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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: O2TX
Facility ID: 00356

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245550**
2. STATE VENDOR OR MEDICAID NO. (L2) **304842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WARREN**
(L4) **410 SOUTH MCKINLEY STREET**
(L5) **WARREN, MN** (L6) **56762**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **04/09/2014** (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) **09/30**

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:

X 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
	52			
(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 :
Yvonne Switajewski, HFE NEII 04/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: MPM
Mark Meath, Enforcement Specialist 06/02/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/01/1991** (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 **04/14/2014** (L33)

DETERMINATION APPROVAL

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

CCN# 24-5550

An extended survey was completed at this facility on Febuary 7, 2014, that included an investigation of complaint H5550006. Conditions in the facility constitute Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ)to resident health or safety.

One April 9, 2014 a Post Certification Revisit (PCR) was completed at this facility. Based on the PCR, the facility had corrected the deficiencies issued pursuant to the extended survey completed February 7, 2014 which included an investigation of complaint number H5550006. As a result of the the PCR, the following remedies imposed at the time of the extended survey are rescinded, effective March 14, 2014:

- Category 1 remedy of State monitoring
- Mandatory Denial of Payment for New Medicare and Medicaid Admissions

Since SQC was identified during the extended survey completed on February 7, 2014, the facility would be subject to a two year loss of NATCEP, effective February 7, 2014.

Refer to the CMS 2567b for both health and life safety code.

Effective March 14, 2014, the facility is certified for 52 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5550

June 1, 2014

Mr. Timothy Byrne, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, Minnesota 56762

Dear Mr. Byrne:

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

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

Effective March 14, 2014 the above facility is certified for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

April 16, 2014

Mr. Timothy Byrne, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, MN 56762

RE: Project Number S5550023 and Complaint Number H5550006

Dear Mr. Byrne:

On February 28, 2014, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective March 5, 2014. (42 CFR 488.422)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective May 7, 2014. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on February 7, 2014 that included an investigation of complaint number H5550006. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On April 9, 2014, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on February 7, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 14, 2014. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on February 7, 2014, as of March 14, 2014.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 14, 2014.

However, as we notified you in our letter of February 28, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 7, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the recommended remedies in our letter of February 28, 2014:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective May 7, 2014 be rescinded as of March 14, 2014. (42 CFR Section 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245550	A. Building B. Wing	4/9/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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 F0250 Reg. # 483.15(g)(1) LSC	03/14/2014	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	03/14/2014	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	03/14/2014
ID Prefix F0323 Reg. # 483.25(h) LSC	03/14/2014	ID Prefix F0329 Reg. # 483.25(l) LSC	03/14/2014	ID Prefix F0334 Reg. # 483.25(n) LSC	03/14/2014
ID Prefix F0356 Reg. # 483.30(e) LSC	03/14/2014	ID Prefix F0371 Reg. # 483.35(i) LSC	03/14/2014	ID Prefix F0428 Reg. # 483.60(c) LSC	03/14/2014
ID Prefix F0497 Reg. # 483.75(e)(8) LSC	03/14/2014	ID Prefix F0502 Reg. # 483.75(j)(1) LSC	03/14/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/KJ	4/16/2014	18619	4/9/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/7/2014

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

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245550	A. Building 02 - KITCHEN ADDTION B. Wing	4/7/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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 K0050	02/14/2014	ID Prefix Reg. # NFPA 101 LSC K0069	02/10/2014	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	Date:	Signature of Surveyor:	Date:
	PS/KJ	4/16/2014	03006	4/7/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/4/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: O2TX
Facility ID: 00356

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245550**

2. STATE VENDOR OR MEDICAID NO. (L2) **304842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WARREN**
(L4) **410 SOUTH MCKINLEY STREET**
(L5) **WARREN, MN** (L6) **56762**

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 **02/07/2014** (L34)

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **52** (L18)

13. Total Certified Beds **52** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE NE II 03/20/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 04/14/2014 (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 **03/01/1991** (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# 24-5550

On 2/7/2014 we completed an extended survey at Good Samaritan Society - Warren. The conditions in the facility at the time of the survey constituted both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ) to resident health or safety. The most serious deficiencies were at S/S level J. In addition at the time of the February 7, 2014 extended survey, an investigation of complaint number H5550006 was conducted and found to be substantiated at deficiency cited at F323, where SQC and IJ was also identified. The IJ was abated on February 7, 2014 at 2:20pm.

As a result of the survey findings we imposed the Category I remedy of State Monitoring effective March 5, 2014. In addition we recommended to CMS RO that the following enforcement remedies be imposed:

- CMP for deficiency at F323, effective February 6

The facility would be subject to a loss of NATCEP effective February 7, 2014. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8231

February 28, 2014

Mr. Timothy Byrne, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, MN 56762

RE: Project Number S5550023, Complaint Number H5550006

Dear Mr. Byrne:

On February 7, 2014, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the February 7, 2014 extended survey the Minnesota Department of Health completed an investigation of complaint number H5550006 that was found to be substantiated.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

> **Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;**
>
> **No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);**
>
> **Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR §**

483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on February 7, 2014, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Lyla Burkman
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601
Telephone: (218)308-2104 Fax: (218)308-2122

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective March 5, 2014. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil Money Penalty for a deficiency cited at F323 effective February 6, 2014. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Good Samaritan Society - Warren is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective February 7, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board.

Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the 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.

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

If substantial compliance with the regulations is not verified by May 7, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 7, 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.

Sincerely,

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

Enclosure (s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ____ B. WING ____	02/07/2014

RECEIVED MAR 14 2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 On February 3rd, 4th, 5th, 6th, and 7th, 2014, the surveyors of this department's staff, visited the above provider and the following correction orders are issued. An extended survey was completed on 2/7/14. 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 verification 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. A recertification survey was conducted by the Minnesota Department of Health on February 3rd. 4th, 5th, 6th and 7th, 2014. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to comprehensively assess for causal factors and risks related to falls which resulted in harm and the high potential for further harm or death. Facility staff had been notified of the IJ on February 6th, 2014, at 12:55 p.m. for the IJ that began on February 6th, 2014. The IJ was removed on February 7th 2014, at 2:20 p.m., however, non-compliance remained at the lower s/s of a G. A complaint investigation had been completed at the time of the extended recertification survey. Investigation/s of complaint H5550006 had been completed and had been substantiated.	F 000	**General Disclaimer** 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 allegations 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. Approved c̄ Addendum 3/20/14 JB	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/13/14

