DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL E SURVEY AGENCY		O76Z sility ID: 00021
1. MEDICARE/MEDICAID PROVIDER N (L1) 245600 2.STATE VENDOR OR MEDICAID NO. (L2) 336240000 (L2)	0.	3. NAME AND ADI (L3) GOOD SAMA (L4) 172 SUMMIT (L5) BLACKDUC	ARITAN SOCIET TAVENUE WEST	FY - BLAC	CKDUCK (L6) 56630	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 7. On-Site Visit	 <u>7</u>(L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Com	
6. DATE OF SURVEY 06/19/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING D	ATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 32 (L37) 16. STATE SURVEY AGENCY REMARK	32 (L18) 32 (L17) 19 SNF (L39) SS (IF APPLICABLE S	B. Not in Comp Requireme ICF (L42)	ce With quirements Based On: cceptable POC bliance with Program nts and/or Applied V IID (L43)		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services 7. Medical Director	
See Attached Remarks 17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PROVAL	Date:
Lyla Burkman, Unit	Supervisor		08/21/2014	(L19)	Enforceme	nt Specialist	09/02/2014 (L20)
	PART II - TO	BE COMPLETEI	D BY HCFA RE	GIONAI	OFFICE OR SINGLE STAT	E AGENCY	
19. DETERMINATION OF ELIGIBILITY _X1. Facility is Eligible to Part 2. Facility is not Eligible			PLIANCE WITH C ITS ACT:	IVIL	 Statement of Financ Ownership/Control I Both of the Above : 	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1	(513)
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	NT	26. TERMINATION ACTION:	(L3	.0)
OF PARTICIPATION 04/01/1992	BEGINNING	DATE	ENDING DATE	E	VOLUNTARY 00 01-Merger, Closure 00	05-Fail to Meet	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	nt 06-Fail to Meet	t Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVI A. Suspension of				04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Sta	atus Change
(L27)	B. Rescind Sus		(L44)			00-Active	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS		
		00140					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	DETERMINATION C	OF APPROVAL DAT	Έ			
		06/23/2014					

CCN: 24-5600

On May 1, 2014 a standard survey was completed at this facility. On May 13, 2014 a Life Safety Code Federal Monitoring (FMS) survey was completed at this facility. The results of this survey lead lead to CMS Region V decision to impose the following remedy:

Mandatory Denial of Payment for New Admissions (MDPNA), effective August 1, 2014

If MDPNA goes into effect, the facility would be subject to a two year loss of NATCEP beginning August 1, 2014.

On June 19, 2014 a Post Certification Revisit by review of the plan of correction was completed for the health deficiencies and on July 30, 2014 a PCR was completed for the FMS and correction was verified effective July 8, 2014. As a result of the PCR the MDPNA was rescinded and the NATCEP prohibition was also rescinded. Effective July 8, 2014, the facility is certified for 32 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5600

August 21, 2014

Mr. Gordon Hormann, Administrator Good Samaritan Society - Blackduck 172 Summit Avenue West Blackduck, Minnesota 56630

Dear Mr. Hormann:

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 July 8, 2014 the above facility is certified for

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

August 21, 2014

Mr. Gordon Hormann, Administrator Good Samaritan Society - Blackduck 172 Summit Avenue West Blackduck, Minnesota 56630

RE: Project Number S5242024, F5600025

Dear Mr. Hormann:

On May 8, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 1, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 13, 2013, A surveyor representing the office of the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS). As the surveyor informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 27, 2014, CMS notified you of the results of the FMS and revealed that your facility continues to not be in substantial compliance and imposed the following remedy:

• Mandatory Denial of Payment for New Medicare Admissions and Medicaid Admissions, effective August 1, 2014.

In addition, CMS notified you in their letter of May 27, 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 August 1, 2014.

Good Samaritan Society - Blackduck August 21, 2014 Page 2

On June 19, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 30, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 1, 2014 and a Federal Monitoring Survey (FMS) completed on May 13, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 8, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 1, 2014 and the FMS completed on May 13, 2014, effective July 8, 2014. As a result of the revisit findings, we recommended to the CMS Region V Office, they concur and have authorized this Department to notify you of the following action related to the imposed remedy in their letter of May 27, 2014:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 1, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 1, 2014, be rescinded. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 1, 2014, be rescinded. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

In thier letter of May 27, 2014, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 29, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 8, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697 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 245600	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 6/19/2014
Name	of Facility		Street Address, City, State, Zip Code	
GC	OOD SAMARITAN SOCIETY - BLACKDU	СК	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630	

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

(Y4) Item	(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	ltem		(Y5)	Date
ID Prefix Reg. # LSC	F0157 483.10(b)(11)	С	orrection ompleted 6/10/2014		ID Prefix Reg. # LSC	F0167 483.10(g)(1)		Correction Completed 06/10/2014		ID Prefix Reg. # LSC	F0279 483.20(d), 483.2	0(k)(1)	Correction Completed 06/10/2014
ID Prefix Reg. #	F0309 483.25	C	orrection ompleted 6/10/2014		ID Prefix Reg. #	F0329 483.25(l)		Correction Completed 06/10/2014		ID Prefix Reg. #	F0428 483.60(c)		Correction Completed 06/10/2014
ID Prefix Reg. # LSC	F0441 483.65	C	orrection ompleted 6/10/2014		ID Prefix Reg. # LSC	F0466 483.70(h)(1)							
ID Prefix Reg. # LSC		C	orrection ompleted		Reg. #					Reg. #			Correction Completed
ID Prefix Reg. # LSC		C	orrection ompleted		Reg. #								
Reviewed By State Agency Reviewed By CMS RO	/ LB/1	nm		Da 08 Da	/21/201	4 Signature of Signature of		2803	5			Date: 06/1 Date:	19/2014
Followup to	Survey Completed on: 5/1/2014						-				a Summary of to the Facility?	YES	NO

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 245600	(Y2) Multiple Constr A. Building B. Wing	I BUILDING 01	(Y3) Date of Revisit 7/30/2014
Name	of Facility		Street Address, City, State, Zip Code	
GO	OD SAMARITAN SOCIETY - BLACKDU	СК	172 SUMMIT AVENUE WEST	
			BLACKDUCK, MN 56630	

