200 SOUT	DRESS, CITY, S TH DEKALB : D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21530	goal to be free side adverse side effects medication use. No interventions includ snack, approach in offer her personal it R1's Monthly Pharm 12/22/17, contained On 9/27/17, was sifew months back. R23's annual MDS, received anti-depresant medepression and the on rounds. The CA depression, identify energy for one day. R23's current physical identified the follow duloxetine HCL (ardepression and any Trazadone (anti-desidentified she received in the follow duloxetine that the follow duloxetine identified she received in the follow of R23's current care identified she received in the follow indicated intervention in the follow of R23's current care identified she received in the follow of R23's current care identified	effects, free of discost from antipsychotic in pharmacological ed redirect, offer a dia positive smilling mitems, (bunny, baby conacy Reviews, from a the following: tarted on low dose Z dated 9/6/17, identifissant medications. F 9/6/17, identified should be a felt tired and consider the following in the following were read indicated R23 had ing she felt tired and consider the following in the following: the felt tired and consider the felt tired	rink or anner, or dog). 12/16 to 12/16 to 12/16 to 12/16 to 12/16 to 12/16 to 13/16 to 14/18, 15/16 to 16/18, 16/18, 17/18, 18/19 a goal or an	21530			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00063		B. WING		I	C 11/2018
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAL		TH DEKALB			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21530	Continued From pa	ge 39		21530			
	medication. There v	ed to taper R23's fluwas no indication the sist had identified the ng.	9				
		rd lacked side effect nti-depressant med					
	medication aide (TN antipsychotic medic the, "Black box war things to look for Zy also stated they trie interventions like or or combative to give helped to soothe he encouraged staff to	1/10/18, at 1:53 p.n MA)-A stated R1 was cation, and she woul ning, that means the prexa, mortality rate of non pharmacologine on one, if grabbine her a stuffed animitar, and if she continutake a step back araintain calm environ	s on d look for e big e." TMA-A ical g, biting, al, which led,				
		1/11/18, at 8:44 a.m e any target behavio s medical record.					
		d lacked documenta side effect monitori					
	p.m. the consulting focused on a different medication reviews and anti-depressan every six months. V behaviors, CP state behaviors, like in the withdrawn and not cetc," however; CP stargeted toward the taking. CP reported	, but looked at anti-pets more frequently, as When asked about taked, "Ya know they sake notes will say residuant to dining out to dining stated the behaviors amedications the residuant."	ated she in for the psychotics at least arget y dent is room were not sident was ities, she				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00063		B. WING			C	
		00063		D. WING		017	11/2018	
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ഭവവ	AMARITAN SOCIETY	- REDWOOD FAI	200 SOUT	H DEKALB	STREET			
GOOD 3	AWARTAN SOCIETT	- KLDWOOD I AL	REDWOO	D FALLS, M	N 56283			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE ' MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21530	Continued From pa	ge 40		21530				
	behaviors or medical side effect monitorial see psychotropic conside effects the facing sleepiness or lack of she hadn't seen the admitted it had slippe and she would write next time she was a R5's admission MD as severely cognitive CAA, dated 2/18/17 Sertraline (anti-depict R5's quarterly MDS verbal behavioral systems of the side of the si	S, dated 2/17/17, ide rely impaired. R5's a r, indicated the use c	about used to d list the er reported s. CP for them, ok the entified R5 dmission of					
	1/18/17- Cymbalta of milligrams (mg) dai 9/30/17-Seroquel (amajor depressive di 1/8/18-Additional ar (anti-depressant) 50 R5's care plan, last R5 received antipsy depressive disorder Monitor for behavior danger to the reside 1/2/18 resident on a related to depression based on clinical prestandards of practicantidepressants. Co	entified the following (anti-depressant) 60 by for depressive epiganti-psychotic) 100 misorder. Inti-depressant Sertra of mg daily for depressant Sertra of mg daily for depressant sert and others. Updantidepressant medican. "Monitor (R5's) coactice guidelines or estant of the sert and others.	sodes. ng daily for aline ession. entified elated to g." resent a ated cation ondition clinical					

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00063		B. WING			C 11/2018	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- REDWOOD FAL		H DEKALB				
	T			D FALLS, M		000000000000		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21530	Continued From pa	ge 41		21530				
	clinically appropriate	e.						