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
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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	Continued From page 1 Deficiency/s had been issued as a result of the substantiated findings at F323 at an Immediate Jeopardy.	F 000		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based interview and document review, the facility failed to provide medically related social services related to behaviors and psychotropic medication use in order to attain or maintain the highest practicable mental and psychosocial well-being for 1 of 1 resident (R10) reviewed who required social service interventions / involvement. Findings include: R10's Face Sheet dated 1/8/14, indicated R10's diagnoses included dementia with delusional features, hallucinations, osteoarthritis, insomnia and anxiety. R10's quarterly Minimum Data Set (MDS) dated 12/4/13, indicated R10 had severe cognitive impairment and required extensive staff assistance with transfers, toileting and bed mobility. The MDS also indicated R10 as displayed verbal and physical aggressive behaviors and wandered almost daily. The Cognitive Loss Care Area Assessment (CAA)	F 250	F250 1. R10 Medically related social services related to behaviors are being provided. The care plan includes them and documentation has been updated to reflect these services. A care plan was held on 3-6-14, with R10 and both daughters in attendance, to review current status of behaviors and current medications, and the changes that have been made since her last quarterly review. There have been multiple medication changes, decreases, and discontinued meds during this time. Several new interventions have been added to deal with behaviors as they occur, or to prevent them from escalating, and these seem to be working. A music therapist will be having weekly one to ones with R10. Daughters expressed satisfaction and appreciation for the changes that have been put in place, and resident's current condition. Daughters were also each given a blank copy of GSS #213 "Suggestion of Concern" form for any future situation that may need resolution. They were instructed that when it is filled out, it is to be given to social services, which will facilitate resolution of any concern with any department. The current behavior management committee procedure has been reviewed by social services and nursing, and is being followed. One to ones	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 250	Continued From page 2 dated 9/913, indicated R10 had multiple behaviors and increased sun-downing (increased behaviors in the evening) syndrome. The CAA also indicated R10's behavioral concerns would be discussed with R10's family. R10's plan of care (POC) dated 1/6/13, indicated R10 had alterations in mood state related to senile dementia with delusional features including anxiety and hallucinations. The POC directed staff to observe for increased anxiety, jerky movements, paranoid thoughts and depression. The POC encouraged staff to provide reassurance, administer medications as ordered, provide one to one visits, provide conversations, prayer books, family photos and to talk about the "days on the farm." The POC also directed staff to monitor R10's whereabouts closely especially when agitated and to report increased wandering to the nurse and physician. In addition, the POC directed the social service department staff to provide one to one visits with R10 as needed. On 2/3/14, at 6:40 p.m. family member (FM)-A stated she was frustrated due to the lack of family notification related the R10's psychotropic medication changes and care services provided to R10 related to fall interventions. FM-A stated she had addressed the concerns with the director of nurses (DON) and also had conversations with the administrator regarding R10's care. However, FM-A stated she had not talked to the licensed social worker (LSW) regarding her concerns. Review of R10's Interdisciplinary Progress Notes (IPN) from 6/14/13 - 2/4/14, revealed R10 had numerous disruptive behaviors. R10's documented behaviors consisted of wandering	F 250	with social worker will continue to be done as needed and will be documented accordingly. A behavior management committee meeting was held on 2-27-14, and documentation related to R10 was included in an Interdisciplinary Progress Note (IDP) in resident's medical record after that meeting. Social Services and the Unit Manager will meet with family to review any further issues and concerns as they arise. 2. All current residents identified as having behavior issues had their mood and behavior records reviewed at the Behavior Management Committee meeting on 2-27-14. Current social service interventions were reviewed. There will be regular communication with families regarding behaviors and medications. Behavior management committee documentation will be included in the individual resident's medical record following the monthly meeting. 3. All residents identified as having mood and behavior issues will have individualized interventions on their care plan, and documentation related to these interventions will be in the IDP notes. Follow-up behavior management committee meeting documentation will also be included in their individual medical records. The Grievances, Complaints or Concerns procedure was reviewed with Social services. Social service will act as liaison as indicated in the procedure, and will meet with families of residents to address and resolve any concerns as they arise. All	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ____ B. WING ____	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 250	Continued From page 3 throughout the facility, pushing at other residents, kicking staff, swearing, attempting to open closed doors and showing signs of "increased anxiety." The notes repeatedly indicated R10 was not easily redirected when upset. The notes also indicated R10 had received numerous different antipsychotic and antianxiety medication changes. The notes also revealed on four separate occasions, R10's increased disruptive behaviors required the facility to contact the emergency room to obtain a physician's order to administer antipsychotic medications intramuscularly. An IPN dated 12/11/13, indicated social service department staff and nursing had met with the family regarding R10's behaviors. However, R10's clinical record lacked documentation of social service involvement. The Mood and Behavior Report dated 10/1/13 - 2/4/14, completed by the nursing assistants, indicated R10 had behaviors almost daily. On 2/5/14, at 11:50 a.m. the LSW stated she was aware of R10's increased behaviors and the need for medical interventions for the reduction of the behaviors. She stated she encouraged staff to provide R10 non pharmacological interventions such as family photo albums, a buttoning activity and to visit with R10. The LSW stated she had participated in the facility behavior committee meetings in which R10's behaviors had been discussed and stated she had also met with R10's family during care conferences and special meetings regarding R10's behaviors. The LSW stated she had kept track of the facility behavior meeting documentation, however, confirmed she had not documented any meetings or family	F 250	departments will be responsible to include social services when they receive a complaint, so that social services can assist with the resolution of any problems. Social Services will facilitate communication between those filing the complaint, the appropriate department, and the administrator as needed. All concerns received by social services will be brought forward daily at the Interdisciplinary Team (IDT) meeting. 4. Audits will be completed each month after the Behavior Management Committee meeting to ensure that the medical records of residents with identified behaviors contain documentation regarding their behaviors, the interventions, and IDP notes reflect that these are being reviewed on an ongoing basis and any communication with families is also be documented in IDP notes. Audits will also be done monthly of any Suggestion or Concern Forms (GSS #213) to ensure that concerns are being addressed in a timely manner. These audits will be done by Administrator/Designee with results to QA for further recommendations. 5. Date of completion: March 14, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 250	Continued From page 4 discussions pertaining to R10 in R10's clinical record. Review of the Behavior Management Committee Meeting minutes / documentation revealed: -On 8/27/13, discussion was noted related to R10's family was offered a room change to a quieter area of the facility in which R10's family had declined. The facility had also offered suggestions made by the clinical psychiatry center, which family had also declined. -On 10/31/13, discussion was noted related to R10's decreased behaviors with clinical psychiatry center recommendations noted. - On 11/14/13, discussion was noted related to R10's episodes of being awake longer than 24 hours with behaviors. The note also indicated R10 had no recent behaviors of trying to kick or hit others when redirected. -On 12/12/13, discussion was noted related to R10's family request for R10 to not receive further doses of Haldol (antipsychotic) as family was planning to meet with R10's primary physician. -On 1/16/14, discussion was held related to R10's behaviors and no changes were needed. On 2/5/14, at 12:30 p.m. the LSW confirmed the behavior committee meeting minutes were kept in a separate book and the discussions or alternative interventions which resulted from the behavior meetings at no time became a permanent part of R10's clinical record. She confirmed she was aware of many family concerns brought forward by R10's family.	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ____ B. WING ____	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 250	Continued From page 5 However, she did not meet regularly with R10 and the family in an attempt to resolve the identified concerns. The Grievance, Complains or Concerns policy revised on 9/2008, ensured the residents and family has the right to voice grievances without discrimination or reprisal. The policy identified "voiced" grievances were not limited to a written formal grievance but also included the resident's verbalized complaints to the center staff. The Grievances, Complaints or Concerns procedure updated 1/2007, directed the social service director directly responsible to facilitate communication between those filing the complaint and the facility administrator. The LSW was to act as the facility liaison in efforts to resolve the grievance, maintain documentation and to report trends and actions to the quality assurance committee.	F 250		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services as directed by their written plan of care (POC) for 1 of 3 residents (R10) in the sample who required assistance with ambulation.	F 282	1. R 10 Resident is being ambulated according to the current care plan. 2. All current residents requiring assistance with ambulation were reviewed and reassessed if indicated and care plan updated if needed and are being ambulated according to their care plan 3. All residents will be ambulated according to their individualized care plan. Written Reports by the Rehabilitation Aides will be reviewed weekly by the DNS. All nursing staff and rehabilitations aides have been educated on such and such a date to ensure their understanding and following the restorative care plan and need for appropriate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 6 Findings include: R10's POC dated 1/6/14, indicated R10 had impaired mobility and directed staff to assist R10 to ambulate with a four wheeled walker and a gait belt for 15 minutes, three times a week, as tolerated. Review of R10's Functional Maintenance Program (restorative nursing documentation) revealed the following: - February 2014, (2/1-2/4) revealed the letter "U" was documented twice. - January 2014, revealed the letter "U" was documented five times. The rest of the form was blank. - December 2013, revealed the letter U was documented four times. The rest of the form was blank. - November 2013, revealed R10 had ambulated on five occasions from 90 up to 540 feet. The letter "U" was documented six times. The rest of the form was blank. -October 2013, revealed R10 had ambulated on four occasions from 360 up to 540 feet. The letter U was documented once. The rest of the form was blank. On 2/4/13, at 3:20 p.m. nursing assistant (NA)-K stated a letter "U" indicated the resident was unable to participate in the program. On 2/5/14, at 9:15 a.m. NA-B/restorative aide stated R10 had difficulty participating in the	F 282	documentation of the plan completed or refused. 4. Audits will be done of the ambulation programs to ensure that ambulation is occurring, observed and documented according to the care plan twice a week with the results of audits to QA for further recommendations. These audits will be completed by DNS/designee. 5. March 14, 2014.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 7 restorative program because R10 was frequently sleeping during the day or R10 would resist services. She stated R10 had not been participating in the restorative program "for a long time." On 2/5/14, at 9:30 a.m. NA-B was observed to assist R10 with use of a four wheeled walker and gait belt to ambulate 200 feet. R10 was alert and tolerated activity well. On 2/5/14, at 11:30 a.m. the interim director of nursing (DON) confirmed R10 had not received assistance with the ambulation program as directed by R10's individual POC. The Restorative Nursing Care policy dated 1/2000, and revised on 2/2005, directed the staff to follow the restorative care as outlined in the resident's POC.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services necessary to improve and / or maintain the resident's abilities to ambulate for 1 of 1 resident (R10) in the sample on an ambulation program.	F 311	1 R 10 Resident is being ambulated according to the current care plan. 2. All current residents requiring assistance with ambulation were reviewed and reassessed if indicated and care plan updated if needed and are being ambulated according to their care plan 3. All residents will be ambulated according to their individualized care plan. Written Reports by the Rehabilitation Aides will be reviewed weekly by the DNS. All nursing staff and rehabilitations aides have been educated on such and such a date to ensure their understanding and following the restorative	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 311	Continued From page 8 Findings include: R10's face sheet dated 1/8/14, indicated R10's diagnoses included senile dementia with delusions, anxiety and osteoarthrosis. R10's quarterly Minimum Data Set (MDS) dated 12/4/13, indicated R10 had severe cognitive impairment, was non ambulatory and required extensive assistance of one staff for bed mobility and transfers. R10's significant change MDS dated 7/24/13, indicated R10 ambulated with extensive assistance of two staff. R10's plan of care (POC) dated 1/6/14, indicated R10 had impaired mobility and directed staff to assist R10 with ambulation with the use of a four wheeled walker and a gait belt for 15 minutes, three times a week, as tolerated. On 2/3/14, continual observations were made from 4:00 p.m. to 8:00 p.m. At 4:00 p.m. R10 was observed sleeping. At 5:45 p.m. R10 was observed in the wheelchair and assisted into the dining room for the evening meal. R10 did not waken for the meal, therefore, was observed to be assisted from the dining room and assisted into a recliner near the nurses station. R10 was observed to remain in the recliner the remainder of the evening. On 2/4/14, at 8:00 a.m. until 10:30 a.m. R10 was continually observed to remain in bed, asleep. From 12:30 p.m. until 3:00 p.m. R10 was observed seated in a recliner near the nurses station, sleeping. At 3:10 p.m. R10 nursing assistant (NA)-K and registered nurse (RN)-A	F 311	care plan and need for appropriate documentation of the plan completed or refused. 4. Audits will be done of the ambulation programs to ensure that ambulation is occurring, observed and documented according to the care plan twice a week with the results of audits to QA for further recommendations. These audits will be completed by DNS/designee. 5. Date of completion: March 14, 2014	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ____ B. WING ____	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 311	Continued From page 9 was observed to transfer R10 from the recliner into a wheelchair and assisted into the bathroom. R10 was observed to stand with verbal cues and bear own weight without difficulty. On 2/5/14, from 7:00 a.m. until 9:30 a.m. R10 was observed asleep in bed. At 9:30 a.m. R10 was served breakfast at the nurses station. At 10:30 a.m. R10 was observed to independently wheel self on the nursing unit. Review of R10's Functional Maintenance Program (restorative nursing documentation) revealed the following: - February 2014, (2/1-2/4) the letter "U" was documented twice. The Documentation Notes on the back of the form indicated R10 had displayed uncooperative behaviors or was "sleepy or asleep" therefore, the restorative program was not provided. - January 2014, the letter "U" was documented five times. The rest of the form was blank. The Documentation Notes indicated R10 had either been sleeping or displayed behaviors and was unable to participate in the restorative program. - December 2013, the letter U was documented four times. The rest of the form was blank. The Documentation Notes indicated R10 had either been sleeping or displayed behaviors and was unable to participate in the restorative program. - November 2013, indicated R10 ambulated on five occasions from 90 up to 540 feet. The letter "U" was documented six times. The rest of the	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ____ B. WING ____	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 311	Continued From page 10 form was blank. The Documentation Notes indicated R10 had either been sleeping or displayed behaviors and was unable to participate in the restorative program. -October 2013, indicated R10 ambulated on four occasions from 360 up to 540 feet. The letter "U" was documented once. The rest of the form was blank. The Documentation Notes indicated R10 had been sleeping on three occasions and was unable to participate in the restorative program. On 2/4/13, at 3:20 p.m. NA-K stated the letter "U" indicated R10 was unable to participate in the program. The Restorative Aide Program form completed by the physical therapist dated 6/17/13, directed staff to use an enclosed framed wheeled walker for 15 minutes, three times a week, as tolerated. The Rehab Review completed on the Interdisciplinary Assessment and Summary Reviews form dated 12/17/13, indicated R10 was not a candidate for an enclosed wheeled walker. The form also indicated R10's POC was accurate in indicating R10 was to ambulate with the nursing staff as tolerated. The restorative review note did not address R10's participation or lack thereof in the current restorative program but indicated R10's POC was to be continued. The review did not address why R10 was not a candidate for the enclosed walker. On 2/3/14, at 6:30 p.m. family member (FM)-A stated she did not want R10 to use an enclosed walker, therefore, the walker had been discontinued per family request.	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 311	Continued From page 11 On 2/5/14, at 9:15 a.m. NA-B stated R10 had difficulty participating in the restorative program because R10 was frequently sleeping during the day or displayed resistive behaviors. She stated R10 had not been participating in the restorative program "for a long time." On 2/5/14, at 9:30 a.m. NA-B was observed to ambulate R10 200 feet without any difficulty. On 2/5/14, at 11:30 a.m. the interim director of nursing (DON) stated she was unaware R10 was in a restorative program. After reviewing R10's restorative documentation, she confirmed R10 was not receiving the restorative services as directed. In addition, The DON confirmed R10 had not been re-evaluated by physical therapy after the discontinuation of the enclosed walker. The DON stated R10's restorative program was in need of a re-assessment. The facility's Restorative Nursing Care policy dated January 2000, and revised on 2/2005, directed staff to ensure each resident received restorative nursing care to the extent possible, based on individual strengths, needs and problems as identified by the nursing assessment.	F 311		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	1. A new fall risk assessment was completed for R10 and new fall interventions put in place, care plan updated and followed 2. All current residents identified at risk for falls were re-evaluated and if appropriate new fall interventions put in place and care plan updated and followed. 3. All residents admitted or resident with change will be re-assessed for falls and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 323	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess 1 of 4 residents (R10) at risk of falls and failed to effectively implement interventions in order to minimize the risk for further falls and /or serious injury or death resulting in an immediate jeopardy (IJ) situation for R10. In addition, R10 sustained actual harm by sustaining hematomas to the scalp following 4 separate falls. The immediate jeopardy began on February 6, 2014, due to the facility's systemic failure to comprehensively assess the falls and implement appropriate interventions to prevent/minimize further falls, injury and / or death. The administrator and the interim director of nursing (DON) were notified on 2/6/14, at 12:55 p.m. of the IJ. The IJ was removed on 2/7/14, at 2:20 p.m., however, non-compliance remained at a scope and severity level of G, which indicated actual harm for R10 due to a scalp hematoma sustained during a fall which required medical interventions. Findings include: R10 was identified by the facility as high risk for falls related to cognitive impairment, impaired gait and mobility, history of falls and unpredictable behaviors. However, the facility failed to comprehensively assess R10's risk factors related to falls which would include possible causal factors related to attempts at unsafe independent transfers.	F 323	interventions put in place and care plan updated to reflect these interventions. In-service on the completion of the Incident report will be presented to the Department Managers on 3/6/2014 by the DNS. 4. The falls incident reports are being reviewed daily by the unit managers to ensure they are completed, necessary to insure immediately interventions are put in place and care plans are up to date. Documentation is tracked daily and tabulated per residents to observe for trends. They then are reviewed daily by the DNS and/or designee at stand up, and monthly at the Resident at Risk Committee meeting. Monthly the Incident Trending Report will be completed monthly by DNS and/or designee. The Resident at Risk Committee will evaluated/analyzed to root cause of falls to avoid future Falls/Accidents monthly at Falls and out comes from the Resident at risk committees all interventions will be put into place and reports will be discussed monthly at the Quality meeting and further recommendations by QA will be followed 5. Date of completion: March 14, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 323	Continued From page 13 R10's Face Sheet dated 1/8/14, indicated R10's diagnoses included dementia with delusional features, hallucinations, osteoarthritis and anxiety. R10's significant change Minimum Data Set (MDS) dated 9/9/13, indicated R10 was dependent upon staff for activities of daily living. The MDS also indicated R10 had sustained two or more falls without injury and two or more falls with injury during the assessment period. The Falls Care Area Assessment (CAA) dated 9/17/13, identified R10 at high risk for falls related to increased confusion and agitation. R10 had received antianxiety and antidepressant medications and R10 had increased wandering within the facility. The CAA also indicated R10 had sustained a decline in activities of daily living which indicated R10 required more assistance with cares. However, the CAA failed to comprehensively assess for causal factors and risks for falls. R10's quarterly MDS dated 12/4/13, indicated R10 had severe cognitive impairment and required extensive assist of one staff for transfers, toilet use and bed mobility. The MDS also indicated R10 was non-ambulatory and totally dependent upon staff for locomotion on and off of the unit. In addition, the MDS indicated R10 had sustained two or more falls without injury, and two or more falls with injury, during the assessment period. However, the facility failed to comprehensively assess for causal factors and risks related to falls. R10's plan of care (POC) dated 1/6/14, indicated R10 had mobility impairment related to senile dementia, osteoarthrosis, dizziness and jerky movements. The POC directed staff to ambulate	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ____ B. WING ____	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 323	Continued From page 14 R10 with a four wheeled walker, ensure R10 wore appropriate foot wear at all times, provide a non skid mat at the bedside, maintain chair alarm to wheelchair and recliner, anti- roll back devices on wheelchair, monitor for signs and symptoms of physical illness and report to the physician as needed. On 2/3/14, continual observations were made from 4:00 p.m. to 8:00 p.m. At 4:00 p.m. R10 was observed sleeping. At 5:45 p.m. R10 was observed in the wheelchair and assisted into the dining room for the evening meal. R10 did not waken for the meal, therefore, was observed to be assisted from the dining room and assisted into a recliner at the nurses station. R10 was observed to remain in the recliner the remainder of the evening. On 2/4/14, at 8:00 a.m. until 10:30 a.m. R10 was continually observed to remain in bed, asleep. From 12:30 p.m. until 3:00 p.m. R10 was observed seated in a recliner near the nurses station, sleeping. At 3:10 p.m. nursing assistant (NA)-K and registered nurse (RN)-A was observed to transfer R10 from the recliner into a wheelchair and assisted R10 to the bathroom. R10 was observed to stand with verbal cues and bear own weight without difficulty. On 2/5/14, from 7:00 a.m. until 9:30 a.m. R10 was observed asleep in bed. At 9:30 a.m. R10 was served breakfast at the nurses station. At 10:30 a.m. R10 was observed to independently wheel self on the nursing unit. At no time during observations did R10 attempt to stand independently or display behaviors which could potentially be disruptive to others.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 323	Continued From page 15	F 323		