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

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	ltem		Y5)	Date
			Correction					Correction					Correction
ID Drofiv			Completed 05/28/2014		ID Drofiv			Completed 06/30/2014		ID Drofiv			Completed 06/15/2014
ID Prefix			05/20/2014					06/30/2014					06/15/2014
•	NFPA 101 K0025				•	NFPA 101 K0027				•	NFPA 101 K0050		_
	10023				200	10027					10000		
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			07/07/2014		ID Prefix			06/30/2014		ID Prefix			06/15/2014
-	NFPA 101				-	NFPA 101				-	NFPA 101		
LSC	K0052				LSC	K0062				LSC	K0064		_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			07/08/2014		ID Prefix					ID Prefix			
Reg. #	NFPA 101				Reg. #					Reg. #			
LSC	K0144				LSC					LSC			_
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #			•		Reg. #			-					
LSC	-									LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix			-		ID Prefix			
Reg. # LSC					Reg. # LSC					Reg. #			_
				<u> </u>	LSC					LSC			
Reviewed B	y	Reviewed E	Зу	Dat	te:	Signature o	f Surve	vor:				Date:	
State Agenc	у	PS/mm		08/	/21/201	-	272	-				07	7/30/2014
Reviewed B	у	Reviewed B	Зу	Dat	te:	Signature o	f Surve	yor:				Date:	
CMS RO													
Followup to	Survey Compl	eted on:				Check	for any	Uncorrected I	Deficie	ncies. Was	a Summary of	I	
	5/13/	/2014				Unc	orrecte	d Deficiencies	(CMS	-2567) Sent	to the Facility?	YES	NO

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 245600	(Y2) Multiple Constru A. Building B. Wing	VITIES ADDITION	(Y3) Date of Revisit 7/30/2014
Name of Facility		Street Address, City, State, Zip Code	
GOOD SAMARITAN SOCIETY - BLACKDU	СК	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630	

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

(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date (Y4) Item	((5)	Date
		Correction			Correction				Correction
ID Prefix		Completed 06/15/2014	ID Prefix		Completed 07/07/2014	ID Prefix			Completed 07/08/2014
Reg. #	NFPA 101		Reg. #	NFPA 101		Reg. #	NFPA 101		
LSC	K0050	-	LSC	K0052		LSC	K0144		_
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed	Reg. #			Correction Completed
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC		Correction Completed	Reg. #			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed				Correction Completed
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			Reg. #			
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	eyor:			Date:	
State Agency	y PS/mn	1	08/21/20	14 27	200			07/3	0/2014
Reviewed By CMS RO	Reviewed	Ву	Date:	Signature of Surve	eyor:			Date:	
Followup to	Survey Completed on: 5/13/2014			-		eficiencies. Was CMS-2567) Sent	-	YES	NO

DEPARTMENT OF HE	ALTH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: O76Z
1. MEDICARE/MEDICAID PR (L1) 245600 2.STATE VENDOR OR MEDIC	OVIDER NO.	3. NAME AND ADI (L3) GOOD SAMA (L4) 172 SUMMIT	DRESS OF FACI	ILITY IETY - B	TE SURVEY AGENCY	Facility ID: 00021 4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 2. Training of the second seco
(L2) 336240000		(L5) BLACKDUC	K, MN		(L6) 56630	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANC (L9)	GE OF OWNERSHIP	7. PROVIDER/SUF 01 Hospital	PPLIER CATEGO 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
	05/01/2014 (L34) :: (L10) TJC Other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IIE 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
 11LTC PERIOD OF CERTIFIC From (a): To (b): 12.Total Facility Beds 	CATION 32 (L18)	10.THE FACILITY 1 A. In Compliance Program Red Compliance 1. Acc	ce With quirements	AS:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	The Following Requirements: 6. Scope of Services Limit 7. Medical Director IF)8. Patient Room Size 9. Beds/Room
13.Total Certified Beds	32 (L17)	X B. Not in Comp Requirement	pliance with Progr nts and/or Applie		* Code: B *	(L12)
14. LTC CERTIFIED BED BRE	AKDOWN	·			15. FACILITY MEETS	
	SNF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L37)	38) (L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY See Attached Remarks	Y REMARKS (IF APPLICA	ABLE SHOW LTC CAN	NCELLATION D	ATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Debra Vincent, I	HFE NEII	05	5/20/2014	(L19)	Mark Meath, Enfor	ccement Specialist 06/20/2014 (L20)
	PART II - TO BE	COMPLETED B	Y HCFA RE	GIONAI	L OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF EL _X1. Facility is Eligit 2. Facility is not	ble to Participate		PLIANCE WITH TS ACT:	CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) :
22. ORIGINAL DATE						
OF PARTICIPATION 04/01/1992	23. LTC AGREEI BEGINNINC		LTC AGREEM		26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	oo ran to moorrigionnom
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	on <u>OTHER</u> 07-Provider Status Change
(L2	27)	n of Admissions: uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARKS	
		00140				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-153	9 32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5600

On May 1, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections are required. The facility has been given an opportunity to correct before remedies would be imposed. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

May 8, 2014

Ms. Angel Normandin, Administrator Good Samaritan Society - Blackduck 172 Summit Avenue West Blackduck, Minnesota 56630

RE: Project Number S5600023

Dear Ms. Normandin:

On May 1, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567 is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 10, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 10, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable. Good Samaritan Society - Blackduck May 8, 2014 Page 4

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 1, 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

Good Samaritan Society - Blackduck May 8, 2014 Page 5

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 November 1, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us Telephone: (651) 201-7205 Fax: (651) 215-0541 Good Samaritan Society - Blackduck May 8, 2014 Page 6

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

5600s14epoc.rtf

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					1 APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u> DMB NO</u>	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		TE SURVEY MPLETED
		245600	B. WING _			05/	/01/2014
NAME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BLACKDUCK			SUMMIT AVENUE WEST CKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	00			
F 157 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of your validate that substar regulations has beet your verification. 483.10(b)(11) NOT (INJURY/DECLINE A facility must immediate consult with the rest known, notify the rest or an interested fan accident involving t injury and has the p intervention; a signi physical, mental, or deterioration in heat status in either life to clinical complication significantly (i.e., a existing form of treat consequences, or t treatment); or a deot the resident from th §483.12(a). The facility must als and, if known, the r	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with	F 15	57			6/10/14
							(X6) DATE
	ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG			TITLE		05/19/2014
	J = 3 = =						

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.