	staff monitor and do following target beh staying asleep, feel speaking slowly, fid	istory documentation ocument every shift naviors. Trouble falling ing bed about self, n lgeting, states life is narm self, being shor	for the ng or noving or not worth					
	R5's medical record of the psychotropic	d lacked side effect i medication	monitoring					
	and 12/17 were rev	nacy reviews betwee iewed. The reviews or side effect monitor	lacked					
		S, dated 11/15/17, io sychotic, antianxiety, dication .						
	8/9/17- Seroquel (a mouth one time dai 11/27/17-Zoloft 75 r depression	vealed the following ntipsychotic medically for dementia with mg one time daily fo	tion) by behaviors. r					
	condition based on Attempt non-pharm	luded the following: hotic medication. Mo clinical standards of acological interventi g snacks, blue comf	practice. on					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00063		B. WING			C 11/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- REDWOOD FAL	200 SOU	DRESS, CITY, S TH DEKALB S DD FALLS, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21530	based on clinical st with pharmacy, hear consider dosage re appropriate. 1/3/18-antianxiety r based on clinical st interventions for more resident separated When calling/yelling non-pharmacologic personal items and TV. R13's point of care identified staff monfor the target behave lacked side effect medication. R13's Monthly pharmand 12/17 were reversed murse (Rany official docume about side effect medication for the target behave and the staff monforth that the staff monforth th	essant. Monitor con- andards of practice. alth care provider, et aduction when clinical medication. monitor andards of practice. bod also included to from (R18) when ag gout, attempt eal interventions of o assist to bathroom. history documentate itor and document ev itor of calling out. R' nonitoring for psychology macy reviews betwee interventions of or psych	Consult c. to ally condition keep gitated. ffering Offer the convery shift 13's record otropic een 1/17 lacked ring. 5 a.m., at have en asked R13.	21530			
	The director of nurs develop, review, an procedures to ensu	THOD OF CORREC sing (DON) or design d/or revise policies are the consultant ph ularities including ta	nee could and armacist				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRI IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE COMF	SURVEY PLETED			
				B. WING			С
		00063		B. WING		01/	11/2018
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAL		TH DEKALB : D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21530	behaviors for anti-p medications and ap monitoring of psych The DON or design appropriate staff on The DON or design systems to ensure of	syschotic/anti-anxiet propriate side effect otropic medications. ee could educate all the policies and pro ee could develop mo ongoing compliance.	cedures. onitoring wenty-one	21530			2/9/18
	monitor each reside unnecessary drug to home's policies and pharmacist must re resident's attending physician does not home's recommend adequate justification believes the resider adversely affected, matter to the medical director is referred to the medical director physician does not the order and if the change the order, the review to the Qualit (QAA) committee referred the attending physician does not the order and if the change the order, the consulting pharmal directly to the QAA.	g. A nursing home nent's drug regimen for Isage, based on the I procedures, and the port any irregularity to physician. If the attecton or does not proper and the pharmac and the pharmac and the pharmac and the pharmac and the pharmacist must all director for review not the attending physician he matter must be responded by part 4658 cian is the medical of macist shall refer the ent is not met as evicent is not met as evicent.	or nursing e to the ending ing rovide ist eing t refer the vician. If e attending ication for does not eferred for sessment .0070. If director, e matter				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00063		B. WING		l l	C 11/2018
	PROVIDER OR SUPPLIER	- REDWOOD FAL	200 SOUT	DRESS, CITY, S TH DEKALB D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21540	by: Based on observati review, the facility fa notify the coumadin of anticoagulant the reviewed for unnece Findings include: R19's Diagnosis Re	ge 44 on, interview, and do ailed to monitor bruisin clinic of possible siderapy for 1 of 2 residers essary medications. eport, printed 1/11/18, admitting diagnosis of the control of t	ing and e effect ents (R19)	21540	Corrected		
	Unspecified sequel- cerebrovascular dis R19's quarterly Min 11/20/17, identified MDS further identifi diagnosis of hyperto disorder or epilepsy R19's current physi contained the follow -Recheck INR 1/16, -Coumadin tablet 2 Monday, dated 12/2 disease, -Coumadin 2 mg ev Wednesday, Thurso dated 12/5/17, for co- -Aspirin 81 mg one	ae of unspecified sease, imum Data Set (MDS no cognitive impairm led R19 had an active ension, hemiparesis, /. cian orders, printed 1 ving: /2018, dated 1/9/185 mg (milligrams) ev 1/17, for cerebrovascular, Friday and Saturerebrovascular diseatablet daily, dated 3/9	S), dated ent. The esseizure /11/18, ery ular rday, use.				