Review of R10's Incident Reports revealed the following:

- On 7/26/13, at 2:30 p.m. R10 fell while ambulating independently. No injury was noted. The post fall investigation dated 7/26/13, indicated R10 had alarms in place, was able to transfer self and was receiving antianxiety medications. The Falls Data Collection (FDC) tool completed on 7/26/13, indicated R10 was at high risk for falls. There were no changes made to R10's POC.

- On 8/2/13, at 9:30 p.m. R10 stood independently from a recliner resulting in a fall. No injury was sustained. The FDC dated 8/2/13, identified R10 at high risk for falls. The investigation indicated R10 had increased behaviors. The FDC was not completed and there were no changes made to the POC.

- On 8/5/13, at 9:30 p.m. R10 was found sitting on the floor in front of an enclosed framed walker. No injuries were noted. The post fall investigation indicated R10 had been agitated and was given medications to decrease behaviors. The report also included, "Behaviors continued at intervals until resident finally succumbed to sleep." The FDC was not completed. There were no changes made to the POC.

- On 8/9/13, at 9:00 p.m. R10 was observed to stand independently and fall backwards. R10 hit head on the floor causing a bruise to the right cheek and complaints of left hip and right elbow pain. A raised red area was also noted on the spine. The post fall investigation indicated R10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 323	Continued From page 16	F 323		

required one to one staffing. The investigation indicated: "Not able to provide constant 1:1 [one to one] staffing plan. Keep resident in close proximity when agitated or be sure she is safe, leave her to calm and re-approach." The FDC was not completed. There were no changes made to the POC.

- On 8/16/13, at 8:05 p.m. R10 fell. No injuries were noted. The post fall investigation identified R10 as having increased agitation and staff were unable to calm here. One to one staff care was unavailable and the resident refused medication to help her relax. The FDC was not completed. There were no changes made to the POC.

- On 8/19/13, at 7:35 p.m. R10 fell in the hallway. No injuries were noted. The post fall investigation identified R10's behaviors as anxiety, agitation, wandering and abusive behaviors which were not reduced after medication administration. Staff had attempted interventions of folding towels, snacks etc. but the interventions had only been successful for a short period of time. The FDC was not complete. There were no changes made to the POC.

- On 8/20/13, at 6:30 p.m. R10 was found on the floor next to the bed. R10 was noted to have hit the right side of forehead and was sent to the emergency room for evaluation. The post fall investigation identified R10 as having a history of independent ambulation. The FDC identified R10 at high risk for falls. There were no changes made to the POC.

- On 8/27/13, at 4:50 p.m. R10 fell from the wheelchair resulting in a 3 centimeter (cm.) red raised area to the left side of head. The post fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 323	Continued From page 17 investigation repeated the incident report. The FDC tool identified R10 as being at high risk for falls. No changes to the POC were identified. Physician's Orders dated 8/28/13, directed R10 to follow up with MD for a repeat CT (computed tomography) scan of head after blunt head trauma and possible drainage of scalp hematoma. Review of R10's Clinic Referral form dated 8/29/13, indicated R10 was seen in the clinic, received a CT scan of head and had 10 cubic centimeters (cc) of fluid removed from a scalp hematoma. No change was noted in the POC. - On 9/30/13, at 7:45 p.m. R10 had slid out of the wheelchair. No injury was noted. The post fall investigation indicated R10 did not realize when she was in danger, or when staff are trying to assist her. An FDC tool dated 8/27/13, indicated R10 was at high risk of falls. There were no changes to the POC. - On 10/4/13, at 8:30 a.m. R10 was found on the floor between the bed and recliner. No injuries were noted. The post fall investigation repeated the incident but did not identify the root cause of the fall. The FDC tool dated 10/4/13, identified R10 at high risk for falls. No changes were made to the POC. - On 10/4/13, at 9:45 p.m. R10 had attempted to self transfer from the wheelchair resulting in a fall. No injuries were noted. The post fall investigation identified R10 as having increased anxiety and restlessness. The results of the investigation directed the staff to assist R10 to ambulate. No change in the POC. - On 11/5/13, at 1:30 am. R10 was found on the	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ____ B. WING ____	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 323	Continued From page 18 floor next to her bed. No injuries were noted. The post fall investigation indicated "no investigation need." The FDC tool dated 11/5/13, identified R10 at high risk for falls. There were no changes to the POC. - On 11/22/13, at 5:40 p.m. R10 was found on the floor in front of her bed. No apparent injury. The post fall investigation repeated the results of the incident. The FDC was not completed. There were no changes to the POC. - On 11/23/13, 10:40 a.m. R10 was found on the floor next to the bed. No apparent injury. The post fall investigation repeated the results of the incident. The FDC was not completed. There were no changes to the POC. - On 12/2/3, at 7:15 p.m. R10 attempted to ambulate independently, fell and hit the right side of her forehead which resulted in a 3 cm bruise. R10 received a cold compress to the area. The post fall investigation indicated R10 required one to one constant monitoring. The FDC was not completed and there were no changes to the POC. - On 12/20/13, at 9:10 p.m. R10 slid from a recliner onto the floor. No apparent injury. The investigation from the fall could not be located. The FDC was not completed and there were no changes to the POC. - On 1/12/14, at 4:00 .p.m. R10 was found on the floor in front of the wheelchair. R10 complained of back pain. The post fall investigation indicated R10 had a history of removing shoes by self. In addition, the investigation indicated staff were to provide continuous monitoring to ensure R10's	F 323		

F 323 | Continued From page 19 | F 323

safety. There were no changes to the POC.

- On 1/24/14, at 8:00 p.m. R10 was found on the floor in another resident's room. No injuries were noted. The post fall investigation included staff direction to monitor the resident and redirect when necessary. The FDC tool was not completed, and there were no changes to the POC.

R10's clinical record lacked a comprehensive assessment of falls in order to determine the root cause of the falls in an attempt to modify the environment / situation in an attempt to minimize further falls.