PRINTED: 05/20/2014

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUU 7	TIPLE CONSTRUCTION	OMB NO.	E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		245600	B. WING		05/	01/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
GOOD S	AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 157	change in room or i specified in §483.1 resident rights under regulations as speci- this section. The facility must react the address and ph- legal representative This REQUIREMEN by: Based on interview facility failed to notif oxygen saturations, blood pressures in consult the physicia administration for 1 for notification of ch and an acute illness Findings include: R6's quarterly Minir indicated R6 had m	 roommate assignment as 5(e)(2); or a change in er Federal or State law or sified in paragraph (b)(1) of cord and periodically update one number of the resident's e or interested family member. NT is not met as evidenced a and document review, the fy the physician of a decline in elevated temperature and a timely manner and failed to an for parameters for oxygen of 3 residents (R6) reviewed hanges who experienced falls 	F 1	 F 157 Notify of Changes 1. DNS had conversation wiphysician on 5-5-14 re: res condition on 4-1-14. At this ti O2 stats are within normal limorder needed at this time how drop below 92% facility staff v physician for order. 2. All residents are being more changes in condition and physician for order. 3. Notification of Change in Status has been assigned to a status has been as a sta	ondition and in R6 s me resident hits, no O2 vever if stats vill contact onitored for sician is Resident	
	activities of daily liv R6's most recent pl 4/22/14, indicated a diabetes, hypertens			 review. Policy will also be review. education provided for clinical and follow up for changes in or Nurses meeting scheduled or 2014 4. Random medical record a completed by DNS or designed month X3 months for physicial 	viewed & I monitoring condition. n May 22, audits will be ee 2 X per	
	R6's nursing progre following informatio	ess notes revealed the n:		notification of resident change condition. Results of audits w reported to facility quality ass	e in /ill be	

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If continuation sheet Page 2 of 30

TATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	``'	IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	CON	IPLETED
		245600	B. WING _			01/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
SOOD S	AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE
F 157	-On 3/21/14, at 6:13 floor in another res hit her head during listed as within norr pressure of 179/76 R6's physician and Follow up neuro ch check flow sheet at following informatic - At 8:30 p.m. 3/21/ 192/89 - At 10:30 p.m. on 3/ was 259/84 - At 12:30 a.m. on 3/ was 239/93 - At 2:30 a.m. on 3/ was 239/93 - At 2:30 a.m. on 3/ was 190/80 - The final blood pr 3/22/14, at 7:00 p.m indicated R6 was a and upper body mo equal in size and re -On 3/23/14, at 12:: note revealed R6's normal limits after H of consciousness) a (within normal limits monitor. The medi that the significantly excess of 200 millin	5 p.m. R6 was found on the ident's room. R6 said she had the fall, neuro checks were mal limits and an initial blood, pulse 78. The note indicated family were notified of the fall. eck information, per the neuro iter the incident revealed the neuro iter th	F 15		e presented to tee, committee endations for education will be	

Facility ID: 00021

If continuation sheet Page 3 of 30

		& MEDICAID SERVICES				<u>). 0938-039</u>
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		245600	B. WING _		05	/01/2014
NAME OF	PROVIDER OR SUPPLIER	• •		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOOD S	AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 157	vital signs included 227/97, a temp of 1 saturations of 85-89 R6 had vomited the At 9:30 a.m. R6's b and was 202/60, te 67 with oxygen satu PRN (as needed) of per minute. R6's te and was 99.5 degre increased to 96% w note further indicate pain or discomfort a R6's family was not email. - The next recorded 4/1/14, was not unt a routine weekly ch recording of 176/58 (tympanic), pulse 5 16. R6's oxygen sa on room air. -R6's next recorded dated 4/15/14, and checked and cleand lacked documentat notified regarding F 4/1/14, and eviden assessment of R6 of monitor R6's condit -R6's nursing home indicated R6 was s nursing home round	an elevated blood pressure of 100.0, a pulse of 91 an oxygen 9%. The note also indicated arefore was kept in her room. 10od pressure was rechecked mp of 100.8 degrees, pulse of urations dipping to 78-85% and oxygen was applied at two liters emperature was rechecked ees, oxygen saturations with the oxygen at 2 liters. The ed R6 was not complaining of and had stopped vomiting. tified of this incident via an d vital sign information after il 4/5/14, four days later when teck revealed a blood pressure 8, temperature of 97.1 1 (regular) and respirations of aturation was recorded as 94% d nursing progress note was indicated R6 had her ears ed. R6's medical record ion that R6's physician was R6's change of condition on ce of any additional or vital signs being taken to tion.		57		

If continuation sheet Page 4 of 30

		AND HUMAN SERVICES			FORM	05/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245600	B. WING		05/	01/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157	Continued From pa	ige 4	F 15	7		
		04/30/14, at 12:34 p.m., NA)-A said R6 was in a had "Given up."				
	registered nurse (R nurse (LPN)-A state over 200 mm Hg we	5/1/14, at 10:03 a.m., both N) -A and licensed practical ed blood pressure readings ould be concerning and would of the blood pressure to see if it				
	259 after a fall with definitely concernin oxygen saturations	confirmed a blood pressure of a potential head injury was g. Both LPN-A and RN-A said in the 70's would also be a ed they would definitely call or something like that.				
	director of nursing (had been an intestin facility on 4/1/14, ar "personally called th blood pressures no from 3/22/14. She have been reviewed	5/1/14, at 10:20 a.m. the (DON) said she thought there nal flu going through the nd said she would have he doctor" with the elevated ted on R6's neuro checks thought R6's information may d with the attending physician				
	remembered receiv on the day of her fa was doing. The DC follow up oxygen sa taken once a shift if abnormal with symp identified she may r call a doctor unless	his effect. The DON ving a call from R6's daughter all wanting to know how she DN stated she would expect aturations and vitals to be f they were noted to be ptoms of an illness. The DON not necessarily expect staff to a temperatures were over 101 ident had been running a low				
		view on 5/1/14, at 10:50 a.m.				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DAT	0. 0938-039 TE SURVEY MPLETED
		245600	B. WING		05	/01/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 172 SUMMIT AVENUE WEST		
GOOD S	AMARITAN SOCIETY	- BLACKDUCK		BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 157	order for oxygen us incident and the fac staff to first apply the then were expected guidance. The DO have standing order against corporate p a previous order for been discontinued parameters for use During interview on physician (MD-C) s were very difficulty compromised renal she had been work cardiology regardin unstable blood press facility definitely sho R6's temperature a saturations on 4/1// "unfortunate" that the she reviewed R6's facility rounds as the report as well as per checking R6's blood during R6's clinic ap The facility policy, et in Resident Status, indicated the center all caps) inform the (except in a medica is incompetent), an physician and, if kn	did not have a physician's se at the time of the 4/1/14, cility medical director preferred ne oxygen when needed and d to call a doctor for further N stated the facility did not rs for oxygen as this was holicy and also stated R6 had r as needed oxygen that had due to lack of clear 5/1/14, at 12:48 p.m. R6's tated R6's blood pressures to control due to R6's I function. MD-C also stated ing in conjunction with g the treatment of R6's ssures. MD-C confirmed the build have called and reported nd decreased oxygen 14, and stated it was his did not happen. MD-C said vital signs information during the facility provided a printed ersonally monitoring and d pressure reading herself	F 1	57		

