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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MSEY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00085

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245558**

2.STATE VENDOR OR MEDICAID NO.
(L2) **677840200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WINDOM**
(L4) **705 SIXTH STREET**
(L5) **WINDOM, MN** (L6) **56101**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **0516/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **78** (L18)

13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Supervisor 06/20/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/20/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/28/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5558

The facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on 04/03/14. On 05/16/14, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on 05/20/14 the Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on 04/03/14, effective 05/13/14. Refer to the CMS-2567B for both health and life safety code.

Effective 05/13/14, the facility is certified for 78 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5558

Electronically Delivered: June 24, 2014

Ms. Nancy Wepplo, Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, Minnesota 56101

Dear Ms. Wepplo:

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 May 13, 2014, the above facility is certified for:

78 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: June 20, 2014

Ms. Nancy Wepplo, Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, Minnesota 56101

RE: Project Number S5558022

Dear Ms. Wepplo:

On April 23, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 3, 2014. 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 May 16, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 20, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 13, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 3, 2014, effective May 13, 2014 and therefore remedies outlined in our letter to you dated April 23, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245558	A. Building B. Wing	5/16/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0221** Reg. # **483.13(a)** LSC	Correction Completed **05/13/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **05/13/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/13/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **05/13/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **05/13/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **05/13/2014**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **05/13/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **05/13/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	06/20/2014	18623	05/16/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/3/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245558	A. Building B. Wing: 01 - MAIN BUILDING 01	5/20/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0045	05/13/2014	ID Prefix Reg. # NFPA 101 LSC K0144	04/15/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/AK	Date: 06/20/2014	Signature of Surveyor: 22373	Date: 05/20/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
4/8/2014	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MSEY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00085

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245558**
2.STATE VENDOR OR MEDICAID NO.
(L2) **677840200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WINDOM**
(L4) **705 SIXTH STREET**
(L5) **WINDOM, MN** (L6) **56101**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/03/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **78** (L18)

13.Total Certified Beds 78 (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 05/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/27/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5558

At the time of the standard survey completed 04/08/14, the facility was not in substantial compliance and the most serious deficiencies 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 are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4684

April 23, 2014

Ms. Nancy Wepplo, Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, Minnesota 56101

RE: Project Number S5558022

Dear Ms. Wepplo:

On April 3, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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), i.e., the plan of correction should be directed to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 13, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 3, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 3, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Please see attached.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility used the wheelchair (w/c) as a restraint device to prevent freedom of movement for 1 of 1 resident (R43) reviewed for restraints. Findings include: R43 was admitted to the facility 11/3/09, with Admission Record diagnoses of senile dementia, nutritional deficiency, and osteoarthrosis. R43 was transferred to the special care unit (locked dementia unit) on 11/4/13, related to episodes of yelling, screaming, physical abuse with cares and exit seeking behaviors.	F 221		

RECEIVED
MAY - 5 2014
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy E. Wepplo — TITLE: Administrator — (X6) DATE: 5-2-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	04/03/2014

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GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

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F 221	Continued From page 1 On 3/31/14, at 5:40 p.m. R43 was observed spilling milk on the dining table and was slapping the milk on the table top to make it splash, staff asked R43 to stop because she was getting her pretty sweater all dirty. R43 continued to slap the milk on the dining table and R39 sitting next to her stated, "Hey stop it." R43 then pushed milk directly at R39. Nursing assistant (NA)-A stopped serving meals to move R43 back, away from the table and he then locked the breaks of the w/c. NA-A proceeded to clean up the spilled milk. R43 repeatedly attempted to pull forward gripping the table and when she could not move closer to the table she made a high pitched sound of distress mmm mmmm mmm mmm (squeak) mmm mmmm mmm mmm (squeak). R43 did not attempt to unlock the wheelchair and seemed unaware of the wheel locks. - At 5:42 p.m. the table mates R62 and R88 had been served and then R43 was served. However, R43 was left pulled back from the table with the w/c locked, and unable to reach the table. NA-A washed his hands, then sat next to R43, unlocked the w/c and pulled R43 forward to the table and attempted to assist her to eat. R43 would not eat, and started flinging her food off the plate. NA-A attempted to ask her to quiet. R43 continued to throw food off of her plate, NA-A pushed R43 back from the table and locked her wheelchair, R43 attempted to use the table to pull herself forward, R43 did not attempt to unlock the wheelchair and seemed unaware of the wheel locks. When she was not able to pull forward, R43 then stretched forward and flung her fork at NA-A who moved away from the table and R43. R43 then reached forward toward her food, but when table mate R39 said "get that slop out of here", R43 pushed her plate at R39 with force. The plate and food were removed from the table.	F 221		

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F 221	Continued From page 2 - At 5:55 p.m. NA-D asked if R43 wanted any Rice Crispies, R43 replied ice cream, which was provided and R43 ate the ice cream without assistance. Care Area Assessments (CAA) summary dated 10/8/13, indicated R43 had short and long term memory loss with poor decision making, was short tempered and easily annoyed nearly every day. R43 had physical behavioral symptoms directed towards others. R43 required extensive assist of two persons for bed mobility, ambulating in the hallway, transfers and toileting, one person physical assist for locomotion on and off the unit, dressing and personal hygiene. R43's significant change Minimum Data Set (MDS) dated 12/31/13, indicated R43 was rarely or never understood, had inattention and disorganized thinking. R43 had a poor appetite seven to 11 days of the look back period. R43 had physical and verbal behavioral symptoms directed towards others one to three days, and threw food four to six days in the look back period. R43 required extensive assist of two persons for bed mobility, transfers and toileting, one person physical assist for locomotion on and off the unit, dressing and personal hygiene and one person physical assist, cueing, encouragement, and supervision for eating. R43 was not assessed as needing a restraint on the MDS. R43's care plan dated 3/16/14, indicated R43 had behavior symptoms related to dementia such as verbal and physical abuse, yelling, throwing food and dishes, spitting food and fluids, running wheelchair into others, and pulling bed linens off. Staff was directed to intervene as necessary to	F 221		

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F 221	Continued From page 3 protect the rights and safety of others, approach R43 and speak in a calm manner, divert attention away from the issue and remove from the situation and take to an alternate location as needed. Staff also was to provide opportunity for positive interaction, and minimize potential for residents disruptive behaviors by offering tasks which divert attention such as encourage to listen to KDOM radio or distract with talk of veteran status. Staff was to attempt non-pharmacological interventions: redirect to room, and play KDOM, minimize potential of resident behavior problems by modifying environmental factors and daily routine. When R43 threw the food staff was to re-direct to resident room and assist R43 to eat there. On 4/1/14, at 10:46 a.m. registered nurse (RN)-B verified the w/c was used as a restraint, and it had not been assessed as a restraint. R43 had been assessed for restraints of a low bed and a tabs alarm in the w/c only. On 4/1/14, at 3:18 p.m. trained medication aide (TMA)-A stated the goal for R43 "last night was just to move her back until someone had time to sit with her (at dinner), and stated I did not realize she was double braked. TMA-A verified the w/c was used as a restraint. TMA-A further stated, "I think her care plan says that we would take her to her room and bring her a tray." On 4/1/14, at 3:30 p.m. NA-A stated "they have already talked to me about that being a restraint." NA-A further stated that "I did know that her care plan said remove her to her room." On 4/2/14, at 1:53 p.m. the director of nursing services (DNS) stated she would have expected	F 221		

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F 221	Continued From page 4 the staff to follow the care plan for behavioral outbursts, and verified the w/c was used as a restraint. The Physical Restraints policy dated as revised on 8/2008, indicated, "Residents will be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms." The Physical Restraints Procedure dated as revised on 8/13, indicated the purpose of the procedure was "To ensure appropriate use of restraints." The procedure identified physical restraints "may include, but are not limited to, hand mitts..." The procedure directed the licensed nurse to identify devices, material or equipment which were "attached or placed adjacent to the resident's body" and to determine whether it was or "could be a restraint for the individual resident." The procedure further indicated, "If the device, material, or equipment cannot be removed easily by the resident and restricts freedom of movement or normal access to one's own body, then this is a restraint and this procedure must be followed." The procedure identified other pertinent restraint information, such as what documentation was required to warrant the use of the restraint, interdisciplinary team involvement/review, and completion of the Physical Restraint Assessment form. In addition, the procedure directed release of the restraint "at least every two hours," supervision and monitoring of restrained residents.	F 221		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279		

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F 279	Continued From page 5 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure risk for bruising and the presence of existing bruises were identified and care planned for 1 of 3 residents (R76) reviewed for non-pressure related skin conditions; in addition, the facility failed to ensure the use of Coumadin (a blood thinner) was identified on the care plan, and a care plan was developed to address the use of Coumadin for 1 of 5 residents (R52) reviewed for unnecessary medications. Findings include: BRUISES R76 did not have a care plan developed to address risk for bruising and the presence of	F 279		

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F 279	Continued From page 6 bruises. On 4/1/14, at 11:03 a.m. R76 was observed to have a large dark purplish colored bruise on the dorsal aspect (the back) of the right hand and a bruise on the left wrist. On 4/2/14, at 4:12 p.m. a registered nurse (RN)-A and surveyor observed R76's existing bruises. RN-A measured the bruises as follows: - The left outer wrist bruise was reddish purple colored, irregular shaped and measured 4.75 centimeters (cm) by 2.5 cm; - The left inner wrist bruise was reddish purple colored, circular shaped and measured 2 cm by 2 cm; - The left elbow bruise was reddish purple colored, circular shaped and measured 1.25 cm by 1 cm. - The bruise on the back of R76's right hand measured 1.0 cm x 0.5 cm, was irregular shaped and reddish purple colored; - The right top mid arm (forearm) had two reddish purple bruises (next to each other), first measured 7 cm by 7.5 cm, the second measured 2.5 cm by 3.0 cm. During the observation, R76's skin was observed to be dry, slightly flaky and thin; RN-A verified R76's skin was "fragile," the bruises should have been identified and reported "to me [RN-A]." The Diagnosis Description dated 10/2/13, identified R76's diagnoses to include coronary artery disease. R76's admission Minimum Data Set (MDS) dated 10/8/13, indicated R76 had moderate cognitive impairment, had no behavior problems, required physical assistance from staff for transfers, bed	F 279		

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F 279	Continued From page 7 mobility, walking in and out of the room, and toilet use; required extensive physical assistance from staff with locomotion on and off the unit, dressing and personal hygiene. The MDS identified no skin problems. The Care Area Assessments (CAAs) also dated 10/8/13, were reviewed and did not identify R76 was at risk for bruising or skin related issues due to aspirin use. The care plan dated 1/9/14, identified a "potential alteration" in R76's skin integrity related to decreased mobility from right lower back/hip pain; identified R76 had poor peri-care and did not identify risk for bruising, such as with use of aspirin. The care plan did not identify the presence of bruises on R76. On 4/3/14, at 9:49 a.m. director of nursing services (DNS) verified bruises should be identified and reported, the bruises should have been assessed and care planned, including risk for bruising. DNS verified the care plan was not updated regarding bruising until "yesterday" and verified the care plan did not identify R76 was at risk for bruising. DNS stated R76 had obtained bruises from prior episodes of "bumping" into objects, such as the wall. During the interview, DNS verified she also observed the bruises and stated she believed R76's bruises were a "mixture of old and new bruises." Although the facility provided a policy on Skin Assessment and Pressure Ulcer Prevention dated as revised on 1/2014, and the Pressure Ulcer Practice Guidelines dated as revised on 9/2010, both policies only had pertinent data regarding pressure ulcers. Both policies lacked	F 279		

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F 279	Continued From page 8 verbiage and direction for identification of non-pressure ulcer skin problems such as bruising risk (such as from medications like aspirin), identification and reporting of bruises, assessment of bruises (such as obtaining measurements and documenting description of the bruises), or care planning of bruises. In addition, the facility lacked a policy and procedure identifying a system of monitoring for the healing of bruises. COUMADIN R52 did not have a care plan developed to address the use of Coumadin (an anticoagulant) daily, monitoring for efficacy or monitoring of potential side effects. On 4/2/14, R52 was observed at 7:40 a.m. at the breakfast meal and again at 3:08 p.m. ambulating in the hallway independently. No signs of unusual bruising or concerns of bleeding were observed or expressed by the R52. The care plan dated 1/23/14, lacked identification of the transient cerebral ischemia diagnosis and the use of Coumadin. In addition, the care plan lacked development of appropriate goals associated with the use of Coumadin, lacked identification of monitoring for efficacy, potential side effects and direction for addressing potential concerns associated with the use of Coumadin. The Order Summary Report dated as signed by physician on 3/11/14, indicated to give R52 Coumadin 2.5 milligrams (mg) by mouth (PO) daily for a diagnosis of transient cerebral ischemia (interruptions in blood flow in the brain potentially caused by blood clots).	F 279		