R10's Interdisciplinary Progress Notes (nurses' notes) included multiple entries of R10 displaying behaviors such as swearing, yelling, "increased restlessness" and wandering. A note dated 2/4/14, at 10:00 p.m. described R10 as compulsive, combative, swearing and as being forgetful of limitations. In addition, the note read: "Staff tried to prevent her from fall PRN [as needed] Xanax [antianxiety medication] was given at 23:00 [11:00 p.m.] She was calmer sitting in recliner."

On 2/4/13, at 1:20 p.m. nursing assistant (NA)-G stated R10 was combative and would kick, hit and disrobe in public. NA-G stated R10 was resistive with cares and would frequently attempt to stand on her own.

On 2/5/14, at 12:41 p.m. the interim director of nursing (DON) reviewed R10's falls. The DON stated prior to her employment at the facility, the facility had not been identifying the circumstances

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 323	Continued From page 20 prior to falls, nor had they attempted to determine the root cause of resident falls. The DON verified the facility did not have a system to monitor each individual to identity a pattern of falls. She confirmed R10 had a pattern of falls. On 2/5/14, at 1:44 p.m. RN-A stated following a fall, staff were supposed to monitor the resident for any signs of injury, monitor the resident's vitals and were to discuss the fall at the regular management meetings. On 2/5/13, at 1:50 p.m. licensed practical nurse (LPN)- B stated following a fall, the resident was to be checked for injury and have vital signs monitored. LPN-B stated staff were to add things such as bed and chair alarms, fall mats by the bed and ensure the resident had appropriate gripper socks. She stated she could not think of any other interventions to attempt which would be appropriate at the time of a fall. On 2/5/13, at 2:25 p.m. the DON confirmed the facility did not have a system to determine the root cause of the falls and had not developed interventions to prevent/minimize falls for R10. She added the facility did not have an established falls committee at this time which could also monitor for a pattern of falls. The DON stated staff are aware of the whereabouts of R10 at all times, utilized chair and bed alarms for R10, had mats in place next to R10's and staff were encouraged to toilet R10 more frequently in an attempt to prevent falls.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 323	Continued From page 21 On 2/5/14, at 4:24 p.m. health information specialist (HIM)-A stated R10 attempted to stand independently several times a day. HIM-A stated staff tried to find different tasks for R10 to do such as puzzle books or folding towels, but R10 had not always responded well to redirection. On 2/5/14, at 4:25 p.m. NA-B stated R10 was not cooperative with staff and attempted to walk on her own. At the same time, NA-D stated R10 exhibited behaviors such a swearing at the top of her lungs, hitting and scratching at staff members. She stated R10 had the ability to walk with staff, but frequently attempted to walk independently which resulted in falls. On 2/5/14, at 4:27 p.m. NA-C stated R10 displayed behaviors and did not respond to redirection. NA-C stated she frequently worked the overnight shift and stated R10 frequently slept until about midnight and then would be awake from 1 a.m. to 3 a.m. looking for her family members. NA-C stated, "We try to keep her safe, but there are only three staff at night." NA-C stated when R10 was seated in a wheelchair, she would attempt to stand by herself. On 2/5/14, at 4;33 p.m. NA-A stated R10 frequently tried to stand up alone. She stated R10 had recently attempted to stand on the evening shift of 2/3/14. NA-A stated R10 did not realize she was not steady on her feet and unable to walk by herself. On 2/5/14, at 4:30 p.m. housekeeper (HSK)-A	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 323	Continued From page 22	F 323		

stated R10 frequently attempted to get out of her chair. She stated when this happened, she stayed with R10 to ensure she did not attempt to stand until nursing staff could assist her.

On 2/5/14, at 4:30 p.m.. RN-A stated staff were to approach R10 in a calm manner and attempt to redirect R10 with food or other activities. She explained staff were also to approach R10 from the front and avoid startling her. RN-A verified R10 attempted self transfers and utilized chair and bed alarms to alert staff when she attempted to stand.

On 2/5/14, at 4:35 p.m. dietary aide (DA)-A stated R10 occasionally attempted to stand up from the dining room table by herself and staff had to redirect her.

A facility policy dated 11/2002, and updated on 11/2013, directed staff to complete the Falls Data Collection Tool and compare the results with the data previous colleted. The policy also directed staff to look for differences that my indicate a change in the resident's risk for falls. It also directed staff to use the tool to explore risk factors and to assist in planning for resident safety. The policy directed staff to update the comprehensive POC and to monitor the resident's condition and the effectiveness of the interventions put in place to prevent further falls. The policy's attachment A- titled Suggested Care Plan Approaches for Fall Prevention reviewed on 9/2010, which had multiple examples aimed at assisting in implementing interventions which may be appropriate for a resident with falls. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 323	Continued From page 23 potential approaches identified included: monitoring for medication side effects which could include: poor balance, confusion, agitation, drowsiness, weakness, dizziness, and multiple other side effects. The IJ that began on 2/6/14, was removed on 2/7/14 at 2:20 p.m. when the facility completed a comprehensive assessment and had R10 evaluated by physical and occupational therapy. A physical therapy (PT) plan was established in which R10 would receive PT for two weeks in order to develop a safe walking program for continued restorative nursing. R10 received a different wheelchair and seat cushion. In addition, laboratory levels were drawn for medical evaluation. R10's POC was updated to include a low bed with a frame not higher than six inches from the floor, a reduction in environmental hazards and a monitoring plan for psychotropic medications was also established. All staff members were educated on how to interact with residents with dementia and how to work with aggressive behaviors and an "At Risk" committee was formed to monitor residents sustaining falls.	F 323		
F 329 SS=D	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.	F 329	1. Her medications were reviewed 01/29/2014 and requested a decrease to her AM Ativan from 0.50mg to 0.25mg, on 2/7/2014 Xanax was put on hold and discontinued 2/14/14. On 2/14/14 Ativan was changed from scheduled to PRN, Family notified and involved with medication reduction next meeting scheduled with family on 3/6/2014. 2. All residents currently on any antipsychotics, anti-anxiety, anti-depressants,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 24 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, interview and document review, the facility failed to adequately identify, assess and monitor clinical indications for the continued use of psychotropic medications and establish parameters for the use of as needed (PRN) behavioral medications for 1 of 6 residents (R10) whose medication regimens were reviewed. Findings include: R10's Face Sheet dated 1/8/14, indicated R10's diagnoses included dementia with delusional features, hallucinations, osteoarthritis, insomnia and anxiety. R10's quarterly Minimum Data Set (MDS) dated 12/4/13, indicated R10 had severe cognitive impairment and required extensive assistance of one staff with transfers, toilet use and bed mobility. The MDS also indicated R10 displayed verbal and physical aggressive	F 329	anxiolytics, and hypnotics were reviewed to ensure that clinical indications for such usage has been identified assessed and monitored for appropriated continued use. All PRN behavioral medications were reviewed for appropriate parameters for use. Non medication type of interventions will be attempted prior to a medication. 3. All residents currently on any antipsychotics, anti-anxiety, anti-depressants, anxiolytics, and hypnotics appropriated and reviewed by the DNS or unit manager to ensure all other methods of resolving the causative have been reviewed prior to addition of a medication. All non-medication type of interventions must be initiated/attempted prior to a medication and documented the results of the non-medication type intervention. Education will be provided to all nursing staff on identifying, assessing and monitoring for continued use of medications and the need to attempt non medication interventions prior to a medication. All new behaviors and diagnosis are reviewed to ensure that there is a proper indication for such medications such as Antipsychotic, Antidepressants, Sedative, and Hypnotic, anxiolytics Medications: Discussion daily by the unit managers and the DNS, to ensure they are assessed, the checklists and documentation are completed according to Good Samaritan Society policy Number III-C.110 and III-C.110.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ____ B. WING ____	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 25 behaviors, wandered almost daily and had received antianxiety and antidepressant medications daily. R10's plan of care (POC) dated 1/6/13, indicated R10 had alterations in mood state related to senile dementia with delusional features including anxiety and hallucinations. The POC directed staff to observe for increased anxiety, jerky movements, paranoid thoughts and depression. The POC encouraged staff to provide R10 reassurance, administer medications as ordered, provide one to one visits, provide conversations, prayer books, family photos and to talk about the "days on the farm." The POC also directed staff to closely monitor R10's whereabouts especially when agitated and to report increased wandering to the nurse and physician. In addition, the POC directed staff to not administer antipsychotic medications without contacting R10's family members. On 2/3/14, at 6:40 p.m. family member (FM)-A stated R10 had received several different medication changes in the past few months including Haldol (an antipsychotic medication) which had to be administered intramuscularly. FM-A stated at times R10 was so sleepy she was not able to hold her head up. FM-A confirmed R10 displayed disruptive behaviors but felt staff may have approached R10 in a manner that may have increased the behaviors. FM-A stated she felt more comfortable with the facility due to current staff changes but would like to see the medication use decreased. On 2/3/14, continual observations were made	F 329	4. Weekly audits will be done to ensure that behaviors have been identified assessed and monitored and targeted behaviors identified on care plan and that there is documentation of the target behavior occurring and what interventions are working or not working. The medication reduction committee will review to ensure that procedure and reductions of such medications is occurring according to regulations. The pharmacy consultant will also be involved in review of behavior medications and communication with nursing staff and attending physicians. These audits will be completed by the DNS/designee. Results of the audits will be reviewed during QA for further recommendations. 5. Date of completion: March 14, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ____ B. WING ____	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 26	F 329		

from 4:00 p.m. to 8:00 p.m. At 4:00 p.m. R10 was observed sleeping. At 5:45 p.m. R10 was observed in the wheelchair and assisted into the dining room for the evening meal. R10 did not waken for the meal, therefore, was observed to be assisted from the dining room and assisted into a recliner near the nurses station. R10 was observed to remain in the recliner the remainder of the evening.

On 2/4/14, at 8:00 a.m. until 10:30 a.m. R10 was continually observed to remain in bed, asleep. From 12:30 p.m. until 3:00 p.m. R10 was observed seated in a recliner near the nurses station, sleeping. At 3:10 p.m. R10 nursing assistant (NA)-K and registered nurse (RN)-A was observed to transfer R10 from the recliner into a wheelchair and taken to the bathroom. R10 was observed to stand with verbal cues and bear own weight without difficulty.

On 2/5/14, from 7:00 a.m. until 9:30 a.m. R10 was observed asleep in bed. At 9:30 a.m. R10 was served breakfast at the nurses station. At 10:30 a.m. R10 was observed to independently wheel self on the nursing unit. At no time was R10 observed to display behaviors that could potentially be disruptive to others.