	11/14 through 12/17 INR 2.4, a note on 9/22/17 on coumad R19's current care	rmacy Reviews, revie 7, contained a note of 5/22/15 INR 2.2, and in. plan, revised 12/28/1 llant therapy related to	n 6/23/14 a note on 7,				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					0	
		00063	b. WING		01/1	1/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - REDWOOD FAI			TH DEKALB : D FALLS, M			
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
21540	Continued From pa	ge 45	21540			
	urine, black tarry st stools, sudden seve vomiting, diarrhea, bruising, blurred vis loss of appetite, sue status, significant of signs."	od tinged or frank blood in ools, darker bright red blood in ere headaches, nausea, muscle joint pain, lethargy, sion, SOB,[shortness of breath] dden changes in mental r sudden changes in vital				
	1/19, identified the -On 12/11/17, no brust on R19's -On 1/1/18, no brust conditions observed -On 1/9/18, at 9:51 measured 4 cm (ce observed and was room. The back of stages of healing. Frelated to the medic bruising in different	ruising observed, a skin tear is left hand. ising observed and no skin				
	bruising was noted back of both upper approximately 3-4 i shades of dark purp protectors on both	on 1/8/18, at 3:45 p.m. large above the elbow and on the arms. The bruising was nches in diameter, in various ole in color. R19 had sleeve forearms covering to the elbow over the upper arms where the located.				
	stated he got bruise coumadin, stating a bruise. He further s about side effects a them know if there	1/10/18, at 8:08 a.m. R19 es on his arms from the any little bump caused a tated the nurses told him and what to watch for; he let was bruising. R19 stated he tors and tried to be careful.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00063		B. WING			C 11/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAL		TH DEKALB : D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21540	Continued From pa	ge 46		21540			
		these bruise are fron er." R19 thought the i					
	p.m. indicated com	ote, dated 1/9/18, at munication to physic .9, no Coumadin cha k INR 1/16/18."	an,				
	bruising on arms ar	dentified on 1/9/18 and elbow there is is no can was notified of the	0				
	medication aide (TN Coumadin, and they scabs. TMA-A reportant administration records administration records effects to look R19 reported or not go to the charge nut the progress notes. aware of any bruising stated R19 had a base of a sta	1/10/18, at 8:28 a.m MA)-A stated R19 way checked for any brited, on the medicating (MAR), there was for. TMA-A further reliced any bruising, shrse, and would docu TMA-A stated she was for R19. TMA-A furth on Monday and the for any bruising the	is on uising or on a list of eported if ne would ment it in vasn't urther he nurse				
	licensed practical n would expect the nu open areas, any ble LPN-C stated she v doctor. LPN-C state	on 1/10/18, at 11:37 urse (LPN)-C stated ursing assistants to reding, or any major would get it reported ed would also docum ther stated R19 weans arms.	she eport any bruising. to the ent the				
	registered nurse (R was a weekly skin a	1/11/18, at 9:18 a.m N)-A stated the expe assessment for antic ng. Nursing would ac	ctation oagulant				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00063	B. WING		04/4	1/2018
NAME 05.	200//250 00 01/201/50			27475 710 0005	1 01/1	1/2010
NAME OF F	PROVIDER OR SUPPLIER		TH DEKALB	STATE, ZIP CODE STREET		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	DD FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 47	21540			
	skin observation sh reported to the phys medical record, ack	skin tears documented on the eet. Serious bruising would be sican. RN-A observed R19's knowledging his weekly skin d documentation and ruising.				