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F 279	Continued From page 9 On 4/2/14, at 3:31 p.m. the RN-A verified R52 received a scheduled dose of Coumadin. - At 4:07 p.m. RN-A stated she monitored R52 for bruising and symptoms of bleeding. Stated nursing assistant (NA) staff should report bruises to the nurses. RN-A verified the use of Coumadin was not addressed on the care plan. RN-A verified the clinical record lacked evidence R52 was monitored for side effects of Coumadin. - At 4:24 p.m. the DNS verified R52's care plan did not address the Coumadin use. DNS stated she would expect the medication to be identified and care planned, and the care plan to direct monitoring for side effects such as bruising. DNS verified the clinical record lacked monitoring for side effects of Coumadin. On 4/3/14, at 11:15 a.m. the consultant pharmacist (CP) was contacted via telephone and verified the use of Coumadin should have been identified R52's care plan and confirmed the medication should be monitored for side effects. CP verified they did not identify the lack of monitoring for side effects and lack of care planning for R52's use of Coumadin. The Brystol-Myers Squibb package insert for Coumadin dated as revised 10/2011, identified potential side effects to monitor for. The insert directed to notify the health care provider of signs or symptoms of bleeding and indicated bleeding risk had potential major health concerns including death. The insert included identification of other potential side effects such as, but not limited to pain, swelling, blood in stools, and unusual bruising. A Pharmaceutical Services Policy & Procedure Manual 6:30 Recommended Laboratory Orders	F 279		

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F 279	Continued From page 10 Required for Drug Monitoring undated was provided. The policy included a table containing a list of medications commonly ordered in long-term care facility that required a laboratory drug monitoring plan. The Drug Category section of the policy listed "Anticoagulants" and directed to complete "INR [International Normalized Ratio] monitoring - per Coumadin protocol - stop order policy requires monthly INRs unless between tests was specified." The facility lacked a policy which directed identification of the use of Coumadin and monitoring for side effects of the drug. The Good Samaritan Society Comprehensive Care Plan and Care Conferences Procedure dated as revised on 9/2013, identified the procedure for development of a resident care plan, which included time frames for development of the care plan, language to be used and an interdisciplinary team approach. The policy directed, "The interdisciplinary team will ensure that the care plan is comprehensive by incorporating the following:" and identified "Physicians' orders and diagnoses that are currently being treated." The policy further directed to "'Monitory for adverse consequences' either as a separate care plan problem or at each point in the care plan that addresses medications."	F 279		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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F 282	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care and services according to the care plan for 1 of 1 resident (R43) reviewed for eating behaviors; for 4 of 4 residents (R43, R88, R67, R62) reviewed for toileting; and for 1 of 1 resident (R50) who was on fluid restrictions due to kidney disease. Findings include: Eating: R43 was admitted to the facility 11/3/09, with Admission Record diagnoses of senile dementia and nutritional deficiency. R43 was transferred to the special care unit (locked dementia unit) on 11/4/13, related to senile dementia with episodes of yelling, screaming, and physical abuse. On 3/31/14, at 5:40 p.m. R43 was observed spilling milk on the dining table and was slapping the milk on the table top to make it splash, staff asked R43 to stop because she was getting her pretty sweater all dirty. R43 continued to slap the milk on the dining table and R39 sitting next to her stated, "Hey stop it. R43 then pushed milk directly at R39. Nursing assistant (NA)-A stopped serving meals to move R43 back, away from the table and he then locked the breaks of the wheelchair (w/c). NA-A proceeded to clean up the spilled milk. R43 repeatedly attempted to pull forward gripping the table and when she could not move closer to the table she made a high pitched sound of distress mmm mmmm mmm mmm (squeak) mmm mmmm mmm mmm (squeak). R43 did not attempt to unlock the wheelchair and seemed unaware of the wheel locks.	F 282		

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F 282	Continued From page 12 - At 5:42 p.m. the table mates R62 and R88 had been served and then R43 was served. However, R43 was left pulled back from the table with the w/c locked, and unable to reach the table. NA-A washed his hands, then sat next to R43, unlocked the w/c and pulled R43 forward to the table and attempted to assist her to eat. R43 would not eat, and started flinging her food off the plate. NA-A attempted to ask her to quiet. R43 continued to throw food off of her plate, NA-A pushed R43 back from the table and locked her wheelchair, R43 attempted to use the table to pull herself forward, R43 did not attempt to unlock the wheelchair and seemed unaware of the wheel locks. When she was not able to pull forward, R43 then stretched forward and flung her fork at NA-A who moved away from the table and R43. R43 then reached forward toward her food, but when table mate R39 said "get that slop out of here", R43 pushed her plate at R39 with force. The plate and food were removed from the table. - At 5:55 p.m. NA-D asked if R43 wanted any Rice Crispies. R43 replied ice cream, which was provided and R43 ate the ice cream without assistance. R43's care plan dated 3/16/14, indicated R43 had behavior symptoms related to dementia such as verbal and physical abuse, yelling, throwing food and dishes, spitting food and fluids, running wheelchair into others, and pulling bed linens off. Staff was directed to intervene as necessary to protect the rights and safety of others, approach R43 and speak in a calm manner, divert attention away from the issue and remove from the situation and take to an alternate location as needed. When R43 threw the food staff was to re-direct to resident room and assist R43 to eat there.	F 282		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 13 On 4/1/14, at 3:18 p.m. trained medication aide (TMA)-A stated the goal for R43 "Last night was just to move her back until someone had time to sit with her (at dinner), and I did not realize she was double braked." TMA-A verified the w/c was used as a restraint. TMA-A further stated, "I think her care plan says that we would take her to her room and bring her a tray." On 4/1/14, at 3:30 p.m. NA-A stated "they have already talked to me about that being a restraint." NA-A further stated that "I did know that her care plan said remove her to her room." On 4/2/14, at 1:53 p.m. the director of nursing services (DNS) stated she would have expected the staff to follow the care plan for behavioral outbursts. Toileting: On 4/2/13, R43 was observed at 7:30 a.m. sitting at the breakfast table. - At 8:00 a.m. R43 turned herself sideways and was observing the dining room quietly. - At 8:15 a.m. R43 was gently rocking her w/c 1 inch back and forth. - At 8:30 a.m. she started a quiet but high pitched whine, while rocking one inch in the w/c. - At 8:36 a.m. the intensity started getting a little higher and R62 joined in at a lower tone. - At 8:41 a.m. R43 waved at NA-A stopped her distressed noise, and was taken to her room. NA-A exited the room immediately R43 was not toileted. - At 8:50 a.m. R43 propelled herself out into the hallway toward the day lounge. She used her feet and sometimes pulled on the hand rail to propel the w/c.	F 282		

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F 282	Continued From page 14 - At 8:55 a.m. R43 was on the return trip to the dining room. R43 was assisted to get closer to her room, stopped in the doorway, sitting next to but facing opposite direction of R88. - At 9:11 a.m. R43 moved back into the hallway. - At 9:15 a.m. R43 was taken to the table to join the bible study. - At 9:20 a.m. R43 was napping in the w/c and then awakened when the pastor started to speak in the bible study. - At 9:23 a.m. R43 had her eyes closed the majority of the time. - At 9:27 a.m. R43 refused communion when she was awoken. - At 9:36 a.m. R43 was awake. - At 9:40 a.m. the residents remained in the dining room, there had been continuous observation for two hours and 10 minutes (started at 7:30 a.m.), R43 had not been toileted at all. - At 9:45 a.m. R43 had taken herself back to her room and was coming back out again, but was moving backward and ran into the doorway, then just kept rocking into the doorway. - At 9:48 a.m. R43 was offered coffee and said a happy ohhhhhhuw" - At 9:59 a.m. R43 was asleep at the table; she had not touched the coffee. - At 10:08 a.m. NA-B sat at the table with R43 and started to roll silverware, NA-A had started to fill the water glasses with ice and water for lunch. - At 10:18 a.m. R43 was still had not been toileted. - At 10:33 a.m. R43 had not been toileted for the three hours of continuous observations. R43 care plan dated 3/16/14, indicated R43 had bladder incontinence related to dementia, and staff was directed to encourage fluids during the day to promote prompted voiding responses. R43	F 282		

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F 282	Continued From page 15 wore a Dri-pride (incontinent) brief and should be checked in the morning, after meals, at bedtime and as needed, and should not be left alone on the toilet. Staff "should monitor and document signs and symptoms (s/s) of UTI (urinary tract infection), such as pain, burning, blood tinged urine, cloudiness, no output, deepening color of urine, urinary frequency, foul smelling urine, low grade fever, altered mental status, change in behavior, or change in eating patterns." Staff was directed to straight catheter (cath) weekly (for urine specimen) every Thursday after R43's bath. In addition, R43 had been identified with a deficit for activities of daily living (ADL) related to physical impairment, unable to totally dress, groom, bathe self, and was resistive with cares. R43 was totally dependent on staff for toilet use; staff was directed to use a two person physical assist for toilet use. On 4/2/13, at 10:42 a.m. NA-A was approached in the kitchen where she was washing her hands to start setting up for lunch. NA-A stated she had gotten R43 up at 5:30 a.m. and she had not been toileted since. NA-A verified it had been over five hours since R43 was toileted. When toileted at 10:51 a.m. R43 had been continent and did just have a small bowel movement in the bathroom. NA-A verified R43 had a history of recurrent UTI's, and should have been toileted every two hours. R88 was admitted to the facility on 1/10/14, from a group home facility, for increasing care needs according to the Admission Record. R88's diagnoses included Schizophrenia, dementia, diabetes, gastro-esophageal reflux disease, and high blood pressure.	F 282		

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F 282	Continued From page 16 R88 was observed on 4/2/14, starting at 7:30 a.m. R88 was dressed and sitting in her favorite chair in front of her room, with breakfast on an over-bed table in front of her. - At 8:58 a.m. R88 remained in the chair in front of her room, with breakfast in front of her. R88 remained in her room from 8:30 a.m. to 9:15 a.m. - At 9:15 a.m. R88 remained in the chair outside of her room. - At 9:24 a.m. during prayer service, R88 attempted to get out of the chair, but then did sit back down. R88 was paying attention to the pastor and smiled when smiled at, but when asked how she was today, she responded tired. - At 9:48 a.m. R88 was given a snack of apple juice and cookies. - At 10:02 a.m. R88 finished her apple juice, but did not eat the cookies. - At 10:08 a.m. R88 had not been toileted (2 1/2 hours of continuous observations). - At 10:13 a.m. R88 picked up her empty juice glass and looked inside of it. - At 10:27 a.m. R88 stood and started to walk into her room. RN-A saw R88 and directed her back to sit down again, she has still not been toileted. R88 sat down and asked what was for dinner today. R88 clapped loudly when she found out fish, and then did a drum beat on the handles of her chair. - At 10:33 a.m. R88 had not been toileted during the three hours of continuous observations. - At 10:35 a.m. R88 was given another cookie, and a pack of snacks. - At 10:37 a.m. another resident went down the hall and R88 said "don't be naughty", when offered a drink of water she said yes, and clapped loudly. - At 10:53 a.m. R88 was taken to the bathroom.	F 282		

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F 282	Continued From page 17 She remained continent and had only voided a little bit. The care plan dated 1/28/14, indicated R88 had an ADL self-care deficit and bladder incontinence and directed staff to toilet in the morning, after meals, at bedtime and as needed. R67 was admitted 4/4/12, per the Admission Record with diagnoses of dementia, hypertension, and osteoporosis. On 4/2/14, at 7:32 a.m. R67 was observed eating breakfast at a table alone. -At 7:47 a.m. NA-B sat and helped R67 eat. -At 8:06 a.m. R67 was given her medications, toileted and went to the beauty shop to get a perm. -At 10:34 a.m. R67 was brought back from the beauty shop and immediately taken to the communal bathroom. The care plan dated 3/28/14, indicated R62 an ADL self-care deficit and directed staff to assist with toilet use and personal hygiene. Frequent bladder incontinence and directed staff to toilet in the morning, after meals, at night and as needed. On 4/2/14, at 10:34 a.m. NA-B verified R67 had been incontinent, and usually was incontinent. R67 was not toileted for 2 1/2 hours. On 4/2/14, at 10:42 a.m. NA-A was approached in the kitchen to discuss R43, R88 and R67. R88 had been gotten up by night staff, NA-A verified that she had not toileted her before breakfast, and that it has been greater than five hours since she had been toileted.	F 282		