R10's current Physician's Orders revealed the following:

The orders dated 7/2013, included:
- Paxil (antidepressant medication) 10 milligram (mg) daily - started on 4/23/13
- Ativan (antianxiety medication) 0.25 mg three times a day - started on 3/21/13.
- Ativan 0.25 mg every fours hours as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ____ B. WING ____	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 27 - Seroquel (antipsychotic medication) 12.6 mg at 2 p.m. and 25 mg at 5 p.m. and 8 p.m., - started on 6/27/13. Medication changes were noted as follows: - On 8/6/13, the nurse practitioner (NP) increased the Paxil to 20 mg daily. - On 8/21/13, the primary physician (MD) discontinued as needed Ativan , added Risperdal (antipsychotic medication) 0.125 mg daily as needed for severe agitation and restarted Namenda (a cognitive enhancer R10 had been on previously) at 5 mg daily for one month then increase to 5 mg twice a day. - On 8/21/13, the NP discontinued the Seroquel. - On 9/28/13, the primary MD increased the Ativan to 0.5 mg three times a day and increased the Paxil to 40 mg a day. - On 10/2/13, the primary MD started Remeron (an antidepressant medication) 7.5 mg at bedtime. - On 10/9/13, the primary MD discontinued the 6 p.m. dose of Ativan -On 10/12/13, NP ordered Haldol (antipsychotic medication) 5 mg to be given via injection immediately. - On 10/15/13, a physicians assistant (PA) ordered Haldol 5 mg to be given via injection immediately. - On 10/16/13, the primary discontinued the Remeron and increased the Risperdal to 0.25 mg twice a day. - On 11/20/13, NP ordered Haldol 5 mg to be given via injection immediately. - On 11/21/13, NP ordered Haldol 10 mg to be given via injection as needed. - On 11/21/13, the primary physician increased the Risperdal to 0.5 mg twice a day. - On 12/11/13, the primary increased Paxil to 40	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 28 mg twice a day and increased Seroquel to 25 mg twice a day and discontinued the Risperdal. - On 12/13/13, The primary added Zoloft (antidepressant) 50 mg daily and Xanax (antianxiety medication) 0.5 mg every 4 hours as needed. The Seroquel and Haldol were discontinued at that time. - On 12/18/13, the primary MD increased the Zoloft to 100 mg daily. - On 1/29/13, the primary MD decreased the Ativan to 0.25 mg in am. The February 2014, Medication Administration Record (MAR's) indicated R10 was receiving: - Xanax 0.5 mg every four hours as needed (R10 had received the medication on 2/1, 2/3 and 2/4.) -Ativan 0.25 mg each morning and 0.5 mg at 1:00 p.m. -Zoloft 100 mg daily. The Interdisciplinary Progress Notes (nurses) notes indicated R10 displayed multiple behaviors and had a history of falls. The notes revealed the following: -6/14/13 at 10:00 p.m. R10 was noted to have increased anxiety (not described), crying and looking for her loved ones and was unable to be redirected or calmed down. - 7/16/13, (no time identified) R10 had frequent attempts to stand and was attempting to leave the facility and required one to one interventions. R10 became verbally abusive towards the staff and began to become physically aggressive with the staff members. -8/2/13, at 10:00 p.m. R10 was wandering throughout the facility, going into other resident	F 329		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 29 rooms, throwing items on the floor and was not able to be redirected. -8/22/13, at 5:00 p.m. R10 was noted to be going to doors, pushing to try to open them, when the door locks she was kicking at it and swearing and hitting at staff. Several staff attempted interventions. "staff concerned she will fall out of w/c (wheelchair), as she keeps standing up so resident assisted into enclosed frame wheeled walker." -8/23/13, the note indicated the family had been offered psychiatric assistance, but refused care from the available psychiatric center. - 9/8/13, R10 was noted to be kicking at doors, other residents and staff while sitting in the wheelchair. Staff documented that they were unable to direct R10. -10/12/13, At 6:30 p.m. R10 had been repeatedly going into other resident's room and nearly knocked another resident to the ground. Staff attempted to provide one to one supervision but R10 became abuse to anybody attempting to provide the supervision. At 11:00 p.m. R10 continued wandering into other resident room, kicking at doors and yelling/swearing. Other residents in the facility complained of R10's behavior, the administrator was notified. The local emergency room was called and ordered Haldol 5 mg IM stat. R10 continued to display behaviors until 2:30 a.m. -10/13/13, R10 slept most of the day -10/15/13, R10 had family visiting until 10:00 on 10/14/13, at 12:30 a.m. on 10/15/13, R10 became agitated and began yelling at the staff, the director of nurses (DON) was notified and directed the staff to call the emergency room. R10 received Haldol 5 mg intramuscularly. -10/15/13, at 6:30 a.m. was noted to be calm, quiet, awake but confused.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 30 -11/13/13, at 5:30 a.m. documentation indicated R10 had been awake all night attempting to get up by herself. - 11/20/13, at 10:45 p.m. R10 was "very disruptive in and out of room, up and down hallways setting off alarm, unable to redirect. The emergency room was called and received and order for Haldol to be given. -11/21/13, at 1:00 p.m. the primary MD was contacted to request R10 be placed in an acute senior behavioral unit but the acute psychiatric center wished to have the medication adjusted while in the facility. -11/21/13, at 5;30 p.m. R10 received Haldol 10 mg IM . No documentation related to R10's behavior at that time were noted in the record. On 12/16/13 a late entry indicated on 11/21/13, R10 was wandering, attempting to ambulate independently, kicking, cussing and attempting to strike at staff. Haldol was administered and had little effect on resident behaviors. -11/25/13, FM-A provided the facility with a letter addressed to the administrator and the DON which demanded the facility only receive medication orders from the primary physician. In addition, the letter indicated under no circumstances was R10 to receive Haldol. The letter was signed by FM-A and a local court administrator. -12/21/13,12:00 a.m. R10 yelling and looking for family members. -12/26/13 at 6:00 a.m. R10 was wandering into other resident rooms. R10 had been up since 1:30 a.m. -1/9/14 11:00 p.m. R10 attempting to stand by self. -2/4/13, at 11:00 p.m. R10 was combative and swearing at staff. R10 was given a prn Xanax.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 31 Review of R10's Medication Administration Record indicated in 12/13, R10 received 11 doses of as needed Xanax, in January 2014, R10 received 11 doses of Xanax and in 2/14, R10 had received 3 doses of Xanax. R10's clinical record contained documentation from nursing assistants which indicated R10 had specific target behaviors almost daily. R10's Psychopharmacological Medications and Sedative/Hypnotics Tracking Tool dated 12/5/13, indicated R10 was receiving Risperdal (antipsychotic) and Haldol but did not identify any of the other medication changes. R10's clinical record lacked a monitoring system which evaluated the identified target behaviors, medications and how R10 responded to medication adjustments In addition, R10's POC did not identify parameters to direct staff as to when the medications were to be administered and alternative non-pharmacological interventions to attempt prior to giving the medications. In addition, the POC did not direct staff to monitor the effectiveness of the medication. On 2/5/14, at 11:17 a.m. the Interim DON stated she had started a medication monitoring system approximately six weeks ago and was unsure how the facility had been monitoring the medications prior to her arrival at the facility. She confirmed R10's family had requested only the primary physician adjust R10's medications and stated R10's behaviors had significantly decreased. She confirmed R10 had slept most of the day hours on 2/4/13, and could not state why R10 was medicated with Xanax at 11:00 p.m. on 2/4/13. The DON confirmed R10's clinical record	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ____ B. WING ____	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 32	F 329		

lacked nonpharmacological interventions which may have been attempted prior to the administration of the medications. She stated R10's family had been offered inpatient care at behavioral units in the past however was not accepted by family. She stated R10's behaviors had significantly decreased in the past two months, but the facility did not have a comprehensive system to monitor R10's response to the medications and medication changes. She stated she was providing education for staff on how to deal with residents with dementia and had planned on providing the nursing staff with additional training regarding medication administration. In addition, she confirmed the facility had not been following the facility policy on how to care for residents receiving mood altering medications.