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II TI	PLE CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		IPLETED
		245600	B. WING _		05/	/01/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 157 F 167 SS=C	a potential for requi-2. Significant char mental or psychoso -3. Need to alter tri- -4. Decision to tran from the center. The policy further in ongoing documenta notification for a su flow chart indicated monitoring a reside policy/procedure, b frequency of the mo Additionally, the po revised 11/13, were entitled Temperature of Fahrenheit or a rep 99 degrees Fahren 483.10(g)(1) RIGH READILY ACCESS A resident has the n the most recent su Federal or State su correction in effect The facility must m examination and m accessible to resid their availability.	ent which results in injury with iring physician intervention. nge in the resident's physical, ocial status. eatment significantly. Insfer or discharge the resident included a flow chart including ation, monitoring and physician spected resident illness. The I staff should continue int according to center ut lacked guidelines for initoring or reassessment. licies for vital signs, last a reviewed and the policy re defined a fever as a single greater than 100 degrees leated oral temperature of over heit. T TO SURVEY RESULTS -	F 15			6/10/14

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						0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		245600	B. WING _		05/	01/2014
IAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 167	Continued From pa	age 7	F 16	7		
	Based on observative review, the facility for Federal survey restand accessible to be and public visitors of the facility of t	tion, interview and document failed ensure the most recent ults were prominently posted be read by all residents, family without having to ask staff to a potential to affect all 31		F167 Right to Survey Results Read Accessible 1. On 4/29/14 the survey results placed in a white binder and hur wheelchair accessible height in facility lobby. The white binder w labeled in large font Minnesota	s were ng at a the main	
	Findings include:			Department of Health Survey.		
	and again on 4/29/ sheath holding the was observed hang bulletin board across sign indicating wha directions as to who posted was observe On 4/29/14, at 9:15 (DON) verified the bulletin board was	 p.m. during the initial tour, 14, at 9:10 a.m. a clear plastic facility's 2013, survey results ging on a screw next to the ss from the main office. No t was in the sheath or ere the survey results were ed. a.m. the director of nursing survey results hanging on the not accessible to residents elchair, and confirmed the 		 Annually the Survey Results I be updated to include the most survey results and plan of corre All current residents will be in their right to review the Minnesc Department of Health Survey ar location of the survey information information will be shared during group activities in the main lobb the Activity Director will be able residents where the binder is low 	recent ctions. formed of ota nd the on. This g large y in which to show	
	contained the most addition, the DON s her what was in the	e a sign indicating the sheath t recent survey results. In stated she had a resident ask e plastic sheath in which the assisted the resident to he results.		 4. Quality Coordinator will composervation audits monthly to end the binder is located according of care. This will be completed in 3month with results to QA for fur recommendations 5. Corrective Action will be com 6-10-14. 	nsure that to this plan nonthly x rther	
F 279 SS=D	483.20(d), 483.20(l COMPREHENSIVE		F 27			6/10/14
		the results of the assessment and revise the resident's				

Facility ID: 00021

If continuation sheet Page 8 of 30

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245600	B. WING			05/0	01/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BLACKDUCK			72 SUMMIT AVENUE WEST LACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From pa comprehensive plan	•	F 2	279			
	plan for each reside objectives and time medical, nursing, and	evelop a comprehensive care ent that includes measurable tables to meet a resident's nd mental and psychosocial tified in the comprehensive					
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	t describe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided s exercise of rights under the right to refuse treatment).					
	by: Based on interview facility failed to ensu- included appropriat a resident receiving of fluid due to a fluid responsible for mor- where the resident them, location of the the frequency of mo- emergency interver of an emergency ar- held on the days the	NT is not met as evidenced y and document review, the ure the written care plan e interventions for the care of dialysis related to delineation d restriction, persons hitoring daily fluid intake, dialyzes and how to contact e residents fistula, directive on onitoring of the fistula, hitions, who to contact in case and which medications were e resident received dialysis for in the sample who received			 F279 Develop comprehensive care Care plan for R5 has been updareflect fluid restrictions, medication hinstructions, Dialysis information, typemergency care of vascular access monitoring of that device. No other residents currently recidialysis. Care plans for all new resider receiving Dialysis will reflect appropriate and interventions pertaining to individuals needs. Education and review of individualizing care plans will be proto all nurses on May 22, 2014. Random audits of care plans will completed by DNS or designee to endote the sector of the	ated to hold be and and eiving lents riate each vided	