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F 282	Continued From page 18 R62 was admitted 9/20/13, with diagnosis of dementia, seizure disorder, and cerebrovascular accident per the Admission Record. On 4/2/14, at 7:31 a.m. R62 was eating breakfast at the table. -At 7:37 a.m. R62 left the table, needing to go to the bathroom. He was taken to the communal bathroom. -At 7:50 a.m. R62 was asleep in front of his food. -At 7:58 a.m. R62 was asleep with head on his chest. -At 8:05 a.m. R62 continued to sleep in front of breakfast. -At 8:10 a.m. he was still asleep, but slightly more upright. -At 8:20 a.m. he continued to sleep, his chin was resting on his chest (severe scoliosis). -At 8:23 a.m. another resident was yelling, and it woke R62 up, who said "Nurse, Nurse, no wonder you don't hear a damn thing." He then told NA-A "to stop running so damn fast." NA-A brought him fresh orange juice and warm coffee and he said "you may have to warm me up too." -At 8:25 a.m. he was back asleep without drinking any of the new liquids. -At 8:30 a.m. he said nurse, "my heel is so d*** sore and I want something done with it, cause once I get home I got nobody to complain to." RN-A said alright, let me look at your medications and see what I have to help with that. - At 8:38 a.m. RN-A brought him his medications and said it would help with his feet and ankles. R62 had trouble swallowing pills and held them in his mouth, and then he spit his pills onto the table and said "tastes like s***, I can't eat them." -At 8:42 a.m. R62 did take his Tylenol, but said	F 282		

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F 282	Continued From page 19 "You always talk me into something else and then I'm stuck with it." He did let the Tylenol melt in his mouth and used water to swallow it down. - At 8:44 a.m. R62 said "Sores here, itching there, It's always something, they cut your foot off, cut your head off and you can't argue with them, about 90% is horse s***." - At 8:40 a.m. R62 used his feet to propel himself (heel reaching forward) quickly over to the counter top. - At 8:55 a.m. R62 moved down past a table and to the windows. - At 8:59 a.m. R62 propelled himself over to the opposite side of the room, facing a wall. - At 9:00 a.m. the pastor arrived to start bible study, staff were still clearing breakfast. - At 9:11 a.m. more people were put at the table with R62, he tried to turn sideways away and a NA-B said don't you want to sing, and turned him back to the table, she walked away and R62 turned sideways again, and started moving away from the table and toward the pastor. - At 9:17 a.m. to 9:25 a.m. R62 remained in the middle of the room, asleep with head on his chest, during the singing. When the pastor started to talk at 9:20 a.m. R62's head elevated, but he remained asleep. Coffee was being served at the tables again. - At 9:36 a.m. R62 was awake and moving back and forth in the w/c about one foot per swing. - At 9:48 a.m. R62 remained asleep in the dining room, (and has now gone two hours without being toileted). R62 was positioned at the table by NA-B and he woke up and said, "Better wake them up again." - At 9:59 a.m. R62 was asleep at the table. At 10:08 a.m. NA-A sat next to R62 and started to roll silverware, he remained asleep. NA-A had started to fill the water glasses with ice and water	F 282		

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F 282	Continued From page 20 for lunch. - At 10:15 NA-A told R62, "I am going to move you back up to the table." R62 turned sideways away from the table and was then taken to the communal bathroom by NA-A (two hours and 30 minutes). - At 10:42 a.m. NA-A verified it had been two hours and 30 minutes and R62 was incontinent. The care plan dated 3/18/14, indicated R62 had a ADL/self-care deficit and bladder incontinence two to three times daily and directed the staff to use assist of two and a mechanical lift to toilet as he requests. At 10:42 a.m. NA-A verified all residents had not been toileted per the care plans. At 11:00 a.m. NA-B verified all residents had not been toileted per the care plans. On 4/2/14, at 1:53 p.m. the DNS stated she would have expected the staff to follow the care plan for toileting R43, R88, R62, and R67. DNS verified that five hours between toileting was not reasonable for R43 and R88, but would need to look at the care plan to see how far off base that was, but again verified five hours was not reasonable. On 4/2/14, at 3:00 p.m. RN-A, was not aware R43 and R88 had not been toileted for over 5 hours, and verified that five hours was an excessive amount of time, two hours would be closer to the expectation, even if both were continent consistently. RN-A verified R43 had recurrent UTI's. The Activities of Daily Living policy revised 2/05, indicated the residents would receive necessary	F 282		

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F 282	Continued From page 21 services to maintain or improve abilities in activities of daily living. Fluid restrictions: R50 lacked consistent fluid intake documentation. R50's diagnoses included end stage renal disease (ESRD), anemia, hypertension, depression and seizure disorder obtained from the annual Minimum Data Set (MDS) dated 3/7/14. Physician Orders dated 12/30/13, indicated R50 was on a 1200 milliliters (ml) per day and received "Nepro as needed for may be used QD [everyday] as a substitute for ProStat d/t [due to] flavor ..." Additionally R50 had another order dated 1/25/14, for "Pro-Stat 64 liquid [Amino Acids-Protein Hydrolys] Give 1 ounce by mouth three times a day every Tues, Thu, Sat ..." Care plan dated 3/21/14, identified R50 needed hemodialysis related to ESRD noted R50 received dialysis three times a week and was on fluid restriction. The care plan directed staff to see the charge nurse before giving any fluids between meals and to document all fluids provided. Review of the Progress Notes dated 3/12/14 through 4/2/14, revealed several nurses had documented giving R50 Nepro supplement 8 oz after R50 refused to take Pro-Stat. On numerous dates R50 had the exact fluid intake recorded without the consumption of the Nepro or Pro-Stat. During further document review of the Medication Administration Records (MAR's) dated 1/1/14 through 4/3/14, revealed either Nepro or Pro-Stat	F 282		

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F 282	Continued From page 22 had been given to R50 and signed off but the record lack documentation on the amount consumed. When interviewed on 4/2/14, at 4:28 p.m. R50 stated she understood her food and fluid restrictions but at times was not very compliant. When interviewed on 4/3/14, at 10:42 a.m. licensed practical nurse (LPN)-B verified R50's was received Pro-Stat 1 oz. on dialysis days and Nepro as needed more so at noon or would send an 8 oz. can with her. LPN-B stated "Dietary will record the intake for the supplements despite we give it and I have never had to record the amount." On 4/3/14, at 12:22 p.m. DNS stated her expectation was the staff was supposed to record all the fluid intakes including the supplements as R50 was on a restriction. She further stated staff was supposed to follow R50's plan of care consistently as directed.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309		

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F 309	Continued From page 23 Based on observation, interview and document review, the facility failed to ensure adequate and consistent fluid intake documentation was being completed for 1 of 1 resident (R50) reviewed for dialysis; in addition, the facility failed to identify and monitor new bruises for 1 of 3 residents (R76) reviewed for non-pressure related skin conditions. Findings include: Fluid Intake: On 4/2/14, at 7:50 a.m. R50 was observed at the dining room (DR) table sitting on her wheelchair (w/c). R50 was observed eating half (1/2) grape fruit, one hard-boiled egg and a bowl of oatmeal. In addition, R50 had cup of tea which was approximately 100 milliliters (ml), grape juice approximately 120 ml and ice chips approximately 120 ml. -At 8:14 a.m. R50 was observed propelling her w/c and left the DR and went back to her room. -At 8:20 a.m. R50 was observed in her room and on the bedside pull table were a marked hospital pitcher with 300 ml of water and another small clear glass with water approximately 100 ml. On 4/2/14, at 4:28 p.m. R50 was observed lying in bed under the bedding's and on the bedside pull table a pitcher was observed with 400 ml of water mixed with ice chips and another small clear glass filled with ice chips in front of R50 as she was watching television. Physician Orders dated 12/30/13, indicated R50 was on "Reduced Sodium diet, regular texture, regular fluid consistency, 2 Grams [gm]. Small Portions. Fluid restriction 1200 ml/day. Daily Protein 75-85 grams Exception to diet allowed as	F 309		

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F 309	Continued From page 24 needed [PRN] special occasion or activity." Physician Orders dated 12/31/13, indicated R50 received "Nepro as needed for may be used QD [everyday] as a substitute for ProStat d/t [due to] flavor ..." Additionally, R50 had another order dated 1/25/14, for "Pro-Stat 64 liquid (Amino Acids-Protein Hydrolys) Give 1 ounce [oz] by mouth three times a day every Tues, Thu, Sat ..." Review of the Dining Report records dated 12/31/13 through 4/2/14, revealed R50's fluid recorded intakes ranged daily between 120 ml and 1180 ml, but the record lack documentation of the supplements provided to R50 on a daily basis depending on the dialysis schedule and R50's requests and preference as noted on the physicians orders above. During further document review of the Medication Administration Records (MAR's) dated 1/1/14 through 4/3/14, revealed either Nepro or Pro-Stat had been given to R50 and signed off. The medical record lack documentation on the amount consumed to determine if R50 remained within the physician ordered fluid restriction. R50's Nutrition Assessment dated 2/26/14, also indicated she was on a 1200 ml/day fluid restriction and was also taking supplements: Nepro 8 oz as needed and Pro-Stat 3 oz on dialysis days. R50's diagnoses included end stage renal disease (ESRD), anemia, hypertension, depression and seizure disorder obtained from the annual Minimum Data Set (MDS) dated 3/7/14. Review of the Progress Notes dated 3/12/14	F 309		

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F 309	Continued From page 25 through 4/2/14, revealed several nurses had documented giving R50 Nepro supplement 8 oz after refusing to take the Pro-Stat on numerous dates which had not been recorded together with the intakes to reflect the exact fluid intake R50 had consumed on those days. The Nutritional Care Area Assessment (CAA) dated 3/18/14, identified R50 with an alteration in nutrition related to ESRD, had poor memory but staff was to encourage her to make good food choices and had a fluid restriction of 1200 ml/daily. Care plan dated 3/21/14, identified R50 needed hemodialysis related to "ESRD E/B [evidenced by] dialysis three x/week and was on fluid restriction." The care plan directed staff to see the charge nurse before giving any fluids between meals and to document all fluids provided. When interviewed on 4/2/14, at 9:03 a.m. cook (C)-A stated R50 had eaten 75 percent (%) with approximately 340 ml of fluids and usually she would record what R50 had in the DR and then if she received other fluids outside of meal times then nursing was supposed to enter them to the record. When interviewed on 4/2/14, at 4:28 p.m. R50 stated she understood her diet and fluid restriction very well and she had been going to dialysis for 12 years now. R50 stated she knew the fluid restriction of 1200 ml daily. She added to state she was aware that a 4 oz glass of ice chips was equivalent to 2 oz of water. She also stated at times when she does not wish to eat the nurses would provide Nepro which was a high protein supplement. R50 further stated she	F 309		

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F 309	Continued From page 26 understood her food and fluid restrictions but at times was not very compliant. When interviewed on 4/3/14, at 10:42 a.m. licensed practical nurse (LPN)-B verified R50's was receiving Pro-Stat 1 oz on dialysis days and Nepro as needed more so at noon or would send an 8 oz can with her. LPN-B stated "Dietary will record the intake for the supplements despite we give it and I have never had to record the amount." She further stated at times R50 on dialysis days because she gets sick to her stomach she would direct when to have the supplement depending on how she felt. When interviewed on 4/3/14, at 11:43 a.m. nursing assistant (NA)-H stated she knew R50 was on a renal diet and fluid restriction but was not aware of how much R50's fluid intake was exactly and when R50 would request for fluids she knew that she was supposed to ask the charge nurse but thought dietary was recording all the intakes. On 4/3/14, at 12:22 p.m. director of nursing services (DNS) stated her expectation was the staff was supposed to record all the fluid intakes including the supplements as R50 was on a restriction. She further stated she was going to check in the electronic record to make sure the nurses got a prompt to enter the amount each time R50 received the supplements and the staff were supposed to follow R50's plan of care consistently as directed to record the amounts The facility dialysis policy revised 2/5/09, indicated at a minimum the plan of care, protocols and procedures would be related to the residents dialysis and would include observation,	F 309		

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F 309	Continued From page 27 monitoring, nutritional needs and fluid restrictions. The policy lacked who would be responsible to oversee intake for residents on fluid restrictions was adequately and consistently recorded in the medical record per the orders. Coumadin use: R76's discolorations (bruises) observed on the back of the right hand, top aspect of the right forearm, the left inner and outer wrist, and the left elbow on 4/1/14, and 4/2/14, were not identified by the facility staff, investigated for potential causal factors or monitored for healing. During the initial stage one observation and interview on 4/1/14, at 11:03 a.m. R76 was observed to have a large dark purplish colored bruise on the dorsal aspect (the back) of the right hand and a bruise on the left wrist. R76 was wearing a long sleeve shirt at the time of the observation which concealed both arms. R76 stated he did not know where the bruises came from and stated he had "thin skin" and stated he bruised easily. R76 stated the bruises were present for a "long time," but was unclear how long. R76 denied the bruises resulted from any abuse, denied awareness of a specific injury, and denied the bruises came from lab draws. On 4/2/14, at 8:30 a.m. R76 was observed to be seated in a wheelchair at a table in the main dining room. R76 was eating breakfast independently, interacting with various facility staff and interacting other residents at the table. The bruises on the back of R76's right hand and left wrist were clearly visible. - At approximately 9:00 a.m. R76 was observed to wheel himself independently out of the dining room. R76 utilized both his hands to push the	F 309		