The facility's Psychopharmacological Medications and Sedative/Hypnotics policy dated 9/2013, directed staff to evaluate behavior interventions and alternatives before using psychopharmacological medications. The goal of the policy was to eliminate unnecessary psychoactive medications. The policy directed staff to identify a behavioral committee/medication reduction committee which was to monitor the resident to determine which medications were warranted. The committee was to ensure the facility was using appropriate medications, interventions and medication reductions as warranted. In addition, the policy specifically directed the staff to identify the parameters for PRN medications and to attempt the nonphamacological intervention prior to the use of the prn medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 334	Continued From page 33	F 334		
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 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	F 334	1. R54 was educated by giving of the VIS statement. The pneumococcal vaccine was given March 6, 2014 and documented on the resident's immunization record. 2. All current residents have received the Vaccination education as well as documented evidence of having received it and if refused or given this is documented on their immunization record. 3. On admission the influenza vaccine and pneumococcal vaccine will be offered with the appropriate education and documentation on their immunization record. If resident received it prior to admission, this info will also be included on their immunization record. Dates will be obtained from the transferring facility and entered into the EMR by HIM or nursing. Education will be provided to all licensed nursing staff involved in admissions and the entering of immunization information into the EMR 4. Audits will be done by the DNS/designee of all new admissions to ensure that educational information, and refusal or giving of vaccine is documented appropriately into the individual resident's medical record. If immunization was given prior to admission the medical record will be reviewed to ensure this information is recorded. Results of these audits will go to QA for further recommendations. 5. Date of completion: March 14, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 334	Continued From page 34 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 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 administer the pneumococcal immunization, or document contraindication or refusal of the immunization for 1 of 5 residents (R54) reviewed for immunizations. In addition, the facility failed to ensure 1 of 5 residents (R54) received the required vaccination education prior to receiving the influenza immunization.	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 334	Continued From page 35 Findings include: Review of R54's medical record revealed R54 was administered influenza vaccine on 10/07/13, however, lacked documentation to verify R54 or R54's legal representative was provided education regarding the risks, benefits and potential side effects of the influenza vaccine prior to its administration. The medical record also lacked documentation pneumococcal immunization had been received, was contraindicated, or refused. On 2/7/14, at 1:10 p.m. health information coordinator (HIC) verified the facility did not have additional documentation regarding R54's pneumococcal immunization being administered, contraindicated or refused. On 2/7/14, at 1:13 p.m. registered nurse (RN)-A verified the facility did not have documentation of administration, contraindication or refusal of R54's pneumococcal vaccine nor documentation of the required education given for the influenza vaccine administered 10/7/13. The facility's Immunization for Residents policy dated 11/13, directed staff to assess the resident's current immunization status for pneumococcal vaccination. The policy also indicated If the resident had received pneumococcal vaccine before admission, this should be noted on the the resident's immunization record, documentation of the administration of pneumococcal vaccination or if the resident chose not to receive the pneumococcal vaccination should also be noted on the resident's immunization record. It also directed staff to "Inform resident or legal	F 334		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 334	Continued From page 36 representative each year when the influenza vaccinations will be given and provide the Vaccination Information Statement from the CDC for the current year. The Vaccination Information Statement contains education information about the benefits and potential side effects of influenza vaccination. Document that education information was provided to the resident on the resident's immunization record."	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356	1. The required daily nursing staffing is posted including all of the appropriate information. 2. This required nursing staffing will be posted daily and will include all of the appropriate information. 3. Licensed staff responsible for creating the required form will be educated on which staff should be included on the staffing form. Staff members included on the form will include the unit managers, licensed staff, certified medicine aide, rehabilitation aides, and certified nursing assistants. All licensed staff involved with this required form were educated on required total number and actual hours worked. The correct method for counting staff for the daily report was completed by adding the unit managers to the report. 4. This report will be audited on a weekly basis for 4 weeks to ensure sustainability with results of audits to QA for further recommendations. This audit will be done by the staffer. The scheduler will check each shift for staffing accuracy for 14 days. 5. Date of Completion: March 14, 2104	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 356	Continued From page 37 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to post the required information on the nurse staff posting. This had the potential to affect all 47 residents residing in the facility, family members and any visitors who chose to view this information. Findings include: On 02/07/2014, the Daily Nursing Staffing forms were reviewed for January 27,2014, through February 5, 2014. The form included columns for shift, census, category of staff, number of staff, actual hours worked (start & end times) and total hours worked for night, day and evening shifts. The form did not include the restorative aid in the number of staff, actual hours worked or total hours worked for nursing assistants and census information was lacking for all shifts on the days reviewed. On 02/07/2014, at 2:12 p.m. the director of nursing (DON) confirmed the required information was lacking. The Daily Nursing Staffing policy dated February 2012, directed staff to post at the beginning of each shift and update as appropriate (for each shift), resident census, the number of licensed and unlicensed nursing staff directly responsible for resident care, actual hours worked and total hours worked.	F 356		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 38	F 371		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff utilized appropriate hand hygiene during meal distribution. This had the potential to effect 2 of 22 residents (R9 and R1) who received bread products in the west dining room and 4 of 15 residents (R59 R14, R29 and R22) who received bread products and/or fresh fruit in the east dining room. Findings include: West dining room: On 2/3/14, at 5:50 p.m. cook-A was observed to wear gloves as she picked up the telephone and announced the supper prayer over the loud speaker system. From 5:51 p.m. to 6:10 p.m. with the same gloves, Cook-A was observed to dish up meals for the 26 residents eating in the west dining room. The meal consisted of soup, turkey and cheese buns, crackers, milk, juice,	F 371	1. R9, R1, R59, R14, R29, R22 are receiving their bread products, fresh fruit in a sanitary manner. 2. All residents are receiving their food with staff using the appropriate hand hygiene/ sanitation. 3. All nursing and dietary staff will be educated on proper hand washing technique and glove removal to contain any food or contaminants from being redistributed once the gloves have been removed. Food distribution and the process for serving residents in accordance with safe practice of food handling will be taught to the designated staff. Alternative methods for preparing food for the resident includes but is not limited to teaching the staff to use utensils, wax towels, or gloves in an effort to prevent touching resident foods. After education the staff will be observed for safe food handling in accordance with the safe handling practice for the prevention of foodborne illnesses. All nursing aides and new staff will be trained in proper hand washing technique and glove removal. All designated staff will provide a return demo on the process as part of the corrective action and orientation. 4. Observation audits will be done of Nursing staff and dietary staff by the dietary manager and licensed nursing staff during meal times on a daily meal basis for compliance. The dietary manager or designee will audit once a day one meal rotating meals for two weeks,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 39 coffee and canned fruit. Cook-A was observed to dish up the soup and pick up and serve the buns with the same gloved hands. Once the buns were placed onto the plate, cook-A consistently held them steady with her left gloved hand as she cut them and separated them in half. Throughout the meal distribution, cook-A was observed to repeatedly push up her eye glasses with the same gloved hands. At no time was cook-a observed to remove her gloves or wash her hands. A total 22 of the 26 residents who ate in the West dining room received a bun during the meal. At 5:57 p.m. dietary aide (DA)-B served R9 the soup and a bun. R9 requested DA-B add crackers to the soup. DA-B was observed to open a package of two soda crackers, remove the crackers from the package, crush them in her bard hands and poured them into R9's soup. DA-B then clapped her hands together over the soup to remove the crumbs from her hands. DA-B was not observed to wash her hands or apply gloves prior to handling R9's crackers. At 6:05 p.m., DA-B was observed to serve R1 soup and a bun. R1 requested assistance with opening the crackers. DA-B was observed to open the crackers, remove them from the packaging and handed the crackers to R1 with her bare hands. DA-B was not observed to wash her hands prior to handling R1's crackers. East Dining Room: On 2/3/14 at 5:56 p.m. licensed practical nurse (LPN)-A was observed to serve R59 his meal. LPN-A asked R59 if he wanted jelly on his toast.	F 371	then one meal per week for two weeks then an audit one meal monthly. Results of these audits will go to QA for further recommendations. When do they wash their hands? 5. Date of Completion: March 14, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 40 With bare hands, LPN-A was observed to pick up R59's toast and apply jelly. At 6:05 p.m. nursing assistant (NA)-E was observed assisting R14 with eating a turkey and cheese sandwich made from a hamburger type bun. With bare hands, NA-E was observed to pick up half of the sandwich and give R14 bites of the sandwich until it was gone. Registered nurse (RN)-C was observed seated across the table assisting another resident with eating and did not intervene. On 2/5/14, at 8:08 a.m. NA-F was observed to set up R29's breakfast tray. With bare hands, NA-F opened R29's banana, picked the banana out of the peeling and placed it on R29's plate. NA-F then picked up R29's toast with bare hands and applied peanut butter to the toast. At 8:20 a.m. NA-F served R22 his breakfast tray. With bare hands, NA-F was observed to open R22's banana, pick the banana out of the peeling and place it on R22's plate. At 8:29 a.m. NA-F was observed assisting R14 with eating her breakfast. With bare hands, NA-F was observed to pick up a half of a slice of toast and give R14 bites until finished. On 2/5/14, at 5:45 p.m. LPN-A verified she touched the toast with bare hands and should not have. LPN-A stated she was trying to figure out a way to put the jelly on the toast without touching it with bare hands. On 2/6/14, at 8:35 a.m. NA-E verified she touched the sandwich with bare hands. NA-E stated, "I thought R14 would pick up the	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ___ B. WING ___	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 41 sandwich herself and when she didn't, I picked it up for her." On 2/6/14, at 9:27 a.m. the dietary director (DD) stated staff should not touch food with bare hands. The DD stated she had instructed staff not to wear gloves in the dining room rather they should have used a fork to hold the toast when applying condiments. The DD also stated staff had been educated to wash their hands and not touch the food. The facility's Food Handling policy and procedure revised 3/09, indicated the purpose was to limit contamination of food served to a highly susceptible population. The procedure included; ready to eat foods will not be touched with bare hands. Proper utensils such as tissues, spatulas, tongs and single use gloves were to be used for food handling. When gloves are used, change the gloves after touching hair or face with the gloved hands.	F 371		
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	F 428	1. R 10 medications have been reviewed by the consulting pharmacist on March 5, 2014 with the findings shared with DNS, Unit Managers and the physicians. 2. The consulting pharmacist will audit all resident's medications monthly and will review for irregularities related to use of psychotropic medications. The pharmacist will meet with the DNS and unit managers at the end of his visit to share irregularities to the attending physician; the DNS or designee will insure the recommendations have been communicated to the physician. The unit managers will follow-up and insure the recommendations have been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ___ B. WING ___	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 42 by: Based on interview and document review, the facility failed to ensure the licensed pharmacist identified and reported irregularities related to the use of psychotropic medication to the attending physician and director of nursing in order to be acted upon for 1 of 1 resident (R10) in the sample who required a report. Findings include: R10's Face Sheet dated 1/8/14, indicated R10's diagnoses included dementia with delusional features, hallucinations, osteoarthritis, insomnia and anxiety. R10's quarterly Minimum Data Set (MDS) dated 12/4/13, indicated R10 had severe cognitive impairment and required extensive assistance of one staff with transfers, toilet use and bed mobility. The MDS also indicated R10 displayed verbal and physical aggressive behaviors, wandered almost daily and had received antianxiety and antidepressant medications daily. R10's current Physician's Orders revealed the following: The orders dated 7/2013, included: - Paxil (antidepressant medication) 10 milligram (mg) daily - started on 4/23/13 - Ativan (antianxiety medication) 0.25 mg three times a day - started on 3/21/13. - Ativan 0.25 mg every fours hours as needed (PRN). - Seroquel (antipsychotic medication) 12.6 mg at 2 p.m. and 25 mg at 5 p.m. and 8 p.m., started on 6/27/13.	F 428	responded to. 3. Discussion was held with consulting pharmacist on this citation. 4. Audits will be done monthly to ensure that consulting pharmacist has reviewed all residents currently on an antipsychotic medication with appropriate follow through for 6 months. These audits will be done by DNs/designee with results to QA for further recommendations. 5. Date of completion: 03/14/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ____ B. WING ____	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 43	F 428		

R10's clinical record revealed the following:

- On 7/26/13, at 2:30 p.m. R10 fell while ambulating independently.
- On 8/2/13, at 9:30 p.m. R10 stood independently from a recliner resulting in a fall.
- On 8/5/13, at 9:30 p.m. R10 was found sitting on the floor in front of an enclosed framed walker.
- On 8/6/13, the nurse practitioner (NP) increased the Paxil to 20 mg daily.
- On 8/9/13, at 9:00 p.m. R10 was observed to stand independently and fell backwards.
- On 8/16/13, at 8:05 p.m. resident fell.
- On 8/19/13, at 7:35 p.m. R10 fell in the hallway.
- On 8/20/13, at 6:30 p.m. R10 was found on the floor next to the bed.
- On 8/21/13, R10's primary physician (MD) discontinued the PRN Ativan, added Risperdal (antipsychotic medication) 0.125 mg daily PRN for severe agitation and restarted Namenda (a cognitive enhancer R10 had previously been on.) at 5 mg daily for one month then increased to 5 mg twice a day.
- On 8/21/13, the NP discontinued the Seroquel.
- On 8/27/13, at 4:50 p.m. R10 fell from the wheelchair resulting in 3 centimeter (cm.) red raised area to the left side of head.
- On 9/28/13, the MD increased the Ativan to 0.5 mg three times a day and increased the Paxil to 40 mg a day.
- On 9/30/13, at 7:45 p.m. R10 slid out of the wheelchair.
- On 10/2/13, the MD started Remeron (an antidepressant medication) 7.5 mg at bedtime.
- On 10/4/13. at 8:30 a.m. R10 was found on the floor between the bed and recliner.
- On 10/4/13, at 9:45 p.m. R10 attempted to self transfer from the wheelchair resulting in a fall. No