Facility ID: 00021

ND PLAN OF NAME OF PR GOOD SAI (X4) ID PREFIX TAG F 279 (F r r s r c r t s	(EACH DEFICIENC' REGULATORY OR L Continued From pa R5's care plan date received hemodialy renal failure. The c staff to not draw blo readings in the left	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	A. BUILDING B. WING S 1	LE CONSTRUCTION	СОМІ 05/(ОN D BE	SURVEY PLETED 01/2014 01/2014 01/2014
GOOD SAI	MARITAN SOCIETY SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa R5's care plan date received hemodialy renal failure. The c staff to not draw blo readings in the left	- BLACKDUCK TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 9 ad 4/8/14, indicated R5 ysis three times a week due to	ID PREFIX TAG	TREET ADDRESS, CITY, STATE, ZIP CODE 72 SUMMIT AVENUE WEST BLACKDUCK, MN 56630 PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DN D BE	(X5) COMPLETIO
GOOD SAI	MARITAN SOCIETY SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa R5's care plan date received hemodialy renal failure. The c staff to not draw blo readings in the left	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 9 ed 4/8/14, indicated R5 ysis three times a week due to	ID PREFIX TAG	72 SUMMIT AVENUE WEST SLACKDUCK, MN 56630 PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETIO
(X4) ID PREFIX TAG F 279 (F r r s r c r t s	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa R5's care plan date received hemodialy renal failure. The c staff to not draw blo readings in the left	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 9 ed 4/8/14, indicated R5 ysis three times a week due to	ID PREFIX TAG	BLACKDUCK, MN 56630 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETIC
F 279 (F 279 (F 279 (F F F F F F F F F F F F F F F F F F F	(EACH DEFICIENC' REGULATORY OR L Continued From pa R5's care plan date received hemodialy renal failure. The c staff to not draw blo readings in the left	A MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 9 ed 4/8/14, indicated R5 /sis three times a week due to	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETIC
F r s r c r t s	R5's care plan date received hemodialy renal failure. The c staff to not draw blo readings in the left	ed 4/8/14, indicated R5 sis three times a week due to	F 279	all residents have care plans that		
r s r c r k s	received hemodialy renal failure. The c staff to not draw blo readings in the left	sis three times a week due to		all residents have care plans that		
t c t f f f f f t c f f t c t f f t c t f f t c t t t t	needed and to repo bleeding, hemorrha signs and symptom site such as redness drainage and to mo blood makes as it r care plan lacked id vascular access R HeRO graft), where blaced, how often t for a Bruit or feel for byer an artery and flow), the delineation fluid nursing and di who was responsibile daily fluid intake. The ndication of which on dialysis days an where R5 dialyzed, to do or who to com related emergency accessing R5's new On 4/30/14, at 11:3 (LPN)-C stated R5 medications held o succinate ER 50 m 60 mg). LPN-C cor	bod or take blood pressure grafted arm, to monitor and o R5's health care provider as ort signs and symptoms of age, bacteremia, septic shock, as of infection to the access as, swelling, warmth or onitor for a bruit (the sound noves through arteries). R5's entification of the type of 5 had (i.e. fistula, Dacron graft, e 5's vascular access was o check the vascular access or a thrill (a vibration that is felt caused by turbulent blood on of fluid related to how much etary was going to provide and le for monitoring R5's total ne care plan also lacked of R5's medication were held d also lacked indication of how to contact them and what tact in case of a dialysis (i.e. excess bleeding from		 each residents individual needs. A will be completed 2 x monthly x3 in Quality assurance committee will further recommendations for ongo audits. Ongoing education will be to nursing staff. 5. Corrective action will be comp 6-10-2014 	Audits months. make bing provided	

Facility ID: 00021

If continuation sheet Page 10 of 30

ΔΤΕΜΕΝΤ	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIP		NO. 0938-039
	F CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		245600	B. WING		05/01/2014
IAME OF F	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE	
SOOD S	AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETIC DATE
F 279	Continued From pa	ge 10	F 279		
		ten care plan lacked the			
F 309	identified compone	nts as listed above. CARE/SERVICES FOR	F 309		6/10/14
SS=D	HIGHEST WELL B		1 308		0,10,14
	provide the necess or maintain the high mental, and psycho	receive and the facility must ary care and services to attain nest practicable physical, psocial well-being, in e comprehensive assessment			
	This REQUIREME	NT is not met as evidenced			
	Based on observat review, the facility f	tion, interview and document ailed to monitor and notify the ne in oxygen saturations,		F309 Provide Care/Services for highe well being	st
	elevated temperatu timely manner and for parameters for 3 residents (R6) rev	re and blood pressures in a failed to consult the physician oxygen administration for 1 of viewed for notification of		1. DNS had conversation with Physic on 5-5-14 re: res condition and failure to notify her of change in R6 condition on -14. At this time resident O2 stats are	to 4-1
	illness. Additionally	enced falls and an acute , the facility failed to monitor 1 resident (R5) who received a fluid restriction.		within normal limits, no O2 order needed at this time however if stats drop below 92% facility staff will contact physician order. Fluid intake is being monitored recorded for R5 during meal times and med pass times. Total daily fluid intake	/ for and
	Findings include:			being documented at the end of each of 2. All residents are being monitored f	day.
	indicated R6 had m	num Data Set dated 1/23/14, oderate cognitive impairment sive staff assistance for all ing.		changes in condition and physician is notified when changes occur. All residents requiring fluid restrictions are monitored and amount of fluid intake is being recorded with a documented tota	5
	R6's most recent pl	hysician's progress note, dated		daily fluid intake at the end of the day.	

Facility ID: 00021

If continuation sheet Page 11 of 30

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI			SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COM	PLETED
		245600	B. WING			05/0	01/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BLACKDUCK			72 SUMMIT AVENUE WEST LACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 309	disease. R6's nursing progre following informatio -On 3/21/14, at 6:15 floor in another resi hit her head during listed as within norr pressure of 179/76, R6's physician and Follow up neuro che check flow sheet af following informatio - At 8:30 p.m. 3/21/ 192/89 - At 10:30 p.m. on 3 was 259/84 - At 12:30 a.m. on 3/ was 239/93 - At 2:30 a.m. on 3/ was 190/80 - The final blood pre 3/22/14, at 7:00 p.m indicated R6 was al	 bion, chronic pain, bion, and chronic kidney bess notes revealed the n: b p.m. R6 was found on the dent's room. R6 said she had the fall, neuro checks were nal limits and an initial blood pulse 78. The note indicated family were notified of the fall. eck information, per the neuro ter the incident revealed the 	F 3	09	 the amount of fluid each departmengive. 3. Notification of Change in Reside Status has been assigned to all nurreview. Policy will also be reviewed education provided for clinical moniand follow up for changes in conditi. Nurses will also be educated on the appropriate documentation of fluid restrictions, monitoring and recording fluid intake on May 22, 3014. DNS weducate dietary staff on documentation Fluid intake during med pass will be reviewed with nurses. 4. Random medical record audits completed by DNS or designee 2 X month X3 months for physician notification of resident change in co and fluid intake documentation to engestion with restrictions are receiving fluids as ordered. Results of audits reported to facility quality assurance committee. Quality assurance committee. Quality assurance committee. Completed to nursing staff. 5. Corrective action will be completed to facility action will be completed to mursing staff. 	ent ses to l & toring on. on g of will tion of on of will be per andition nsure ving will be e mittee for will be	
	note revealed R6's normal limits after h of consciousness) a (within normal limits monitor. The media that the significantly	37 a.m. the nursing progress neuro checks were within her fall on 3/21/14. LOC (level and orientation were WNL s) as well. Continue to cal record lacked evidence v elevated blood pressures in neters of mercury (mm Hg) on					