	Anticoagulation Value purpose was to increadverse effects and anticoagulation there	led Pro Time: Measuring ues, dated 9/12, identified the rease recognition of potential I proper dosing of rapy, to decrease reporting g physican or health care				
	The director of nurs could review policie monitoring side effe DON or designee c develop a system o	HOD OF CORRECTION: sing (DON) and/or designee as and procedures related to ects for anticoagulants. The ould educate staff and f compliance with rapy side effecting monitoring.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
21830	MN St. Statute 144. Residents of HC Fa	.651 Subd. 10 Patients & ac.Bill of Rights	21830			2/9/18
	Subd. 10. Particip notification of family	pation in planning treatment; y members.				
	in the planning of the includes the opportunities with incopportunity to requestare conferences, a	Il have the right to participate neir health care. This right unity to discuss treatment and dividual caregivers, the lest and participate in formal and the right to include a ther chosen representative or				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:					
		00063		B. WING		01/1	1/2018
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
00000	AMADITAN COCIETY	DEDWOOD FAL	200 SOUT	H DEKALB	STREET		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAL	REDWOO	D FALLS, M	N 56283		
	OUR MARK DV OTA	TEMENT OF BEFORENO					
(X4) ID	-	TEMENT OF DEFICIENCI MUST BE PRECEDED B		ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORM		PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
17.0			- /	17.0	DEFICIENCY)		
21830	Continued From pa	ge 48		21830			
	-						
	both. In the event t						
	present, a family m	ember or other repr	esentative				
	chosen by the resid	lent mav be include	d in such				
	conferences.	,					
		vho enters a facility	ie				
	unconscious or con	_					
	communicate, the f						
	efforts as required						
	either a family mem						
	writing by the reside	ent as the person to	contact in				
	an emergency that	the resident has be	en				
	admitted to the faci						
	family member to p						
	planning, unless the						
	to believe the reside						
	directive to the conf						
	specified in writing						
	member included in						
	notifying a family m						
	family member to p	articipate in treatme	ent				
	planning, the facility	/ must make reasor	nable				
	efforts, consistent v	vith reasonable med	dical				
	practice, to determi						
	executed an advan						
	esident's health car		_				
	this paragraph, "rea						
	` '	e personal effects o	i trie				
	resident;						
		e medical records o					
	resident in the poss						
	(3) inquiring of a	ny emergency conta	act or				
	family member con						
	whether the resider						
	directive and wheth						
	physician to whom						
	' '	u io resident HUIIIlal	iy goes ioi				
	care; and	a mbandalan tan	41				
		e physician to whor					
	resident normally g						
	whether the resident has executed an advance						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				D WING			С
		00063		B. WING		01/	11/2018
NAME OF I	PROVIDER OR SUPPLIER			, ,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAL		TH DEKALB : D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21830	directive. If a facilit designated emerge member to participa accordance with thi liable to resident for the notification of the emergency contact family member was patient's privacy rig (c) In making rea family member or d the facility shall atte members or a desig examining the persand the medical recopossession of the facility a family memergency contact admission, the facil social service agency that the resithe facility has been member or designated emerge service agency or lothat assists a facility subdivision is not liadamages on the grother family member.	y notifies a family me ney contact or allows ate in treatment plans paragraph, the fact damages on the grate family member or or the participation of improper or violated hts. Is conable efforts to not esignated emergency conal effects of the resords of the resident acility. If the facility is ember or designated within 24 hours after within 24 hours after ity shall notify the cocy or local law enforced in unable to notify a fatted emergency contact agency and local by shall assist the fact ying a family member or designated in unable to notify a fatted emergency contact agency and local by shall assist the fact ying a family member or implementing the pounds that the notific or emergency contact family member was family m	s a family ning in illity is not ounds that of the dithe otify a cy contact, y ontact by sident in the s unable or the unty cement are aw illity in er or ty social t agency is or cation of ct or the	21830			
	by:	ent is not met as evi			Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		C		
		00063	B. WING		01/1	1/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- REDWOOD FAI	TH DEKALB D FALLS, M			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID FALLS, IVI	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21830	Continued From pa	ge 50	21830			
	preference for frequ	ailed to identify a resident's uency of shaving for 1 of 2 iewed for activities of daily				
	Findings include:					
	R30's significant change Minimum Data Set (MDS), dated 11/28/17, indicated R30 required physical assist of one staff for personal hygiene, including shaving. R30's Brief Interview for Mental Status (BIMS) indicated a score of 14, indicating he was cognitively intact.					