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F 309	Continued From page 28 wheels of the wheelchair and steered the wheelchair without difficulty. R76 spoke with the surveyor briefly, discussed the weather and recalled the interview with the surveyor on 4/1/14. R76 wheeled himself out of the dining room and down the hallway towards his unit and room. R76's bruises on the right hand and left wrist were clearly visible. - At 4:12 p.m. a registered nurse (RN)-A stated she was not aware R76 had bruises. At the time of the interview, RN-A and surveyor observed R76 to be seated in a recliner chair in the lounge area at the end of the hallway and wearing a long sleeved shirt. R76 rolled back his sleeves and exposed both forearms and wrists. At the time of the observation measurements of the bruises were requested. The provided measurements were as follows: - The left outer wrist bruise was reddish purple colored, irregular shaped and measured 4.75 centimeters (cm) by 2.5 cm; - The left inner wrist bruise was reddish purple colored, circular shaped and measured 2 cm by 2 cm; - The left elbow bruise was reddish purple colored, circular shaped and measured 1.25 cm by 1 cm. - The bruise on the back of R76's right hand measured 1.0 cm x 0.5 cm, was irregular shaped and reddish purple colored; - The right top mid arm (forearm) had two reddish purple bruises (next to each other), first measured 7 cm by 7.5 cm, the second measured 2.5 cm by 3.0 cm. During the observation, R76's skin was observed to be dry, slightly flaky and thin; RN-A verified R76's skin was "fragile," the bruises should have been identified and reported "to me [RN-A]" and again verified she was not aware of the bruises.	F 309		

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F 309	Continued From page 29 On 4/2/14, at 4:30 p.m. the DNS verified the bruises should have been identified and reported. DNS stated she was not aware of R76 having bruises prior to surveyor notification, but acknowledged R76's bruises "could be" included in incident reports which were awaiting further review. DNS verified when bruises were identified by staff, an incident report should be completed including assessment of the bruises, monitoring of the bruises and determination of a potential source of injury. DNS verified R76 received the medication aspirin and stated R76 was "at risk for bruising." On 4/3/14, at 8:42 a.m. DNS verified R76's clinical record lacked identification of the bruises and an incident report had not been completed prior to 4/2/14. The DNS verified the care plan did not identify R76 was at risk for bruising due to Aspirin (to relieve minor aches and pains) use. . On 4/3/14, at 9:14 a.m. NA-E, NA-F, NA-G, NA-H of R76's unit were interviewed together. The NA staff verified the undated Center Weekly Bath Schedule indicated R76 received shower assistance from staff on Tuesdays at 7:00 a.m. and Saturdays at 6:00 a.m. - NA-E stated R76's wrist and arm bruises were "old" and described them as being present on R76's wrist and forearm for "months." NA-E stated R76 bruised easily and described R76 as "picking" at his skin. NA-E explained they believed R76 sustained the bruises from bumping into the walls and objects of the bathroom. NA-E explained R76 required one staff assist for ambulation and the bathroom was "narrow." NA-E stated they believed R76 was a reliable reporter. - NA-F stated they gave R76 his shower "last	F 309		

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F 309	Continued From page 30 Saturday;" NA-F verified they were aware of the bruises. NA-F explained the bruises were old and R76 denied knowing how he obtained them specifically. NA-F explained that during showers he/she "looks for new bruises." NA-F stated when they first noted the bruises they asked R76, "Where did this come from?" NA-F explained R76 denied knowing how the bruises were obtained and stated he/she "reported it to the nurse." When asked what happened after the bruises were reported to the nurse, NA-F made a quick dismissive gesture with both hands and stated he/she was told "we [nurses] know about them." NA-F stated they were aware of their reporting responsibility and continued to "just report" the bruises as he/she "sees them." NA-F stated they believed R76 was a reliable reporter. - NA-G verified they did not know of the bruises and had not given R76 a shower last Tuesday. NA-G stated bruises "should be" reported to the nurse. - NA-H stated R76 was a reliable reporter. NA-H explained R76's bruises "were old." NA-H denied giving R76 a shower on Tuesday. On 4/3/14, at 9:30 a.m. a LPN-B stated staff had not reported R76's bruises to her "today," but stated NA staff consistently reported bruises to her. LPN-B stated the NA staff had "reported bruises [for another resident]" to her "today." LPN-B explained if a bruise was reported and the injury was of unknown origin, she would do some "detective work" and explained it was not "a cut and dried issue." LPN-B stated she would determine if the bruises were suspicious; determine if shape was from a "pinch" or from the "sling." LPN-B stated R76 had fragile skin, received aspirin and had "old skin" and was at "increased risk for bruising." When asked	F 309		

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F 309	Continued From page 31 regarding care planning of bruises, LPN-B stated in the "old way" she completed a temporary care plan when a bruise was identified. LPN-B stated she did not know what she would do now. LPN-B stated bruises required "monitoring" and described monitoring the healing of the bruise, such as size and color changes and stated bruises should be "measured." LPN-B stated R76 was okay to sit alone on the toilet, but "forgets" and attempts to ambulate without assistance. LPN-B stated staff intervened when noted, but stated R76 could obtain injuries from slight brushing against the wall or an object. LPN-B stated she believed R76's bruised areas were a mixture of old and new bruises. LPN-B stated "in the past" monitoring of bruises was documented on the treatment sheets. The Diagnosis Description dated 10/2/13, identified R76's diagnoses to include congestive heart failure and coronary artery disease. The Physical Nursing Data (Complete within 24 hours of admission.) section of the Initial Interdisciplinary Data Collection Tool was undated and identified R76 no skin concerns and no falls. R76's admission MDS dated 10/8/13, indicated R76 had moderate cognitive impairment, had no behavior problems, required physical assistance from staff for transfers, bed mobility, walking in and out of the room, and toilet use; required extensive physical assistance from staff with locomotion on and off the unit, dressing and personal hygiene. The MDS identified no skin problems. The CAAs also dated 10/8/13, were reviewed and did not identify R76 was at risk for bruising or skin related issues due to Aspirin use. The quarterly MDS dated 12/27/13, identified	F 309		

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F 309	Continued From page 32 R76's cognition had declined and he had severe cognitive impairment, R76 required more assistance with activities of daily living and R76 had no behavioral or skin problems. The care plan dated 1/9/14, identified a "potential alteration" in R76's skin integrity related to decreased mobility from right lower back/hip pain; identified R76 had poor peri-care and did not identify risk for bruising, such as with use of aspirin. The care plan did not identify the presence of bruising. The nursing Progress Notes indicated on 3/20/14, at 6:40 p.m. R76 had a small skin tear on left lateral side and the skin tear was covered with clear OpSite dressing (transparent dressing for wounds). The note indicated staff reminded R76 to not take the dressing off and indicated R76 was scratching his wrist when he "noticed later on that it began to bleed." - A note on 3/22/14, at 10:05 p.m. indicated R76 requested staff to change the dressing on the left hand. R76 stated he "bumped his hand a few days ago," and there was noted bruising and slight bleeding. The note indicated a "TELFA Island Dressings [a convenient all-in-one Non-Adhering] Dressing" was put on R76's left hand. No progress notes indicated R76's bruises were identified. Further review of the clinical record indicated R76's bruises were not identified, monitored or care planned. R76's Order Summary Report dated 3/25/14, indicated R76 received Aspirin 81 mg (milligrams) by mouth daily for a diagnosis of coronary arthrosclerosis native graft. The report indicated the aspirin order was started on 10/2/13	F 309		

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F 309	Continued From page 33 On 4/3/14, at 9:49 a.m. DNS verified bruises should be identified and reported, verified the physician should be notified; the bruises should be assessed and care planned, including risk for bruising. DNS verified the care plan was not updated regarding bruising until "yesterday" and verified the care plan did not identify R76 as at risk for bruising. DNS stated the physician was notified "yesterday" and stated the physician had met with R76 and family regarding the increased risk for bruising on R76. DNS confirmed if a resident was noted to have issues of bumping into walls, such as having a bathroom which was too small, "the resident may need to be moved." DNS stated R76 had obtained bruises from prior episodes of "bumping" into objects, such as the wall. DNS specifically provided a copy of notes which DNS stated, "[R76] self reported injury to us" and identified the injury occurring in the bathroom. When notified NA staff had stated the bruises were old and had been reported to a nurse, DNS stated when the NA staff reported the bruise to the nurse, the nurse should have followed the previously stated procedure. During the interview, DNS verified she also observed the bruises and stated she believed R76's bruises were a "mixture of old and new bruises." DNS further verified R76 had no incident reports completed over the past year. The Good Samaritan Society Abuse and Neglect Procedure dated as revised on 7/2012, indicated the purpose of the policy was, "To ensure that all identified incidents involving injuries of unknown origin are promptly investigated to determine probable cause of unknown origin injuries." The Procedure section directed to complete an Incident Report and "When no determination of the cause of injury can be made" to "Notify the	F 309		

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F 309	Continued From page 34 center administrator immediately" of "injury of unknown source." The policy indicated if the "cause of injury can be identified through interviews of staff and residents, AND this is NOT a case of alleged or suspected abuse or neglect" the findings should be documented in the "'Investigation'" section of the Incident Report. The Good Samaritan Society Incident Report Procedure dated as revised 1/2011, indicated incident reports were to be used to document resident and visitor incidents, to conduct an investigation of each incident and to gather objective information and identify root causes to prevent similar occurrences from happening in the future. The procedure defined an incident as "an occurrence with or without injury," and directs to complete an incident report for each resident and/or visitor incident that occurs. The procedure directed to update the care plan if new interventions were attempted and an investigation would be initiated as soon as possible after the incident had occurred. Although the policy identified how to complete the incident report, the policy did not identify to include injuries such as bruises when completing an Incident Report. Although the facility provided a policy on Skin Assessment and Pressure Ulcer Prevention dated as revised on 1/2014, and the Pressure Ulcer Practice Guidelines dated as revised on 9/2010, both policies only had pertinent data regarding pressure ulcers. Both policies lacked verbiage and direction for identification of non-pressure ulcer skin problems such as bruising risk (such as from medications like Aspirin), identification and reporting of bruises, assessment of bruises (such as obtaining measurements and documenting description of	F 309		

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F 309	Continued From page 35 the bruises), or care planning of bruises. In addition, the facility lacked a policy and procedure identifying a system of monitoring for the healing of bruises.	F 309		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to check/change or offer toileting every two hours for 4 of 4 residents (R43, R88, R67, R62) observed who were dependent on others and incontinent of bladder. Findings include: R43 was admitted to the facility 11/3/09, with Admission Record diagnoses of senile dementia and nutritional deficiency. R43 was transferred to the special care unit (locked dementia unit) on 11/4/13, with episodes of yelling, screaming, and physical abuse. On 3/31/14, at 5:40 p.m. R43 was observed spilling milk on the dining table and was slapping	F 315		

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F 315	Continued From page 36 the milk on the table top to make it splash, staff asked R43 to stop because she was getting her pretty sweater all dirty. R43 continued to slap the milk on the dining table and R39 sitting next to her stated, "Hey stop it. R43 then pushed milk directly at R39. Nursing assistant (NA)-A stopped serving meals to move R43 back, away from the table and he then locked the breaks of the wheelchair (w/c). NA-A proceeded to clean up the spilled milk. R43 repeatedly attempted to pull forward gripping the table and when she could not move closer to the table she made a high pitched sound of distress mmm mmmm mmm mmm (squeak) mmm mmmm mmm mmm (squeak). R43 did not attempt to unlock the wheelchair and seemed unaware of the wheel locks. - At 5:42 p.m. the table mates R62 and R88 had been served and then R43 was served. However, R43 was left pulled back from the table with the w/c locked, and unable to reach the table. NA-A washed his hands, then sat next to R43, unlocked the w/c and pulled R43 forward to the table and attempted to assist her to eat. R43 would not eat, and started flinging her food off the plate. NA-A attempted to ask her to quiet. R43 continued to throw food off of her plate, NA-A pushed R43 back from the table and locked her wheelchair, R43 attempted to use the table to pull herself forward, R43 did not attempt to unlock the wheelchair and seemed unaware of the wheel locks. When she was not able to pull forward, R43 then stretched forward and flung her fork at NA-A who moved away from the table and R43. R43 then reached forward toward her food, but when table mate R39 said "get that slop out of here", R43 pushed her plate at R39 with force. The plate and food were removed from the table. - At 5:55 p.m. NA-D asked if R43 wanted any Rice Crispies. R43 replied ice cream, which was	F 315		