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		AND HUMAN SERVICES				FORM	05/20/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245600	B. WING	i		05/	01/2014
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- BLACKDUCK			72 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	the overnight shift v -On 4/1/14, at 11:25 vital signs included 227/97, a temp of 1 saturations of 85-85 R6 had vomited and 9:30 a.m. R6's bloo and was 202/60, ter 67 with oxygen satu PRN (as needed) o per minute. R6's ter and was 99.5 degree increased to 96% w note further indicate pain or discomfort a R6's family was not email. - The next recorded 4/1/14, was not unti- routine weekly cheor recording of 176/58 (tympanic), pulse 5 16. R6's oxygen sato on room air. -R6's next recorded lacked documentati- notified regarding R 4/1/14, and eviden assessment of R6 of monitor R6's condit -R6 was seen on m doctor per a physici	were reported to a physician. 5 a.m. the note indicated R6's an elevated blood pressure of 100.0, a pulse of 91 an oxygen 9%. The note also indicated d was kept in her room. At od pressure was rechecked mp of 100.8 degrees, pulse of urations dipping to 78-85% and oxygen was applied at two liters emperature was rechecked ees, oxygen saturations with the oxygen at 2 liters. The ed R6 was not complaining of and had stopped vomiting. tified of this incident via an d vital sign information after il 4/5/14, four days later at a ck revealed a blood pressure 8, temperature of 97.1 1 (regular) and respirations of aturation was recorded as 94% d nursing progress note was indicated R6 had her ears ed. R6's medical record ion that R6's physician was R6's change of condition on uce of any additional or vital signs being taken to	F	309			

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CENTER STATEMENT AND PLAN C	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245600 - BLACKDUCK	. ,	S S		FORM MB NO. (X3) DATE COM 05/0	05/20/2014 APPROVED 0938-0391 E SURVEY PLETED 01/2014
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 309	recorded at 93% or R6's blood pressure During interview on nursing assistant (N downhill spiral and During interview on registered nurse (R nurse (LPN)-A said 200 mm Hg would B require a recheck o came down. Both c 259 after a fall with definitely concernin oxygen saturations concern, both verifie fax the doctor with s During interview on director of nursing (had been an intestin facility on 4/1/14, ar "personally called th blood pressures no from 3/22/14. She have been reviewed on rounds but was documentation to th remembered receiv on the day of her fa was doing. The DC follow up oxygen sa taken once a shift if abnormal with symp identified she may r call a doctor unless	a room air, pulse was 66 and e recording was 199/74. 04/30/14, at 12:34 p.m., NA)-A said R6 was in a had "Given up." 5/1/14, at 10:03 a.m., N)-A and licensed practical blood pressure readings over be concerning and would of the blood pressure to see if it confirmed a blood pressure of a potential head injury was g. Both LPN-A and RN-A said in the 70's would also be a ed they would definitely call or something like that. 5/1/14, at 10:20 a.m. the (DON) said she thought there nal flu going through the hd said she would have he doctor" with the elevated ted on R6's neuro checks thought R6's information may d with the attending physician unable to provide his effect. The DON ving a call from R6's daughter II wanting to know how she DN stated she would expect aturations and vitals to be f they were noted to be ptoms of an illness. The DON not necessarily expect staff to a temperatures were over 101 ident had been running a low	F	309			

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		AND HUMAN SERVICES				FORM	05/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245600	B. WING	i		05/	01/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BLACKDUCK			72 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Continued From pa	ige 14	F:	309			
	observed resting in pale in color and ur	oximately 10:30 a.m. R6 was her room in a chair. R6 was hable to answer basic w she felt or how long she had ty.					
	DON stated R6 did for oxygen use at th and the facility med first apply the oxyge call a doctor for furt stated the facility di oxygen as this was also stated R6 had	5/1/14, at 10:50 a.m. the not have a physician's order he time of the 4/1/14, incident lical director preferred staff to en and then were expected to ther guidance. The DON d not have standing orders for against corporate policy and d a previous order for as t was discontinued due to lack s for use.					
	physician (MD-C) s were very difficult to compromised renal she had been work cardiology regardin unstable blood press facility definitely sho R6's temperature a saturations on 4/1/1 "unfortunate" that th she reviewed reside during facility round printed report as we blood pressure read appointments.	5/1/14, at 12:48 p.m. R6's tated R6's blood pressures o control due to R6's I function. MD-C also stated ing in conjunction with g the treatment of R6's ssures. MD-C confirmed the build have called and reported ind decreased oxygen 14, and stated it was his did not happen. MD-C said ent vital signs information ds as the facility provided a ell as personally checking R6's ding herself during R6's clinic					
	in Resident Status,	r will IMMEDIATELY (written in					

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TATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /	IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	CO	MPLETED
		245600	B. WING _		05	/01/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 309	(except in a medica is incompetent), an physician and, if kn family or legal repre- cases: -1. Resident accide a potential for requi- -2. Significant char mental or psychoso -3. Need to alter tre- -4. Decision to tran- from the center. The policy further in ongoing documenta notification for a su flow chart indicated monitoring a reside policy/procedure, b frequency of the me Additionally, the po revised 11/13 were entitled Temperature of Fahrenheit or a rep 99 degrees Fahren R5 was on a 1200 or restriction and the or monitored, R5's quarterly MDS had intact cognition eating.	e resident, if appropriate al emergency or when resident d consult with the resident's own, notify the resident's esentative in the following ent which results in injury with iring physician intervention. nge in the resident's physical, ocial status. eatment significantly. nsfer or discharge the resident hcluded a flow chart including ation, monitoring and physician spected resident illness. The d staff should continue ent according to center ut lacked guidelines for onitoring or reassessment. licies for vital signs, last reviewed and the policy re defined a fever as a single greater than 100 degrees beated oral temperature of over	F 30			