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 44 injuries were noted. - On 10/9/13, the MD discontinued the 6 p.m. dose of Ativan -On 10/12/13, NP ordered Haldol (antipsychotic medication) 5 mg to be given via injection immediately. - On 10/15/13, a physicians assistant (PA) ordered Haldol 5 mg to be given via injection immediately. - On 10/16/13, the MD discontinued the Remeron and increased the Risperdal to 0.25 mg twice a day. - On 11/5/13, at 1:30 am. R10 was found on the floor next to her bed. - On 11/20/13, NP ordered Haldol 5 mg to be given via injection immediately. - On 11/21/13, NP ordered Haldol 10 mg to be given via injection as needed. - On 11/21/13, the MD increased the Risperdal to 0.5 mg twice a day. - On 11/22/13, at 5:40 p.m. R10 was found on the floor in front of her bed. - On 11/23/13, 10:40 a.m. R10 was found on the floor next to the bed. - On 12/2/3, at 7:15 p.m. R10 attempted to ambulate independently, fell and hit the right side of her forehead which resulted in a 3 cm. bruise. - On 12/11/13, the MD increased Paxil to 40 mg twice a day and increased Seroquel to 25 mg twice a day and discontinued the Risperdal. - On 12/13/13, The MD added Zoloft (antidepressant) 50 mg daily and Xanax (antianxiety medication) 0.5 mg every 4 hours as needed. The Seroquel and Haldol were discontinued at that time. - On 12/18/13, the MD increased the Zoloft to 100 mg daily. - On 12/20/13, at 9:10 p.m. R10 slid from a recliner onto the floor.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 45 - On 1/12/14, at 4:00 .p.m. R10 was found on the floor in front of the wheelchair. - On 1/24/14, at 8:00 p.m. R10 was found on the floor in another residents room. - On 1/29/13, the MD decreased the Ativan to 0.25 mg in am. R10's February 2014, Medication Administration Record (MAR's) indicated R10 was receiving: -Ativan 0.25 mg each morning and 0.5 mg at 1:00 p.m. -Zoloft 100 mg daily - Xanax 0.5 mg every four hours as needed (R10 had received the medication on 2/1, 2/3 and 2/4.) Review of R10's Interdisciplinary Progress Notes from 6/14/13 - 2/4/14, revealed R10 had numerous disruptive behaviors. The behaviors ranged from wandering throughout the facility, pushing at other residents, kicking staff, swearing, attempting to open closed doors and showing signs of "increased anxiety." The notes repeatedly indicated R10 was not easily redirected when upset. The note further indicated R10 had received numerous different antipsychotic and antianxiety medication changes. On four separate occasions, R10's increased disruptive behaviors required the facility to contact the emergency room to obtain a physician's order to administer antipsychotic medications intramuscularly. Review of R10's Pharmacist Medication Regimen Review dated 7/2/13 - 2/3/14, indicated the consultant pharmacist had identified R10 had received medication changes with fall occurrences. However, the documentation lacked	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 46 indication of the correlation of the use of antianxiety and / or antipsychotic medications contributing to R10's falls and did not identify nor address interventions/suggestions as to how the facility could improve monitoring in an attempt to minimize the falls. In addition, the pharmacist had identified R10 was in need of electrolyte monitoring (laboratory testing) blood work. The clinical record also lacked indication the laboratory test was completed. On 2/6/14, at 11:00 a.m. the health information specialist (HIM)-A confirmed R10's current clinical record did not contain electrolyte lab test / results. HIM-A stated the director of nursing was responsible to follow up with any concerns related to the pharmacy recommendations. On 2/6/14, at 1:50 p.m. the consultant pharmacist stated due to staffing changes, the facility had difficulty following up on pharmacy recommendations. However, he confirmed he had not identified the numerous medication changes nor recommended to the facility to decrease the number of medication changes in an attempt to evaluate the effectiveness of the medications, He also confirmed he had not identified nor alerted the facility to a pattern in relationship to R10's frequent medication changes and fall history.	F 428		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be	F 497	1. Evaluations have been completed on all nursing staff with dates of hire between October 1 and March 31. 2. All nursing staff will receive an evaluation yearly. All staff with anniversary dates between October 1, 2013 and March 31, 2014 will be evaluated by the Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 497	Continued From page 47 sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 5 nursing assistants (NA) (NA-G, NA-H, NA-I, NA-J) received an annual performance review. Findings include: On 2/07/13, NA-G personnel file was reviewed and indicated a hire date of 03/09/89. No performance evaluations were available for this employee. On 2/07/13, NA-H personnel file was reviewed and indicated a hire date of 10/21/98. No performance evaluations were available for this employee. On 2/07/13, NA-I personnel file was reviewed and indicated a hire date of 04/20/01. No performance evaluations were available for this employee. On 2/07/13, NA-J personnel file was reviewed and indicated a hire date of 8/30/05. No performance evaluations were available for this employee.	F 497	Nursing Services to be completed by March 14, 2014. Nursing staff with anniversary dates including April, 2014 and August and September, 2013 will be completed by April 30, 2014. All anniversary dates during the month of May, 2014 and June and July, 2013 will be completed by May 31, 2014. 3. All subsequent evaluations of staff after this initial process will be completed annually during their anniversary month. Strengths and weaknesses will be identified and an individualized plan for education will be determined. All staff are required to complete annual learning center requirements per Good Samaritan policy. Annual skill validations are being selected for annual education requirements and orientation processes. 4. This process will be completed and monitored and audited by the DNS to ensure that annual evaluations are completely timely by month of hire. Educational processes will be conducted and monitored by the Staff Development Coordinator for compliance and completion. Results of these audits will go to QA for further recommendation 5. Date of completion: March 14, 2014	

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

PRINTED: 02/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 497	Continued From page 48 On 2/07/13, at 2:00 p.m. registered nurse (RN-B) confirmed NA-G, NA-H, NA-I, and NA-J lacked documentation of performance reviews completed since their date of hire. On 2/07/13, at 2:30 p.m. the administrator verified performance evaluations were to be completed annually for employees. The Performance Evaluation policy dated 7/07, directed the use of the job-specific Performance Evaluation (PE) form for post-orientation, annual or more frequent performance evaluations.	F 497		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to obtain a basic metabolic panel laboratory results according to physician orders for 1 of 10 residents (R10) who had lab work ordered. Findings include: R10's Face Sheet dated 1/8/14, identified diagnoses of dementia, hypertension, hypothyroidism and anxiety. The Physicians Progress note dated 7/17/13, directed R10 to return to the clinic in two week to	F 502	1. All lab results are being communicated to the Center in a timely fashion. 2. All current lab results during the time of survey process were reviewed to insure appropriate follow through had occurred. 3. Education was provided for unit managers regarding the timeliness of lab results. An internal system was put into place to monitor this process. 4. Audits for timeliness and completion will be conducted weekly for 4 times. Audits will be completed by the DNS/designee. 5. Completion date will be March 14, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING ______ B. WING ______	02/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 502	Continued From page 49	F 502		

have a follow up basic metabolic panel (BMP) (laboratory test which monitors the electrolyte balances of the blood). The clinical record lacked documentation which indicated R10 had received the lab work as ordered.

R10's current Physician's Orders dated 12/18/13, included orders for Lasix (a diuretic medication which may cause changes in the blood electrolyte levels) 20 milligrams (mg) every other day.

The Pharmacists Medication Regimen Review dated 10/2/13, indicated the pharmacist had questioned if R10 had a current BMP.

On 2/6/14, at 11:00 a.m. the health information specialist (HIM)-A confirmed R10's current medical record did not contain a BMP. She stated she would contact the local clinic for the most current lab results.

On 2/6/14, at 2:45 p.m. HIM-A stated she had received a copy of a BMP dated 7/3/13, from the clinic. She confirmed the facility did not have a copy of the 7/3/13, labs prior to the State Agency request, HIM-A confirmed the order for labs to be completed on 7/17/13, had been missed and also verified the facility had not followed up on the request by the consultant pharmacist regarding the labs in 10/13. The HIM stated the laboratory tests/ results were to be obtained as ordered by the physician.

The Laboratory Services policy revised in 1/2009, directed the staff to provide laboratory services as directed by the attending physician.

Good Samaritan Society
410 S. McKinley Street
Warren, MN 56762

3/20/14

Addendum to 2567

F323 Root cause analysis will be completed at the time of the fall.

F502 R10 had the completed results of lab drawn 07-03-13 and the results returned and noted by Tracy Mostad, DNS on 07-03-14.

Submitted by:

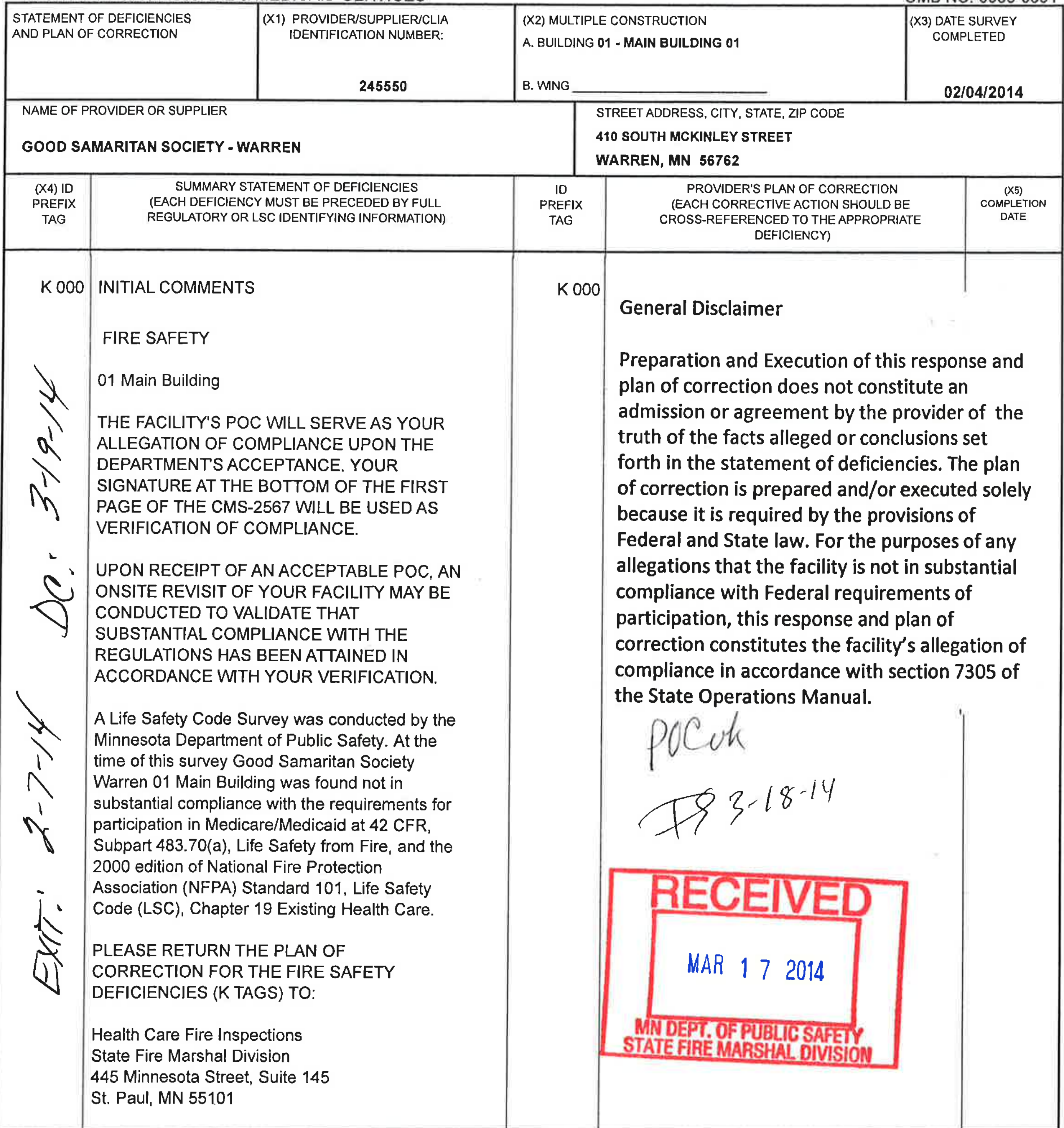
Linda Dunnigan, MSN, RN, DNS

3/20/14
Approved
[illegible]