	R30's Care Area Assessment, dated 12/12/17, identified R30 required limited assist with ADL's (activities of daily living.) The assessment did not identify R30's shaving frequency preference.					
	R30's care plan, dated 12/19/17, indicated R30 required staff to comb hair, identifying can wash face, arms and hands after set up. The care plan did not identify R30's preference for frequency of shaving.					
	was observed to ha stated he needed h used an electric raz plugged into the wa dresser in R30's ro- clean shaven. R30	on 1/8/18, at 2:50 p.m. R30 live long gray facial hairs. R30 elp from staff to shave and cor. An electric razor was all and laying on top of the liked to be stated the last time he was ang was "a couple three days				
	R30's continued to stated staff had nev would like to be sha	on 1/9/18, at 11:09 a.m., have gray facial hair. R30 ver asked him how often he aved, that he had not been hat he would like to be shaved				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00063		B. WING		I	C 11/2018
GOOD SAMARITAN SOCIETY - REDWOOD FAI			DRESS, CITY, S TH DEKALB				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21830	daily. During observation nursing assistant (N shower. After the sl back to his room. N shaved up." NA-B s razor that was located R30 receives she had assisted R week as well. When believed R30 was on NA-B stated she did preference for frequency stated she followed group sheet did not NA-B stated if the general shave daily, resider weekly on their show she assisted R30 week, he had facial During interview on registered nurse (R residents are asked shaving preference RN-A stated staff slincluding R30, ever shaved. If resident's shaving, shaving necare plan. RN-A stated address the frequence During an interview interim director of necessity.	on 1/9/18, at 2:12 p NA)-B assisted R30 mower, NA-B assisted R30 mower, NA-B assisted R30 mower, NA-B stated, "Let's go shaved R30, using the don R30's dressed about shaving shaved on his bad not know what R30 mency of shaving was the group sheet and direct to shave R30 mount are shaved one to wer day. NA-B stated the his shower the postubble as well. 1/11/18, at 11:35 p. N)-A stated she beliff a upon admission about the group sheet and the postubble as well. 1/11/18, at 11:35 p. N)-A stated she beliff a upon admission about the group sheet and the postubble as well. 1/11/18, at 11:35 p. N)-A stated she beliff a upon admission about the saking resigned to be addressed to be addressed to be addressed to be addressed to shaving. 1/11/18, at 12:34 mount of shaving. 1/11/18, at 12:34 mount of shaving.	with a and R30 bet you he electric r. NA-B B stated previous high NA-B bet he daily. Indicate to ime and when revious m. eved when revious m. eved when revious m. eved bout their or sure. dent's, to be a with he did not me did not me did not me did not me did at each and at each me did at each me did at each me did at each me did not me did at each me did not me did n	21830			

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G:		(X3) DATE SURVEY COMPLETED	
			D 14/10/0		•	С
		00063	B. WING _		01/	11/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	200.5	ET ADDRESS, CITY SOUTH DEKALI	, STATE, ZIP CODE 3 STREET		
G00D 3	AWARITAN SOCIETY	- REDWOOD FAL RED	WOOD FALLS,	MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
21830	Continued From pa	ge 52	21830			
	preference needed plan.	to be addressed on the ca	re			
	6/14, directed "Any carry out activities on necessary services grooming, and pers "General Personal,"	Activities of Daily Living, daresident who is unable to of daily living will receive to maintain good nutrition, onal and oral hygiene." Daily Hygiene/Grooming: onaly Hygiene	care			
	The Director of Nur educate on policies resident choices an	HOD OF CORRECTION: sing (DON) or designee co and procedures regarding d conduct audits to ensure es and routines are followers.)			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty (One			