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OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(AZ) IVIULI		(X3) DA	IE SUKVET	
		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245600		B. WING _		05	05/01/2014	
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	((EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETIO DATE	
	-	F 30	09			
was on a 1200cc da	aily fluid restriction which					
on a daily fluid restri and directed staff to giving R5 any fluids document all fluids lacked identification fluid restriction and much fluid between	riction due to renal disease o see the charge nurse before between meals and to provided. The care plan of the amount of the daily ount and did not delineate how meals and medication					
responsible for the know how much flu during the medicati would give R5 no m med pass during th directions or care p identified how much the med pass. LPN no more than 400 c passes in 24 hours was responsible for fluid intake to ensure	care of R5, stated she did not id she was allotted to give R5 on pass. LPN-C stated she nore than 100 cc of fluid for the e day shift but there were no lan interventions which n fluid LPN-C was allotted for -C stated R5 would be given cc of fluid for all of the med and she did not know who r monitoring R5's total daily re that R5 was staying within					
	(EACH DEFICIENCY REGULATORY OR L Continued From pa which required herr mellitus. On 4/30/14, at 11:2 was on a 1200cc da started day R5 had 9/4/14. R5's physician order include an order for R5's care plan date on a daily fluid restri- and directed staff to giving R5 any fluids lacked identification fluid restriction amore much fluid between passes R5 was allo On 4/30/14, at 11:2 responsible for the know how much fluid during the medicati would give R5 no m med pass during th directions or care p identified how much the med pass. LPN no more than 400 of passes in 24 hours was responsible for fluid intake to ensur the 1200 cc fluid re On 4/30/14, at 12:0	On 4/30/14, at 11:24 a.m. RN-B confirmed R5 was on a 1200cc daily fluid restriction which started day R5 had her first dialysis treatment on	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFU TAGContinued From page 16 which required hemodialysis and type II diabetes mellitus.F 3On 4/30/14, at 11:24 a.m. RN-B confirmed R5 was on a 1200cc daily fluid restriction which started day R5 had her first dialysis treatment on 9/4/14.F 3R5's physician orders dated 3/19/14, did not include an order for a restricted fluid intake.FR5's care plan dated 4/23/14, indicated R5 was on a daily fluid restriction due to renal disease and directed staff to see the charge nurse before giving R5 any fluids between meals and to document all fluids provided. The care plan lacked identification of the amount of the daily fluid restriction amount and did not delineate how much fluid between meals and medication passes R5 was allowed.On 4/30/14, at 11:20 a.m. LPN-C, who was responsible for the care of R5, stated she did not know how much fluid she was allotted to give R5 during the medication pass. LPN-C stated she would give R5 no more than 100 cc of fluid for the med pass during the day shift but there were no directions or care plan interventions which identified how much fluid LPN-C was allotted for the med pass. LPN-C stated R5 would be given no more than 400 cc of fluid for all of the med passes in 24 hours and she did not know who was responsible for monitoring R5's total daily fluid intake to ensure that R5 was staying within the 1200 cc fluid restriction amount.On 4/30/14, at 12:05 p.m. the dietary manager	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORREC (EACH CORRECTVE ACTION SHI CROSS-REFERENCE D' TO THE APP DEFICIENCY) Continued From page 16 which required hemodialysis and type II diabetes mellitus. F 309 On 4/30/14, at 11:24 a.m. RN-B confirmed R5 was on a 1200cc daily fluid restriction which started day R5 had her first dialysis treatment on 9/4/14. F 309 R5's care plan dated 4/23/14, indicated R5 was on a daily fluid restriction due to renal disease and directed staff to see the charge nurse before giving R5 any fluids between meals and to document all fluids provided. The care plan lacked identification of the amount of the daily fluid restriction amount and did not delineate how much fluid between meals and medication passes R5 was allowed. On 4/30/14, at 11:20 a.m. LPN-C, who was responsible for the care of R5, stated she did not know how much fluid she was allotted to give R5 during the medication pass. LPN-C stated she would give R5 no more than 100 cc of fluid for the med pass. LPN-C stated R5 would be given no more than 400 cc of fluid for the med pass. LPN-C stated R5 would be given no more than 400 cc of fluid for the med pass. LPN-C stated R5 would be given no more than 400 cc of fluid for all of the med passes in 24 hours and she did not know who was responsible for monitoring R5's total daily fluid intakte to ensure that R5 was staying within the 1200 cc fluid restriction amount.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) ID PREFX TAG PROVIDER'S PLANO CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OF THE APPROPRIATE DEFICIENCY) Continued From page 16 which required hemodialysis and type II diabetes mellitus. F 309 On 4/30/14, at 11:24 a.m. RN-B confirmed R5 was on a 1200cc daily fluid restriction which started day R5 had her first dialysis treatment on 9/4/14. F 309 R5's physician orders dated 3/19/14, did not include an order for a restricted fluid intake. F 309 R5's care plan dated 4/23/14, indicated R5 was on a daily fluid restriction due to renal disease and directed staff to see the charge nurse before giving R5 any fluids between meals and to document all fluids provided. The care plan lacked identification of the amount of the daily fluid restriction amount and did not delineate how much fluid between meals and medication passes R5 was allowed. On 4/30/14, at 11:20 a.m. LPN-C, who was responsible for the care of R5, stated she did not know how much fluid between all and to cycle to give R5 during the medication pass. LPN-C stated she would give R5 no more than 100 cc of fluid for the med pass during the day shift but there were no directions or care plan interventions which identified how much fluid bet PN-C was allotted for the med pass. LPN-C stated Ste sould be diven the R5 was situal daily fluid intake to ensure that R5 was situal within the 1200 cc fluid restriction amount.	

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		(X1) PROVIDER/SUPPLIER/CLIA				E SURVEY
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 245600		(X2) MULTIPLE CONSTRUCTION A. BUILDING			PLETED	
		B. WING	05/01/2014			
NAME OF F	PROVIDER OR SUPPLIER		ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 309	daily. The dietary n plan did not delinea allotted with meals allotted during med responsible to mor intake. The dietary way to tell how mu daily because the f not account for the with each med pass the residents total Review of the facili sheets from the Dir intake was not con residents. Many of "Not Available" and recorded between Review of R5's Me indicated fluid intal passes had not be through 4/24/14. O staff had begun to each med pass an	age 17 vas a total of 1080 cc of fluid nanager confirmed R5's care ate how much fluid R5 was and how much fluid R5 was d pass, and who was hitor R5's total daily fluid manager verified there was no ch total fluid intake R5 received acility's computer system did amount of fluid R5 was given is, and nobody was monitoring fluid intake each day. ity's fluid intake monitoring nning Report revealed fluid sistently recorded for all the entries were identified as d R5's dietary fluid intake was 240 cc to 1080 cc daily. dication Administration sheets ke provided during the med en recorded from 9/4/13, on 4/25/14, the MAR identified record R5's fluid intake with d indicated R5 was provided ad 240 cc fluid daily.	F 309			
F 329 SS=D	was no planned de or dietary to provid daily fluid intake wa	3 p.m. RN-C confirmed there elineation for fluids for nursing e R5. RN-C verified R5's total as not being monitored. EGIMEN IS FREE FROM DRUGS	F 329			6/10/14