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F 315	Continued From page 37 provided and R43 ate the ice cream without assistance. Care Area Assessments (CAA) summaries with significant change Minimum Data Set (MDS) dated 10/8/13, indicated: R43 had short and long term memory loss with poor decision making, was short tempered and easily annoyed nearly every day. R43 had physical behavioral symptoms directed towards others. R43 required extensive assist of two persons for bed mobility, ambulating in the hallway, transfers and toileting, one person physical assist for locomotion on and off the unit, dressing and personal hygiene. R43 received one person physical assist, cueing, encouragement, and supervision for eating. R43's significant change MDS dated 12/31/13, indicated: R43 was rarely or never understood, had inattention and disorganized thinking. R43 had a poor appetite seven to 11 days of the look back period. R43 had physical and verbal behavioral symptoms directed towards others one to three days, and threw food four to six days in the look back period. R43 required extensive assist of two persons for bed mobility, transfers and toileting, one person physical assist for locomotion on and off the unit, dressing and personal hygiene. R43 received one person physical assist, cueing, encouragement, and supervision for eating. R43 was occasionally incontinent of bowel and bladder. R43's care plan dated 3/16/14, indicated R43 had behavior symptoms related to dementia such as verbal and physical abuse, yelling, throwing food and dishes, spitting food and fluids, running wheelchair into others, and pulling bed linens off. Staff was directed to intervene as necessary to	F 315		

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	245558	A. BUILDING _____ B. WING _____	04/03/2014

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F 315	Continued From page 38 protect the rights and safety of others, approach R43 and speak in a calm manner, divert attention away from the issue and remove from the situation and take to an alternate location as needed. When R43 threw the food staff was to re-direct to resident room and assist R43 to eat there. R88 was admitted to the facility on 1/10/14, from a group home facility, for increasing care needs according to the Admission Record. R88's diagnoses included Schizophrenia, dementia, diabetes, gastro-esophageal reflux disease, and high blood pressure. R88 was observed on 4/2/14, starting at 7:30 a.m. R88 was dressed and sitting in her favorite chair in front of her room, with breakfast on an over-bed table in front of her. - At 8:58 a.m. R88 remained in the chair in front of her room, with breakfast in front of her. R88 remained in her room from 8:30 a.m. to 9:15 a.m. - At 9:15 a.m. R88 remained in the chair outside of her room. - At 9:24 a.m. during prayer service, R88 attempted to get out of the chair, but then did sit back down. R88 was paying attention to the pastor and smiled when smiled at, but when asked how she was today, she responded tired. - At 9:48 a.m. R88 was given a snack of apple juice and cookies. - At 10:02 a.m. R88 finished her apple juice, but did not eat the cookies. - At 10:08 a.m. R88 had not been toileted (2 1/2 hours of continuous observations). - At 10:13 a.m. R88 picked up her empty juice glass and looked inside of it. - At 10:27 a.m. R88 stood and started to walk into	F 315		

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F 315	Continued From page 39 her room. RN-A saw R88 and directed her back to sit down again, she has still not been toileted. R88 sat down and asked what was for dinner today. R88 clapped loudly when she found out fish, and then did a drum beat on the handles of her chair. - At 10:33 a.m. R88 had not been toileted during the three hours of continuous observations. - At 10:35 a.m. R88 was given another cookie, and a pack of snacks. - At 10:37 a.m. another resident went down the hall and R88 said "don't be naughty", when offered a drink of water she said yes, and clapped loudly. - At 10:53 a.m. R88 was taken to the bathroom. She remained continent and had only voided a little bit. The admission MDS dated 1/20/14, a Brief Interview for Mental Status Changes (BIMS) score of 2, indicated severe cognitive impairment. R88 displayed delirium with fluctuating disorganizing thinking, minimal depression, and verbal behaviors directed towards others. R88 required extensive assistance of one person for bed mobility, transfers, dressing, personal hygiene and toileting. R88 required limited assistance of one for with ambulation, locomotion and eating. R88 was frequently incontinent, but did have continent episodes. R88 was frequently incontinent of urine. R88's CAA summaries for cognitive loss, communication, urinary incontinence, behavioral symptoms, falls, nutritional status, dental care, pressure ulcer, and psychotropic drugs. The care plan dated 1/28/14, indicated R88 had an ADL self-care deficit and balder incontinence	F 315		

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F 315	Continued From page 40 and directed staff to toilet in the morning, after meals, at bedtime and as needed. R67 was admitted 4/4/12, per the Admission Record with diagnoses of dementia, hypertension, and osteoporosis. On 4/2/14, at 7:32 a.m. R67 was observed eating breakfast at a table alone. -At 7:47 a.m. NA-B sat and helped R67 eat. -At 8:06 a.m. R67 was given her medications, toileted and went to the beauty shop to get a perm. -At 10:34 a.m. R67 was brought back from the beauty shop and immediately taken to the communal bathroom. The MDS dated 2/11/14, R67 had a BIMS score of 1, which indicated severe cognitive impairment. R67 required extensive physical assist of two persons for toileting, and extensive physical assist of one person for bed mobility, transfers, dressing, personal hygiene, ambulation on and off the unit, and locomotion on and off the unit. R67 was frequently incontinent of bladder. CAA's summaries for cognitive loss, visual function, communication, urinary incontinence, psychosocial wellbeing, falls, nutritional status, and pressure ulcer. The care plan dated 3/28/14, indicated an ADL self-care deficit and direct4ed staff to assist with toilet use and personal hygiene. Frequent bladder incontinence and directed staff to toilet in the morning, after meals, at night and as needed. The care plan dated 3/28/14, indicated R62 an	F 315		

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F 315	Continued From page 41 ADL self-care deficit and directed staff to assist with toilet use and personal hygiene. Frequent bladder incontinence and directed staff to toilet in the morning, after meals, at night and as needed. On 4/2/14, at 10:34 a.m. NA-B verified R67 had been incontinent, and usually was incontinent. R67 was not toileted for two and a half hours. On 4/2/14, at 10:42 a.m. NA-A was approached in the kitchen to discuss R43, R88 and R67. R88 had been gotten up by night staff, NA-A verified that she had not toileted her before breakfast, and that it has been greater than five hours since she had been toileted. R62 was admitted 9/20/13, with diagnosis of dementia, seizure disorder, and cerebrovascular accident per the Admission Record. On 4/2/14, at 7:31 a.m. R62 was eating breakfast at the table. -At 7:37 a.m. R62 left the table, needing to go to the bathroom. He was taken to the communal bathroom. -At 7:50 a.m. R62 was asleep in front of his food. -At 7:58 a.m. R62 was asleep with head on his chest. -At 8:05 a.m. R62 continued to sleep in front of breakfast. -At 8:10 a.m. he was still asleep, but slightly more upright. -At 8:20 a.m. he continued to sleep, his chin was resting on his chest (severe scoliosis). -At 8:23 a.m. another resident was yelling, and it woke R62 up, who said "Nurse, Nurse, no wonder you don't hear a damn thing." He then told NA-A	F 315		

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F 315	Continued From page 42 "to stop running so damn fast." NA-A brought him fresh orange juice and warm coffee and he said "you may have to warm me up too." -At 8:25 a.m. he was back asleep without drinking any of the new liquids. -At 8:30 a.m. he said nurse, "my heel is so d*** sore and I want something done with it, cause once I get home I got nobody to complain to." RN-A said alright, let me look at your medications and see what I have to help with that. - At 8:38 a.m. RN-A brought him his medications and said it would help with his feet and ankles. R62 had trouble swallowing pills and held them in his mouth, and then he spit his pills onto the table and said "tastes like s***, I can't eat them." -At 8:42 a.m. R62 did take his Tylenol, but said "You always talk me into something else and then I'm stuck with it." He did let the Tylenol melt in his mouth and used water to swallow it down. - At 8:44 a.m. R62 said "Sores here, itching there, It's always something, they cut your foot off, cut your head off and you can't argue with them, about 90% is horse s***." - At 8:40 a.m. R62 used his feet to propel himself (heel reaching forward) quickly over to the counter top. - At 8:55 a.m. R62 moved down past a table and to the windows. - At 8:59 a.m. R62 propelled himself over to the opposite side of the room, facing a wall. - At 9:00 a.m. the pastor arrived to start bible study, staff were still clearing breakfast. - At 9:11 a.m. more people were put at the table with R62, he tried to turn sideways away and a NA-B said don't you want to sing, and turned him back to the table, she walked away and R62 turned sideways again, and started moving away from the table and toward the pastor. - At 9:17 a.m. to 9:25 a.m. R62 remained in the	F 315		

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F 315	Continued From page 43 middle of the room, asleep with head on his chest, during the singing. When the pastor started to talk at 9:20 a.m. R62's head elevated, but he remained asleep. Coffee was being served at the tables again. - At 9:36 a.m. R62 was awake and moving back and forth in the w/c about one foot per swing. - At 9:48 a.m. R62 remained asleep in the dining room, (and has now gone two hours without being toileted). R62 was positioned at the table by NA-B and he woke up and said, "Better wake them up again." - At 9:59 a.m. R62 was asleep at the table. At 10:08 a.m. NA-A sat next to R62 and started to roll silverware, he remained asleep. NA-A had started to fill the water glasses with ice and water for lunch. - At 10:15 NA-A told R62, "I am going to move you back up to the table." R62 turned sideways away from the table and was then taken to the communal bathroom by NA-A (two hours and 30 minutes). - At 10:42 a.m. NA-A verified it had been two hours and 30 minutes and R62 was incontinent. The MDS dated 9/26/13, had a BIMS score of 8, which indicated moderate cognitive impairment. A PHQ9 score of 13 which indicated moderate depression. R62 received two person physical assist for transfers and toileting. R62 received one person physical assist for toileting, dressing, and locomotion on and off the unit. R62 was frequently incontinent of bowel and bladder. The CAAs dated 9/26/13, summaries for cognitive loss/dementia, visual function, communication, ADLs, urinary incontinence, psychosocial wellbeing, mood state, behavioral	F 315		

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F 315	Continued From page 44 symptoms, activities, falls, pressure ulcer, psychotropic drugs and pain. The care plan dated 3/18/14, indicated R62 had a ADL/self-care deficit and bladder incontinence two to three times daily and directed the staff to use assist of two and a mechanical lift to toilet as he requests. On 4/2/14, at 10:42 a.m. NA-A verified all of the above residents had not been toileted per the care plans. On 4/2/14, at 11:00 a.m. NA-B verified all of the above residents had not been toileted per the care plans. On 4/2/14, at 1:53 p.m. the DNS stated she would have expected the staff to follow the care plan for toileting R43, R88, R62, and R67. DNS verified that five hours between toileting was not reasonable for R43 and R88, but would need to look at the care plan to see how far off base that was, but again verified five hours was not reasonable. On 4/2/14, at 3:00 p.m. RN-A, was not aware R43 and R88 had not been toileted for over five hours, and verified that five hours was an excessive amount of time, two hours would be closer to the expectation, even if both were continent consistently. RN-A verified R43 had recurrent UTI's. The Activities of Daily Living policy revised 2/05, indicated the residents would receive necessary services to maintain or improve abilities in activities of daily living.	F 315		

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F 329	Continued From page 45	F 329		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and document review, the facility failed to identify adequate indications for use or monitor for efficacy of Ativan (an antianxiety medication) for 2 of 5 residents (R35, R43); failed to identify, care plan and monitor for side effects for the use of Coumadin (an anticoagulant medication) for 1 of 5 residents (R52); lacked indications for the use of Zantac	F 329		

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F 329	Continued From page 46 and Protonix (used for acid reflux) for 1 of 5 residents (R35) reviewed for unnecessary medications. Findings include: Anti-anxiety medication: The facility failed to identify adequate indications for use and monitoring to ensure the medication was effective for Ativan for R35. On 4/1/14, at 9:32 a.m. R35 was observed sitting in her wheelchair (w/c) in her room asleep. -At 10:14 a.m. R35 remained in her w/c asleep. -At 11:02 a.m. R35 was again observed asleep in her w/c in her room. On 4/2/14, at 9:32 a.m. R35 was observed calling out for help in her room. R35 was interviewed on 4/3/14, at 10:52 a.m. and reported she slept good. When asked what helps her with sleep, she stated the doctor gives her "a little relaxer." The med care plan dated 9/27/12, noted R35 had a history of Xanax (a medication used to treat anxiety) 0.25 milligrams (mg) every bedtime. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 8/14/13, indicated R35 continued to exhibit memory loss and needed supervision with decision making due to compromised judgment and reasoning. The Psychotropic Drug Use CAA dated 8/14/13, indicated R35 used Celexa (an antidepressant) daily for anxiety with symptoms of crying and restlessness. Symptoms of insomnia were not noted on the CAA.	F 329		