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

F5550023

PRINTED: 02/28/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Good Samaritan Society Warren 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	**General Disclaimer** 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 allegations 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. POC ok [illegible] 3-18-14 RECEIVED MAR 17 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 2-7-14 DC: 3-19-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 3/13/14

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
	245550	A. BUILDING 01 - MAIN BUILDING 01 B. WING ____	02/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Good Samaritan Society Warren (Marshal Manor) was built in 1968 as a 1-story building without a basement and was determined to be Type II (111) construction. In 1973 a 1-story addition was constructed to the east of the original building and was determined to be Type II (000) construction. In 2010 a kitchen addition was constructed to the north of the original building's dining room. It is 1-story, no basement and Type II(000) construction. In 2013 a connecting link was constructed to the east connecting the new hospital with the facility. This addition is i-1story , no basement and Type II(000) construction. The building is divided into 6 smoke zones with 1/2 hour fire rated barriers. An apartment building is attached to the southwest wing that is separated with a 2-hour fire barrier. The facility is completely protected with an automatic sprinkler system installed in	K 000		

PRINTED: 02/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code (1999 edition) with automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). Because the kitchen addition and connecting link was constructed after 2003, the facility was surveyed as two buildings, 01 Main Building 02 Kitchen addition and connecting link. The facility has a capacity of 60 beds and had a census of 47 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	K 029 The corridor door to the old dish room, designated 300k, has had a self-closure arm installed on it. The Environmental Services Supervisor &/or designee, will be responsible for ensuring all doors within the facility, that are used to separate other spaces for smoke resisting patricians, have self-closing arms installed on them. Completion Date: 2/5/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 029	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations and testing of corridor doors, it was determined that one of ten hazardous area corridor doors tested is not in accordance with National Fire Protection Association (NFPA) 101 "The Life Safety Code" 2000 edition (LSC) section 18.3.2.1. This deficient practice could allow the products of combustion to travel from this hazardous area into the corridor system if a fire occurs within the room, which could negatively impact all 60 of the residents, the staff and any visitors of the facility. Findings include: During the facility tour on February 4, 2014. between 10:45 am and 12:15 pm, observations and testing of corridor doors by surveyor 03006, revealed that the corridor door to the old dish room that is now storage room 300R is not self-closing. This finding was verified by the Director of Maintenance during the facility tour and at the exit conference.	K 029		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on an interview with staff, observations, and testing of all exits and exit discharges, it was	K 038	K 038 First, the information on the number of residents effected is not accurate. There are not 16 residents on the 100 wing, there are only 6. Most of the 100 wing cannot be used for resident rooms because they do not meet the sight line standards. The Exit door on the 100 wing, Northwest part of the building, has been opened and is no longer blocked shut. The snow has been removed from around the outside of the door and a path has been made along the building to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 038	Continued From page 4 determined that 1 exit is not in accordance with National Fire Protection Association (NFPA) 101 "The Life Safety Code" 2000 edition (LSC) section 7.2. This deficient practice could negatively affect the 16 residents, any visitors and staff in that wing of the facility by limiting their exiting in an emergency. Findings include: Prior to the facility tour on February 4, 2014. at approximately 10:30 am, observations by surveyor 03006 and an interview with staff, revealed that the 100 north west wing exit door is blocked against exiting due to construction of the new apartments to safe guard the resident from injury. The apartment foundation is in place however it has not been back filled leaving a hole. An interview with the Administrator and the Director of Maintenance revealed that no temporary exiting plan has been developed for this wing leaving a dead end corridor of approximately 100 feet. This wing contains sleeping rooms for up to 16 residents with a census of 3 residents at the time of the survey. Those clients are in the rooms nearest the nurses ' station on the opposite end of the wing from the exit. The staff stated it has been this way since approximately November 15, 2013 and that the sub-contractor will be back filling the foundation this week. The facility staff and the contractors removed the snow and set up an exit discharge from this door to the parking lot during the survey. This finding was verified by the Director of Maintenance at the time of the inspection and with the Administrator during the exit conference.	K 038	the adjacent parking lot. Maintenance staff will keep this pathway clear of snow. There was also a barrier erected to ensure resident and staff safety when existing the building. The pathway is next to a construction site. The pathway is wide per regulation and does allow for easy and safe egress from the building. In the future, the area next to the exit door on the 100 wing will be excavated, footing will be poured and the connection between the skilled facility and the assisted living will be built. Before this starts we will move the current residents to other parts of the building. This will mean there will be no residents on the 100 wing. The residents will not be returned to their previous room until construction is completed and egress from the 100 wing is reestablished. The Environmental Supervisor &/or his designee will ensure that the snow is removed from the doorway and the pathway to the parking lot to ensure proper egress. Administrator and the Social Services Supervisor will ensure that all the residents currently on the 100 wing are relocated to other areas of the building and ensuring that the 100 wing is empty of residents when construction begins. Completion: 2/6/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**02/04/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET** **WARREN, MN 56762**

(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 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on a review of fire drill records, it was determined that the facility staff have not conducted fire exit drills in accordance with National Fire Protection Association (NFPA) 101 "The Life Safety Code" (LSC) 2000 edition section 19.7.1.2. Not conducting fire exit drills could allow confusion and delay in the staff response, which would negatively impact all 60 of the residents, all staff and any visitors to the facility, in a fire emergency. Findings include: Prior to the facility tour on February 4, 2014. at approximately 10:40 am, a review of the fire exit drill records for Good Samaritan Society Warren for 2013, by surveyor 03006, revealed that the facility staff had conducted only 2 overnight fire drills in 2013 and missed the day shift fire drill in the first quarter of 2013. This finding was verified by the Director of Maintenance at the time of the inspection and during the exit conference.	K 050	K050 Currently fire drills have had multiple persons responsible for ensuring that the drills are done timely and accurately. There has been a person assigned for each month. This has caused confusion which has resulted in the drills not being completed accurately. We have now designated 1 person to be responsible for the fire drills. The Environmental Services Supervisor &/or his designee will be responsible to ensure that the drills are done each month ~~at~~ and that they are done on the appropriate shifts/times. Completion 2/14/2014	

F5550023

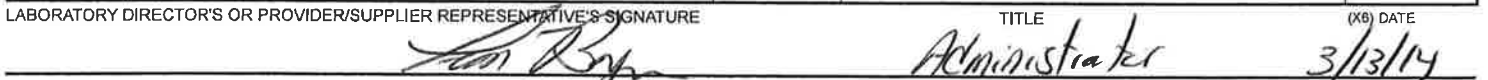
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245550	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - KITCHEN ADDTION B. WING	(X3) DATE SURVEY COMPLETED 02/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 02 Kitchen Addition and Connecting Link THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Good Samaritan Society Warren 02 Kitchen Addition was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. 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	K 000	General Disclaimer nd Execution of this response and :tion does not constitute an agreement by the provider of the facts alleged or conclusions set statement of deficiencies. The plan n is prepared and/or executed solely is required by the provisions of d State law. For the purposes of any s that the facility is not in substantial ce with Federal requirements of tion, this response and plan of on constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. POC ok [initials] 3-18-14	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/13/14

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
	245550	A. BUILDING **02 - KITCHEN ADDTION** B. WING ______	02/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET** **WARREN, MN 56762**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Good Samaritan Society Warren (Marshal Manor) was built in 1968 as a 1-story building without a basement and was determined to be Type II (111) construction. In 1973 a 1-story addition was constructed to the east of the original building and was determined to be Type II (000) construction. In 2010 a kitchen addition was constructed to the north of the original building's dining room. It is 1-story, no basement and Type II(000) construction. It is 1-story, no basement and Type II(000) construction. In 2013 a connecting link was constructed to the east connecting the new hospital with the facility. This addition is i-1story , no basement and Type II(000) construction. The building is divided into 6 smoke zones with 1/2 hour fire rated barriers. An apartment building is attached to the southwest wing that is separated with a 2-hour fire barrier. The facility is completely protected with an	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **02 - KITCHEN ADDTION** B. WING ______	**02/04/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET** **WARREN, MN 56762**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code (1999 edition) with automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). Because the kitchen addition and connecting link was constructed after 2003, the facility was surveyed as two buildings, 01 Main Building 02 Kitchen addition and connecting link. The facility has a capacity of 60 beds and had a census of 60 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2	K 050	K050 Currently fire drills have had multiple persons responsible for ensuring that the drills are done timely and accurately. There has been a person assigned for each month. This has caused confusion which has resulted in the drills not being completed accurately. We have now designated 1 person to be responsible for the fire drills. The Environmental Services Supervisor &/or his designee will be responsible to ensure that the drills are done each month at that they are done on the appropriate shifts/times. Completion 2/14/2014	

PRINTED: 02/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING 02 - KITCHEN ADDTION B. WING ______	02/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 050	Continued From page 3 This STANDARD is not met as evidenced by: Based on a review of fire drill records, it was determined that the facility staff have not conducted fire exit drills in accordance with National Fire Protection Association (NFPA) 101 "The Life Safety Code" (LSC) 2000 edition section 19.7.1.2. Not conducting fire exit drills could allow confusion and delay in the staff response, which would negatively impact all 60 of the residents, all staff and any visitors to the facility, in a fire emergency. Findings include: Prior to the facility tour on February 4, 2014. at approximately 10:40 am, a review of the fire exit drill records for Good Samaritan Society Warren for 2013, by surveyor 03006, revealed that the facility staff had conducted only 2 overnight fire drills in 2013 and missed the day shift fire drill in the first quarter of 2013. This finding was verified by the Director of Maintenance at the time of the inspection and during the exit conference.	K 050		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on an interview with staff and a review of facility documentation, it was determined that the kitchen hood fire suppression system has not been maintained in accordance with National Fire Protection Association (NFPA) 96 The Standard	K 069	K069 We have a new contract with Simplex/Grinnell to provide and handle all of our fire prevention and service needs. They were contacted about the kitchen hood fire suppression system. They came and service the hood on 2/10/14. They now have us on a twice annual service contract for the hood. The Environmental Services Supervisor &/or his designee will ensure that the system is maintained per current life safety codes. Completion 2/10/2014	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **02 - KITCHEN ADDTION** B. WING ______	**02/04/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET** **WARREN, MN 56762**

(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 069	Continued From page 4 for Ventilation Control and Fire Protection of Commercial Cooking Operations 1998 edition nor the Minnesota State Fire Code 2007 (MSFC). This deficient practice could allow the system to fail allowing a kitchen fire to spread which could negatively impact the all the residents, any staff and any visitors in the kitchen area. Findings include: Prior to the facility tour on February 4, 2014. at approximately 10:40 am, a review of the hood suppression testing records form Nardini for the Good Samaritan Society Warren, by surveyor 03006, revealed that the kitchen hood suppression system has not been serviced every six months as required. The last service was done 2-25-2013. This finding was verified by the Director of Maintenance at the time of the inspection and during the exit conference.	K 069		