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F 329	Continued From page 47 The Mood & Behavior Report dated 12/1/13 through 4/3/14, revealed no mood or behavior occurred during that time frame. The Progress Notes from 12/1/13 through 4/3/14, were reviewed and the following was noted: -On 1/14/14, noted "sleeps well at night." -On dated 1/16/14, written by the social worker noted Ativan order was appropriate for a "couple of weeks" due to her house being sold and demolished. The Progress Notes from 12/1/13 through 4/3/14, lacked any documentation regarding sleep patterns. The January 2014 Medication Record revealed R35 started receiving Ativan 0.5 mg on 1/14/14, and Tylenol (a mild analgesic) 650 mg every bedtime was stopped on 1/20/14. The Nursing Home Medication Review dated 1/14/14, noted R35 reported the sleeping pill at bedtime (Tylenol) was not working and R35 wanted alprazolam (Xanax). The note indicated Ativan 0.5 mg every bedtime for sleep per patient request. The quarterly Minimum Data Set (MDS) dated 1/17/14, included a Brief Interview of Mental Status (BIMS-tool used to measure cognition) of 14 (indicating cognitively intact). The MDS indicated R35 had trouble falling asleep, staying asleep or sleeping too much on two to six days out of fourteen. The alteration in cognition care plan dated 1/20/14, noted R35 required supervision with decision making and the alteration in mood care	F 329		

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F 329	Continued From page 48 plan dated 1/30/14, directed to provide 1:1 visits; to provide encouragement and emotional support as needed, offer conversation to divert attention, allow time to vent when anxious/sad and monitor for insomnia (offer bathroom, snack, repositioning or 1:1 time). The Order Summary Report dated 3/11/14, included physician orders for Celexa 10 mg for anxiety and Ativan 0.5 mg every bedtime for insomnia. The Admission Record dated 4/3/14, indicated R35 was admitted to the facility on 8/20/12, and included diagnoses of insomnia and anxiety. When interviewed on 4/3/14, at 7:59 a.m. registered nurse (RN)-D reported mood or behavioral charting is only done if a concern is identified. RN-D stated the night shift nurse documents on sleep patterns monthly and no sleep logs are kept. RN-D reported Tylenol had not been working and because R35 had taken Ativan at home, it was ordered for sleep with insomnia as the target behavior. The director nursing services (DNS) was interviewed on 4/3/14, at 10:01 a.m. stated there should be a monthly sleep review and sleep information could also be found with incidental charting. DNS stated a sleep assessment should be reviewed quarterly and when a new medication is started. DNS further stated she expected alternatives to medication to be identified and tried for sleep and would expect documentation of the need for sleep medication. The physician for R35 was interviewed on 4/3/14, at 10:27 a.m. and stated she ordered Ativan	F 329		

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F 329	Continued From page 49 because the R35 had been on it before and wanted it. The physician stated the previous medication (Tylenol) was not helpful. When interviewed on 4/3/14, at 11:15 a.m. the consultant pharmacist (CP) stated R35 was receiving Ativan because she requested it. CP stated a dose reduction of Ativan could be attempted and Celexa would be due for an evaluation too. CP also stated there should be target mood/behavior documentation and he did not have target symptoms for Ativan for R35. CP further stated he thought R35 was getting Ativan for anxiety, not sleep and the Celexa should help with anxiety too. The facility Psychopharmacological Medications and Sedative/Hypnotics policy dated February 2005, and revised January 2007, directed "Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: without adequate monitoring or without adequate indications for its use." The facility Psychopharmacological Medications and Sedative/Hypnotics procedure dated February 2005 and last revised 9/13, directed "Prior to administration of non-emergency psychopharmacological and/or sedative/hypnotics, the following must be completed: If the resident is experiencing sleep disturbances, complete the Sleep Assessment (GSS #4820)." R43 lacked ongoing monitoring for efficiacy of Ativan. Observation on 3/31/14, at 5:40 p.m. R43 was observed spilling milk on the dining table and was	F 329		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 50 slapping the milk on the table top to make it splash, staff asked R43 to stop because she was getting her pretty sweater all dirty. R43 continued to slap the milk on the dining table and R39 sitting next to her stated, "Hey stop it." R43 then pushed milk directly at R39. Nursing assistant (NA)-A stopped serving meals to move R43 back, away from the table and he then locked the breaks of the w/c. NA-A proceeded to clean up the spilled milk. R43 repeatedly attempted to pull forward gripping the table and when she could not move closer to the table she made a high pitched sound of distress mmm mmmm mmm mmm (squeak) mmm mmmm mmm mmm (squeak). R43 did not attempt to unlock the wheelchair and seemed unaware of the wheel locks. - At 5:42 p.m. the table mates R62 and R88 had been served and then R43 was served. However, R43 was left pulled back from the table with the w/c locked, and unable to reach the table. NA-A washed his hands, then sat next to R43, unlocked the w/c and pulled R43 forward to the table and attempted to assist her to eat. R43 would not eat, and started flinging her food off the plate. NA-A attempted to ask her to quiet. R43 continued to throw food off of her plate, NA-A pushed R43 back from the table and locked her wheelchair, R43 attempted to use the table to pull herself forward, R43 did not attempt to unlock the wheelchair and seemed unaware of the wheel locks. When she was not able to pull forward, R43 then stretched forward and flung her fork at NA-A who moved away from the table and R43. R43 then reached forward toward her food, but when table mate R39 said "get that slop out of here, " R43 pushed her plate at R39 with force. The plate and food were removed from the table. R43 was admitted to the facility 11/3/09, with	F 329		

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	245558	A. BUILDING _____ B. WING _____	04/03/2014

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F 329	Continued From page 51 Admission Record diagnoses of senile dementia and depressive disorder. R43 was transferred to the special care unit (locked dementia unit) on 11/4/13, related to senile dementia, episodes of yelling, screaming, physical abuse with cares and exit seeking behaviors. The CAAs summary dated 10/8/13, indicated: R43 had short and long term memory loss with poor decision making, was short tempered and easily annoyed nearly every day. R43 had physical behavioral symptoms directed towards others. R43 required extensive assist of two persons for bed mobility, ambulating in the hallway, transfers and toileting, one person physical assist for locomotion on and off the unit, dressing and personal hygiene. R43 received one person physical assist, cueing, encouragement, and supervision for eating. R43 was not assessed as needing a restraint on the MDS. R43's significant change MDS dated 12/31/13, indicated R43 was rarely or never understood, had inattention and disorganized thinking. R43 had a poor appetite seven to 11 days of the look back period. R43 had physical and verbal behavioral symptoms directed towards others one to three days, and threw food four to six days in the look back period. R43 required extensive assist of two persons for bed mobility, transfers and toileting, one person physical assist for locomotion on and off the unit, dressing and personal hygiene and one person physical assist, cueing, encouragement, and supervision for eating. The MAR for March and April 2014 were reviewed and R43 had last received Ativan dose on 3/23/14, at 2:40 p.m. A Monthly Medication	F 329		

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F 329	Continued From page 52 Review dated 2/22/14, did not address the lack of consistent behavior monitoring and trending. On 4/3/14, at 9:19 a.m. the DNS stated they do not have a shift behavioral tracking tool, they document behaviors as they occur (by exception). On 4/3/14, at 9:50 a.m. RN-B stated "We have a new system here. The expectation was to document at point of care." There was no continuous shift by shift monitoring. The psychopharmacological medications and sedative/hypnotics policy dated 1/07, indicated an unnecessary drug is any drug when used: in excessive dose including duplicate therapy, for excessive duration, without adequate monitoring, without adequate indications for use, in the presence of adverse consequences which indicate the dose should be reduced or discontinued, or any combination of the reasons above. Coumadin use: R52 used Coumadin (an anticoagulant) daily and had no side effect monitoring. The Order Summary Report dated as signed by physician on 3/11/14, indicated to give R52 Coumadin 2.5 mg by mouth (PO) daily for a diagnosis of transient cerebral ischemia (interruptions in blood flow in the brain potentially caused by blood clots). R52's quarterly MDS dated 1/10/14, indicated R52 was cognitively intact, had no behavior problems and was independent with all activities of daily living (ADLs). The MDS identified R52 received an anticoagulant (such as Coumadin)	F 329		

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F 329	Continued From page 53 daily during the assessment period. R52's laboratory (lab) tests indicated on 2/11/14, R52's international ratio (a lab test used to check clotting time and efficacy of Coumadin) was checked. Although the clinical record indicated R52's use of Coumadin was monitored for efficacy, the clinical record lacked evidence R52 was monitored for side effects of Coumadin. Review of R52's MARs for January, February, March and April 2014, indicated R52 received Coumadin as ordered and included identification of R52's INR blood draws. MARs lacked identification or direction for monitoring of potential side effects of Coumadin. The Interdisciplinary Progress Notes 1/5/14, through 4/2/14, lacked documentation of potential side effect monitoring for the use of Coumadin. The care plan dated 1/23/14, lacked identification of the transient cerebral ischemia diagnosis and the use of Coumadin. In addition, the care plan lacked development of appropriate goals associated with the use of Coumadin, lacked identification of monitoring for efficacy, potential side effects and direction for addressing potential concerns associated with the use of Coumadin. On 4/2/14, R52 was observed at 7:40 a.m. at the breakfast meal and again at 3:08 p.m. ambulating in the hallway independently. No signs of unusual bruising or concerns of bleeding were observed or expressed by the R52. On 4/2/14, at 3:31 p.m. RN-A verified R52 received a scheduled dose of Coumadin. - At 4:07 p.m. RN-A stated she monitored R52 for	F 329		

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F 329	Continued From page 54 bruising and symptoms of bleeding. Stated NA staff should report bruises to the nurses. RN-A verified the use of Coumadin was not addressed on the care plan. RN-A verified the clinical record lacked evidence R52 was monitored for side effects of Coumadin. - At 4:24 p.m. the DNS verified R52's care plan did not address the Coumadin use. DNS stated she would expect the medication to be identified and care planned, and the care plan to direct monitoring for side effects such as bruising. DNS verified the clinical record lacked monitoring for side effects of Coumadin. On 4/3/14, at 11:15 a.m. the CP was contacted via telephone and verified the use of Coumadin should have been identified of the care plan and confirmed the medication should be monitored for side effects. CP verified they did not identify the lack of monitoring for side effects and lack of care planning for the use of Coumadin. A Pharmaceutical Services Policy & Procedure Manual 6:30 Recommended Laboratory Orders Required for Drug Monitoring undated was provided. The policy included a table containing a list of medications commonly ordered in long-term care facility that required a laboratory drug monitoring plan. The Drug Category section of the policy listed "Anticoagulants" and directed to complete "INR [International Normalized Ratio] monitoring - per Coumadin protocol - stop order policy requires monthly INRs unless between tests was specified." The facility lacked a policy which directed identification of the use of Coumadin and monitoring for side effects of the drug. The Brystol-Myers Squibb package insert for	F 329		

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F 329	Continued From page 55 Coumadin dated as revised 10/2011, identified potential side effects to monitor for. The insert directed to notify the health care provider of signs or symptoms of bleeding and indicated bleeding risk had potential major health concerns including death. The insert included identification of other potential side effects such as, but not limited to pain, swelling, blood in stools, and unusual bruising. R34 lacked an indication for receiving both Zantac (Ranitidine) and Protonix (both used to treat acid reflux). When interviewed on 4/2/14, at 9:32 a.m. R34 stated "I have never been a big eater and never really got hungry easy." He further stated, "I take a lot of medications now more than in the past when I lived out in the farm and my memory is not really good that I can tell you what they are for but the nurses give them to me as ordered." When asked if his stomach would be upset or have heart burn at times R34 stated, "I feel fine am just not and never been a big eater." Windom Good Samaritan Center Pharmacy Care Plan dated 2/24/11, identified R34 had diagnoses of esophageal stricture, gastritis, gastroesophageal reflux disease and received Protonix 40 mg and Zantac 150 mg twice daily (BID). Review of Physician Progress Notes dated 12/18/12 through 4/1/14, lacked evidence of documentation for indication of both medications. In addition, R34's reports of stomach upset or heartburn were not documented. Review of the Physician Orders signed and dated	F 329		

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F 329	Continued From page 56 4/1/14, revealed R34 had an order dated 2/25/11, for Protonix (pantoprazole) 40 mg PO everyday *Give half (1/2) hour before meal. In addition, R34 had an order dated 8/27/13, for Zantac 150 mg PO BID. The Medication Regimen Review policy dated 1/07, indicated once a month medication regimen review (MMR) review by licensed pharmacist to identify selection of medications based on assessing relative benefits and risks to the resident, evaluation of a resident's signs and symptoms in order to identify the underlying causes including adverse consequences of medications selection and use of medications in doses and for the duration appropriate to each residents clinical condition, age, and underlying causes of symptoms. Monitoring of medications for efficacy and clinically significant adverse consequences, potential medication irregularities and response to these irregularities, medication related errors. The policy lacked a direction to ensure appropriate monitoring for medications was in place.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal 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	F 334		

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F 334	Continued From page 57 immunized during this time period; (iii) The resident or the resident's legal 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 legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the	F 334		

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F 334	Continued From page 58 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R91) was offered a Pneumococcal vaccination or had documentation of a contraindication or refusal. Findings include: The Admission Record dated 4/3/14, indicated R91 was admitted to the facility on 1/21/14. Review of R91's Immunization Record lacked documentation if a pneumococcal vaccination had been received, was contraindicated or refused. The Immunization Record indicated the legal representative received education regarding potential benefits and potential side effects on 1/23/14. When interviewed on 4/3/14, at 11:34 a.m. registered nurse (RN)-E stated she thought R91 or the family refused the Pneumococcal vaccination but she was not sure and could not find any documentation of the refusal. RN-E	F 334		

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F 334	Continued From page 59 stated she called R91's daughter and they do want R91 to be given a Pneumococcal vaccination and it would be given now. The facility Immunization For Residents procedure revised 11/13, directed "If the resident has not received one dose of pneumococcal vaccine after age 65 and an order was not received at the time of admission, obtain a physician's order for vaccination unless contraindicated or the resident chooses not to be vaccinated."	F 334		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and document review, the facility failed to identify adequate indications for use or monitor for efficacy of Ativan (an antianxiety medication) for 21 of 5 residents (R35, R43); failed to identify, care plan and monitor for side effects for the use of Coumadin (an anticoagulant medication) for 1 of 5 residents (R52).	F 428		

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F 428	Continued From page 60 Findings include: The consultant pharmacist (CP) failed to identify a medication irregularity regarding adequate indications for use and monitoring to ensure the medication was effective for Ativan (an antianxiety medication) for R35. Anti-anxiety medication: The facility failed to identify adequate indications for use and monitoring to ensure the medication was effective for Ativan for R35. On 4/1/14, at 9:32 a.m. R35 was observed sitting in her wheelchair (w/c) in her room asleep. -At 10:14 a.m. R35 remained in her w/c asleep. -At 11:02 a.m. R35 was again observed asleep in her w/c in her room. On 4/2/14, at 9:32 a.m. R35 was observed calling out for help in her room. R35 was interviewed on 4/3/14, at 10:52 a.m. and reported she slept good. When asked what helps her with sleep, she stated the doctor gives her "a little relaxer." The med care plan dated 9/27/12, noted R35 had a history of Xanax (a medication used to treat anxiety) 0.25 milligrams (mg) every bedtime. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 8/14/13, indicated R35 continued to exhibit memory loss and needed supervision with decision making due to compromised judgment and reasoning. The Psychotropic Drug Use CAA dated 8/14/13, indicated R35 used Celexa (an antidepressant) daily for anxiety with symptoms of crying and restlessness. Symptoms of insomnia were not	F 428		

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F 428	Continued From page 61 noted on the CAA. The Mood & Behavior Report dated 12/1/13 through 4/3/14, revealed no mood or behavior occurred during that time frame. The Progress Notes from 12/1/13 through 4/3/14, were reviewed and the following was noted: -On 1/14/14, noted "sleeps well at night." -On dated 1/16/14, written by the social worker noted Ativan order was appropriate for a "couple of weeks" due to her house being sold and demolished. The Progress Notes from 12/1/13 through 4/3/14, lacked any documentation regarding sleep patterns. The January 2014 Medication Record revealed R35 started receiving Ativan 0.5 mg on 1/14/14, and Tylenol (a mild analgesic) 650 mg every bedtime was stopped on 1/20/14. The Nursing Home Medication Review dated 1/14/14, noted R35 reported the sleeping pill at bedtime (Tylenol) was not working and R35 wanted alprazolam (Xanax). The note indicated Ativan 0.5 mg every bedtime for sleep per patient request. The quarterly Minimum Data Set (MDS) dated 1/17/14, included a Brief Interview of Mental Status (BIMS-tool used to measure cognition) of 14 (indicating cognitively intact). The MDS indicated R35 had trouble falling asleep, staying asleep or sleeping too much on two to six days out of fourteen. The alteration in cognition care plan dated 1/20/14, noted R35 required supervision with	F 428		

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F 428	Continued From page 62	F 428		

decision making and the alteration in mood care plan dated 1/30/14, directed to provide 1:1 visits; to provide encouragement and emotional support as needed, offer conversation to divert attention, allow time to vent when anxious/sad and monitor for insomnia (offer bathroom, snack, repositioning or 1:1 time).

The Order Summary Report dated 3/11/14, included physician orders for Celexa 10 mg for anxiety and Ativan 0.5 mg every bedtime for insomnia.

The Affiliated Consultant Pharmacists of Minnesota document dated 1/30/14, 1/20/14, and 3/21/14, revealed the consultant pharmacist reviewed R35's medications three times after the physician ordered Ativan.

The Admission Record dated 4/3/14, indicated R35 was admitted to the facility on 8/20/12, and included diagnoses of insomnia and anxiety.

When interviewed on 4/3/14, at 7:59 a.m. registered nurse (RN)-D reported mood or behavioral charting is only done if a concern is identified. RN-D stated the night shift nurse documents on sleep patterns monthly and no sleep logs are kept. RN-D reported Tylenol had not been working and because R35 had taken Ativan at home, it was ordered for sleep with insomnia as the target behavior.

The director nursing services (DNS) was interviewed on 4/3/14, at 10:01 a.m. stated there should be a monthly sleep review and sleep information could also be found with incidental charting. DNS stated a sleep assessment should be reviewed quarterly and when a new

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F 428	Continued From page 63 medication is started. DNS further stated she expected alternatives to medication to be identified and tried for sleep and would expect documentation of the need for sleep medication. The physician for R35 was interviewed on 4/3/14, at 10:27 a.m. and stated she ordered Ativan because the R35 had been on it before and wanted it. The physician stated the previous medication (Tylenol) was not helpful. When interviewed on 4/3/14, at 11:15 a.m. the CP stated R35 was receiving Ativan because she requested it. CP stated a dose reduction of Ativan could be attempted and Celexa would be due for an evaluation too. CP also stated there should be target mood/behavior documentation and he did not have target symptoms for Ativan for R35. CP further stated he thought R35 was getting Ativan for anxiety, not sleep and the Celexa should help with anxiety too. The facility Psychopharmacological Medications and Sedative/Hypnotics policy dated February 2005, and revised January 2007, directed "Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: without adequate monitoring or without adequate indications for its use." The facility Psychopharmacological Medications and Sedative/Hypnotics procedure dated February 2005 and last revised 9/13, directed "Prior to administration of non-emergency psychopharmacological and/or sedative/hypnotics, the following must be completed: If the resident is experiencing sleep disturbances, complete the Sleep Assessment (GSS #4820)."	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 64 R43: The consultant pharmacist did not ensure adequate, ongoing monitoring was in place for antipsychotic and anti-anxiety medications. R43 was admitted to the facility 11/3/09, with Admission Record diagnoses of senile dementia and depressive disorder. R43 was transferred to the special care unit (locked dementia unit) on 11/4/13, related to senile dementia, episodes of yelling, screaming, physical abuse with cares and exit seeking behaviors. The CAAs summary dated 10/8/13, indicated: R43 had short and long term memory loss with poor decision making, was short tempered and easily annoyed nearly every day. R43 had physical behavioral symptoms directed towards others. R43 required extensive assist of two persons for bed mobility, ambulating in the hallway, transfers and toileting, one person physical assist for locomotion on and off the unit, dressing and personal hygiene. R43 received one person physical assist, cueing, encouragement, and supervision for eating. R43 was not assessed as needing a restraint on the MDS. R43's significant change MDS dated 12/31/13, indicated R43 was rarely or never understood, had inattention and disorganized thinking. R43 had a poor appetite seven to 11 days of the look back period. R43 had physical and verbal behavioral symptoms directed towards others one to three days, and threw food four to six days in the look back period. R43 required extensive assist of two persons for bed mobility, transfers and toileting, one person physical assist for locomotion on and off the unit, dressing and	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 65 personal hygiene and one person physical assist, cueing, encouragement, and supervision for eating. A Monthly Medication Review dated 2/22/14, did not address the lack of consistent behavior monitoring and trending. Pharmacy monthy drug reviews were completed, last on 3/21/14. The CP did not address the irrgeularity of the monitoring of the Ativan with the facility. The MAR for March and April 2014 were reviewed and R43 had last received Ativan dose on 3/23/14, at 2:40 p.m. A Monthly Medication Review dated 2/22/14, did not address the lack of consistent behavior monitoring and trending. On 4/3/14, at 9:19 a.m. the DNS stated they do not have a shift behavioral tracking tool, they document behaviors as they occur (by exception). On 4/3/14, at 9:50 a.m. RN-B stated "We have a new system here. The expectation was to document at point of care." There was no continuous shift by shift monitoring. When interviewed on 4/3/14, at 11:15 a.m. the CP stated there should be target mood/behavior documentation for Ativan. CP did not identify the lack of care planning and monitoring for side effects of R52's use of Coumadin. The Order Summary Report dated as signed by physician on 3/11/14, indicated to give R52 Coumadin 2.5 mg by mouth (PO) daily for a diagnosis of transient cerebral ischemia (interruptions in blood flow in the brain potentially	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 66 caused by blood clots). The Brystol-Myers Squibb package insert for Coumadin dated as revised 10/2011, identified potential side effects to monitor for. The insert directed to notify the health care provider of signs or symptoms of bleeding and indicated bleeding risk had potential major health concerns including death. The insert included identification of other potential side effects such as, but not limited to pain, swelling, blood in stools, and unusual bruising. The care plan dated 1/23/14, lacked identification of the transient cerebral ischemia diagnosis and the use of Coumadin. In addition, the care plan lacked development of appropriate goals associated with the use of Coumadin, lacked identification of monitoring for efficacy, potential side effects and direction for addressing potential concerns associated with the use of Coumadin. On 4/2/14, R52 was observed at 7:40 a.m. at the breakfast meal and again at 3:08 p.m. ambulating in the hallway independently. No signs of unusual bruising or concerns of bleeding were observed or expressed by the R52. On 4/2/14, at 3:31 p.m. the RN-A verified R52 received a scheduled dose of Coumadin. - At 4:07 p.m. RN-A stated she monitored R52 for bruising and symptoms of bleeding. Stated NA staff should report bruises to the nurses. RN-A verified the use of Coumadin was not addressed on the care plan. RN-A verified the clinical record lacked evidence R52 was monitored for side effects of Coumadin. - At 4:24 p.m. the DNS verified R52's care plan did not address the Coumadin use. DNS stated	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 67 she would expect the medication to be identified and care planned, and the care plan to direct monitoring for side effects such as bruising. DNS verified the clinical record lacked monitoring for side effects of Coumadin. On 4/3/14, at 11:15 a.m. the CP was contacted via telephone and verified the use of Coumadin should have been identified R52's care plan and confirmed the medication should be monitored for side effects. CP verified they did not identify the lack of monitoring for side effects and lack of care planning for R52's use of Coumadin. The Good Samaritan Society Procedure for Medication Regimen Review dated as issued 1/2007, identified each resident would have their drug regimen reviewed monthly by a licensed pharmacist. The procedure indicated the review would identify selection of medications based on assessing relative benefits and risks to the resident, evaluation of a resident's signs and symptoms in order to identify the underlying causes including adverse consequences of medications, selection and use of medications in doses and for the duration appropriate to each resident's clinical condition, age and underlying causes of symptoms, monitoring of medications for efficacy and clinically significant adverse consequences, potential medication irregularities and response to these irregularities. The policy indicated CP would inform DNS of these in a written report. The policy included a table which identified potential medication interaction concerns with Coumadin (warfarin) and the potential impact.	F 428		

Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.

F-221
Corrected Date: May 13, 2014

It is the current policy and procedure of GSS-Windom to follow the care plan for every resident.

R43's care plan was reviewed and found to be appropriate.

All residents in the special care unit (SPCU) are at risk for staff not following the care plan when eating related behaviors occur.

Nursing Staff working on March 31, 2014 were re-educated by the surveyor in regard to following the care planned approaches for behavior interventions. Further re-education for other special care unit staff occurred on April 1, 2014 by the assistant case manager. All nursing staff will be educated regarding behavior management by May 9, 2013.

An audit of the all residents in the special care unit during meal times will be conducted for 3 meals per day times 5 days for one week to assure freedom of movement is not prevented by wheelchair brakes being applied inappropriately during behavior episodes and that care planned interventions are used. Audits will be conducted by the CQI Coordinator or designee.

Additional audits will occur 1 meal per day times 5 days per week for 3 weeks and then monthly for 3 months by the CQI Coordinator or designee. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

F-279
Corrected Date: May 13, 2014

It is the current policy and procedure of GSS-Windom to assess and develop appropriate care plans for every resident.

The care plan for R76 was updated, based on skin observation, to include the risk for bruising and the presence of bruises related to aspirin use on April 2, 2014.

All residents taking aspirin are at risk and will have their care plans reviewed and updated as necessary by May 9, 2014.

The case managers were educated on April 14, 2014, regarding aspirin and its potential for bruising.

An audit of appropriate care planning for all residents with newly prescribed aspirin orders will be conducted 1x per week x3 months by the CQI Coordinator or designee. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

R52's care plan was updated regarding use of Coumadin on April 3, 2014.

All residents taking Coumadin are at risk and had their care plans reviewed and updated as necessary by April 22, 2014.

The case managers were educated on April 14, 2014, regarding Coumadin and its side effects.

An audit of appropriate care planning for all residents with newly prescribed Coumadin orders will be conducted 1x per week x3 months by the CQI Coordinator or designee. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

F-282
Corrected Date: May 13, 2014

It is the current policy and procedure of GSS-Windom to provide services according to the care plan for every resident.

R43, R88, R67, R62, and R50's care plans were reviewed and found to be appropriate.

All residents in the special care unit are at risk for staff not following care plan interventions for toileting and eating related behaviors.
All residents who have fluid restrictions are at risk for a lack of fluid intake documentation.

Nursing Staff working on March 31, 2014 were re-educated by the surveyor in regard to following the care planned approaches for behavior interventions for R43. Further re-education regarding behavior interventions while eating for other special care unit staff occurred on April 1, 2014 by the assistant case manager.
Special care unit staff were re-educated on April 4, 2014 by the SPCU case manager regarding the expectation of using the already developed toileting tool based on resident's individualized toileting plans.
All nursing staff will be educated regarding behavior management by May 9, 2013.

It is the current procedure for licensed nurses to document supplement fluid intake in the medical record. LPN-B will be re-educated by May 9, 2014, on this current procedure.
Our fluid intake daily tool was amended to include a column for actual fluid intake.
All nursing staff and dietary staff will be re-educated by May 9, 2014, regarding the use of the amended tool for those on fluid restrictions.

An audit of the all residents in the special care unit during meal times will be conducted for 3 meals per day times 5 days for one week to assure freedom of movement is not prevented by wheelchair brakes being applied inappropriately during behavior episode and that care planned interventions are used. Audits will be conducted by the CQI Coordinator or designee.
Additional audits will occur 1 meal per day times 5 days per week for 3 weeks and then monthly for 3 months by the CQI Coordinator or designee. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

An audit of following the care plan for toileting on the special care unit will be conducted daily for 2 weeks using both observation and the toileting tool. Further audits will occur weekly times 6 and then monthly for 3 months by the CQI Coordinator or designee. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

An audit of proper completion of the fluid intake tool will occur daily for 4 weeks and then weekly for 12 weeks by the CQI Coordinator or designee. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

F-309
Corrected Date: May 13, 2014

It is the current policy and procedure of GSS-Windom to assure adequate and consistent fluid intake documentation is completed.

Our fluid intake daily tool was amended to include a column for actual fluid intake. This provided a correction for R50, as well as any other residents at risk from this deficient practice.

Other residents on fluid restriction were identified.

All nursing staff and dietary staff will be re-educated by May 9, 2014, regarding the use of the amended tool for those on fluid restrictions.

An audit of proper completion of the fluid intake tool will occur daily for 4 weeks and then weekly for 12 weeks by the CQI Coordinator or designee. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

It is the current policy and procedure of GSS-Windom to identify and monitor all residents for all new non-pressure related skin conditions.

The care plan for R76 was updated, based on skin observation, to include the risk for bruising and the presence of bruises related to blood thinner use on April 2, 2014. On April 3, 2014, an incident report for R76 was completed, including an investigation which showed no abuse or neglect had occurred. At R76's care conference on April 3, 2014, resident was offered a different room with a larger bathroom, due to concern for bumping his hands in his current narrow bathroom. Resident declined a room change.

Any resident taking a blood-thinner is at risk and will receive a skin inspection, with care plans being updated as indicated.

GSS-Windom amended its incident report completion procedure to also include identification of injuries such as bruises. Additionally, GSS-Windom wrote a procedure regarding non-pressure related injuries such as bruises. A part of the new procedure includes guidelines for monitoring the healing of bruises.

The Director of Nursing received education from our National Campus consultant regarding the existing skin module available through our clinical applications documentation system. Education will be provided to all nursing staff regarding this daily skin inspection and reporting system, and new non-pressure related injuries procedures, and the amended incident report procedure, by May 13, 2014. The case managers were educated on April 14, 2014, regarding blood thinners and its potential for bruising.

An audit of appropriate care planning for all residents with newly prescribed blood thinner orders will be conducted 1x per week x3 months by the CQI Coordinator or designee. Additionally, an audit of the skin module documentation for appropriate care planning and completion of incident reports will be conducted 1x per week x3 months by the CQI Coordinator or designee. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

F-315
Corrected Date: May 13, 2014

It is the current policy and procedure of GSS-Windom that those who are incontinent will receive appropriate care and services.

R43, R88, R67, and R62's care plans were reviewed and found to be appropriate. On April 4, 2014, the SPCU nurse manager re-educated the SPCU staff on following the individualized toileting plans for these 4 SPCU residents.

All residents in the special care unit are at risk for not staff not following care plan interventions for toileting. On April 4, 2014, the SPCU nurse manager re-educated the SPCU staff on following the individualized toileting plans for all SPCU residents.

An audit of following the care plan for toileting on the special care unit will be conducted daily for 2 weeks using both observation and the toileting tool. Further audits will occur weekly times 6 and then monthly for 3 months. All audits will be by the CQI Coordinator or designee. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

F-329
Corrected Date: May 13, 2014

It is the current policy and procedure of GSS-Windom to identify indications for use and adequate monitoring of the efficacy of the medications.

R43 has passed away.
For R35, a sleep assessment will be completed by May 13, 2014 per current GSS guidelines. The physician will be informed of the need for clarification of the indication for use, target behaviors, and non-pharmacological interventions for sleep of Ativan, by May 13, 2014.

All residents currently on Ativan for sleeplessness will be reviewed and reassessed via a sleep assessment if warranted with care plan updated and new interventions if indicated, by May 13, 2014.

The nurses will be educated on sleep assessments, the need for adequate indications and target behaviors for the use of Ativan, geriatric sleep patterns, and non-pharmacological interventions for promoting sleep, by May 13, 2014.

All residents admitted in the next 3 months, who are taking Ativan for sleeplessness, will be audited for proper indications of use and efficacy by the CQI Coordinator or designee. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

R52's care plan was updated regarding use of Coumadin on April 3, 2014.

All residents taking Coumadin are at risk and had their care plans reviewed and updated as necessary by April 22, 2014.

The case managers were educated on April 14, 2014, regarding Coumadin and its side effects.

An audit of appropriate care planning for all residents with newly prescribed Coumadin orders will be conducted 1x per week x3 months by the CQI Coordinator or designee. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

R34's Zantac was discontinued on April 3, 2014.

All residents taking more than one anti-ulcer drug of the same therapeutic class will be reviewed for indication of use by May 13, 2014.

The nurses will be educated regarding each residents medication regimes, which must be free from unnecessary drugs, by May 13, 2014.

All residents admitted in the next 3 months will have their medication regime reviewed for duplicate anti-ulcer drugs of the same therapeutic class by the CQI Coordinator or designee. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

F-334
Corrected Date: May 13, 2014

It is the current policy and procedure of GSS-Windom to offer a pneumococcal vaccination to every new resident when appropriate or to obtain written documentation if it is refused.
Resident #91 was given a pneumococcal vaccination on April 6, 2014, following education and after receiving informed consent from her responsible party.

All current residents are at risk from the deficient practice. An audit of all pneumococcal immunization records will be completed by May 13, 2014, to ensure all current residents have been offered the vaccination or have signed the appropriate refusal form.

The licensed nurses and infection control nurse will be educated on the current policy and procedure regarding resident immunizations.

Audits of new resident immunization records will be performed weekly by infection control nurse as delegated by QCI coordinator for 3 months to ensure current immunization policy and procedure is being followed. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

F-428
Corrected Date: May 13, 2014

It is the current policy and procedure of GSS-Windom for the resident medication regime to be reviewed monthly by the consulting pharmacist with appropriate recommendations given.

The consulting pharmacist was informed of the deficient practice regarding resident R35, R43, and R52. A new pharmacy drug review report will be completed for these residents by May 13, 2014, focusing on efficacy and monitoring of side effects. Care plan updates will be made as indicated based on the recommendations.

Residents at risk are all those currently taking Coumadin or Ativan for sleeplessness. The consulting pharmacist will review these residents for appropriate efficacy and monitoring of side effects. Care plans will be updated as recommended.

All future residents taking Coumadin or Ativan for Insomnia will be monitored for efficacy and side effects.

The monthly drug review reports will be audited for those residents taking Coumadin or Ativan for Insomnia to ensure the consulting pharmacist has completed a monthly assessment for 6 months by the CQI Coordinator or designee. Audit reports will be reviewed by the CQI committee with appropriate follow-up initiated.

Good Samaritan Society®
WINDOM

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Windom, MN 56101-1814

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Sogge Memorial
Remick Ridge Estates
Mikkelsen Manor
Home Care

May 2, 2014

Gloria Derfus, ~~Unit Supervisor~~
MN Dept. of Health
PO Box 64900
St. Paul, MN 55164-0900

Dear Ms. Derfus:

Please find enclosed our plan of correction for our survey. If you should have any questions or concerns, please contact me. Thank you.

Sincerely,

Nancy E. Wepplo

Nancy Wepplo
Campus Administrator

Enclosure: Plan of Correction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/08/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on April 8, 2014. At the time of this survey, Good Samaritan Society Windom was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	Please see attached. POC ok PS 5-6-14 RECEIVED MAY - 5 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 5-13-14

EXIT: 4-3-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy E. Wepplo — TITLE: Administrator — (X6) DATE: 5-2-14

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

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Windom is a one-story building with partial basement, and was constructed at five different times. The original building was constructed in 1959, with building additions in 1962, 1972, 1994 and 2000. All buildings were determined to be of Type II(111) construction. The facility is fully sprinklered. The building has a fire alarm system with smoke detection in the corridors, including all spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a capacity of 78 beds and had a census of 76 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 045 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in	K 045		5-13-14

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K 045	Continued From page 2 darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and a staff interview, a required exit discharge in the means of egress was not illuminated in accordance with NFPA 101 (2000), Chapter 19, Section 19.2.8. and Chapter 7, Section 7.8. In an emergency evacuation situation, this deficient practice could adversely affect 12 of 78 residents. FINDINGS INCLUDE: On 04/08/2014 at 12:20 PM, observation revealed illumination of the exterior exit discharge path, leading from the exit discharge door on the 200 Wing corridor, was provided by a single light fixture of the single bulb type. This arrangement was not in accordance with the requirements at NFPA 101 (00) Chapter 7, Section 7.8. This finding was verified with the assistant building engineer at the time of discovery.	K 045		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		4-15-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/08/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	**705 SIXTH STREET** **WINDOM, MN 56101**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain the emergency generator (genset) in accordance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.1.3 and NFPA 110 (1999). In a fire or other emergency, this deficient practice could adversely affect 78 of 78 residents. FINDINGS INCLUDE: On 04/08/2014 at 11:35 AM, during a review of the genset weekly and monthly inspection/test logs, the following findings were made: A). Documentation for weekly inspection of the genset was incomplete, as the data for multiple weeks within calendar year 2013 were missing; B). During the months of January through May and November through December of calendar year 2013, the genset had not been either 1). Exercised at not less than 30% of the EPS nameplate rating; 2). Loaded to maintain the minimum exhaust gas temperature as recommended by the manufacturer; 3). Had a 2-hour load bank test performed. This finding was confirmed with the assistant building engineer.	K 144		

Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.

K-45
Corrected Date: May 13, 2014

A new light fixture was ordered on April 22, 2014, and barring any shipping issues should arrive and be installed by May 13, 2014. All other similar light fixtures were assessed and will be corrected as well. The Maintenance Director is responsible for the correction.

The Safety Coordinator and Maintenance Director will monitor the facility for future issues through the Safety Meeting audits and the CQI committee.

K-144
Corrected Date: April 15, 2014

A load bank test was conducted on April 15, 2014 by Cummins Central Power and the generator was found to be in compliance. Going forward, a load bank test will be scheduled annually by the Maintenance Director.

Documentation of the weekly inspection of the genset is the responsibility of the Maintenance Director. The Maintenance Director was re-educated by the Fire Marshall and Administrator on April 8, 2014. An audit of the documentation will occur 1x/month for 3 months by the Campus Maintenance Director or designee with results being reported to the CQI committee.

The Safety Coordinator and Maintenance Director will monitor the facility for future issues through the Safety Meeting audits and the CQI committee.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4684

April 23, 2014

Ms. Nancy Wepplo, Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, Minnesota 56101

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5558022

Dear Ms. Wepplo:

The above facility was surveyed on March 31, 2014 through April 3, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

When all orders are corrected, the order form should be signed and returned to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792
Fax: (651) 201-3790

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 me.

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 about this letter.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/31/14 through 4/3/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	