Facility ID: 00021

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	OF DEFICIENCIES	& MEDICAID SERVICES		PLE CONSTRUCTION		938-039
IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	(X3) DATE SURVEY COMPLETED			
		B. WING _		05/01/2014		
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
good s	AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	JLD BE COMPLETIC	
F 329	Continued From page 18 without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.		F 32	9		
	by: Based on observative review the facility fative were reviewed with address potential c adverse reactions a elevated blood press to evaluate the effet antihypertensive m beta-blocker (a class hypertension that re heart muscle contra (R6) reviewed for the Findings include:	NT is not met as evidenced tion, interview and document ailed to ensure low pulse rates the physician in order to oncerns with medication and failed to demonstrate ssures were reviewed in order activeness of multiple edications including a ss of medications used to treat educes the rate and force of action) for 1 of 5 residents unnecessary drugs.		 F329 Drug regimen is free from unnecessary drugs 1. R6 s Physician is aware of R6 pressures and pulses. DNS discus current medications, pulses and blc pressures with primary physician. N staff are taking R6 s pulse prior to metoprolol administration. Orders obtained to hold metoprolol for puls than 50. R6 s physician has review medications, will have pharmacy consultant review and all recommendations will be acted upo 2. All current and future residents 	sed ood Nursing all e less ved all	

Facility ID: 00021

		& MEDICAID SERVICES					0938-039	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 245600		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/01/2014			
							NAME OF PROVIDER OR SUPPLIER	
GOOD SAMARITAN SOCIETY - BLACKDUCK			172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630					
(X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 329	Continued From pa	age 19	F 3	29				
	Continued From page 19 indicated R6 had moderate cognitive impairment and required extensive staff assistance for all activities of daily living. R6's most recent physician's progress notes, dated 4/22/14 identified active diagnoses of diabetes, hypertension, chronic pain, hypothyroidism, anemia and chronic kidney disease. R6's most recent physician's order sheets, dated 4/21/14, identified orders for metoprolol succinate (extended release) ER tablet (a beta-blocker) 24 hour give 100 milligrams (mg) by mouth daily for essential hypertension, Cozaar (an antihypertensive medication) give 50 mg orally twice a day for essential hypertension and Cardura (doxazosin mesylate) give two mg orally daily for hypertension. R6's vital sign recordings for the months of March and April 2014 revealed R6's pulse was taken ten times, of those recordings eight of ten were below 60, with a warning notation generated by the electronic medical record "Low of 60.0 exceeded." Review of R6's blood pressure readings for the same time period revealed systolic blood pressures in excess of 180 millimeters of mercury (mm Hg) five out of 11 recordings. Additional blood pressure and pulse information was reviewed for the previous six months and revealed a consistent pattern of documented pulses in the 50's and blood pressures running over 180 mm Hg systolic.				medications will be reviewed for er that appropriate parameters are se administration. DNS will work with pharmacy consultant to developed guidelines for expected normal parameters for pulse and blood pre Facility medical director will review guidelines. 3. Nursing staff will be educated of developed guidelines for expected parameters for pulse and blood pre and following medication parameter May 22, 2014. 4. Random audits will be complet DNS or designee 2 x per month x 3 months to ensure that developed guidelines for expected normal parameters for pulse and blood pre are being followed. Findings will be presented to Quality assurance committee, committee will make fur recommendations for ongoing aud 5. Corrective action will be complet 6-10-2014	et for facility facility essure. on the normal essure ers on red by a essure ers on red by a		
	R6's most recent p 4/22/14, revealed a The progress notes	hysician progress notes, dated blood pressure of 199/74. s revealed that her primary nade a comment that R6's						

If continuation sheet Page 20 of 30

STATEMEN	F OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	<u>). 0938-039</u> TE SURVEY MPLETED	
		245600			05	104/2044	
NAME OF	PROVIDER OR SUPPLIER	240000		STREET ADDRESS, CITY, STATE, ZIP CODI		6/01/2014	
	AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630	_		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 329	vitals were reviewe hypertension. No of R6's chart which in blood pressures or evaluated to detern regimen was effect administration of th defined. During interview or practical nurse (LP the metoprolol for a confirmed staff was pulse prior to the a as this directive wa electronic medicati During interview or consultant pharmat hold metoprolol for was concerned abo and high blood pre- when R6's blood pi and April were revie On 5/1/14, at appro observed resting in pale in color and w questions about ho resided at the facili During interview or stated R6's blood pi control due to R6's MD-C also stated s conjunction with ca treatment of R6's u	and listed a diagnosis of other evidence was noted on dicated the pattern of elevated decreased pulses was nine if the current drug tive, or if parameters for ne metoprolol should be a 5/01/14, at 9:15 a.m. licensed N)-A said she would not give a pulse below 60 and s not routinely checking R6's dministration R6's metoprolol as not indicated on R6's on administration record. a 5/1/14, at 9:30 a.m. the cist (CP) said he would usually a pulse less than 60. The CP but the consistently low pulses ssures and stated "holy cow" ressure readings for March ewed at this time via phone. by imately 10:30 a.m. R6 was a ner room in a chair. R6 was as unable to answer basic ow she felt or how long she had	F 3	329			

If continuation sheet Page 21 of 30

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
		245600			05/	01/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 72 SUMMIT AVENUE WEST		
GOOD S	AMARITAN SOCIETY	- BLACKDUCK		BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 329		-	F 329			
	irregular pulse. M resident vital signs rounds as the facili well as personally of	not concerned with R6's D-C said she reviewed information during facility ty provided a printed report as checking R6's blood pressure ing R6's clinic appointments.				
	succinate ER from Services Business 2/2011, revealed by common side effect	s package insert for metoprolol McKesson Packaging Unit of McKesson, revised radycardia (slow pulse) was a t of metoprolol and that e contraindicated in a patient ardia.				
F 428 SS=D	11/13, lacked guide parameters for puls 483.60(c) DRUG R	for vital signs, revised on lines for expected normal se or blood pressures. EGIMEN REVIEW, REPORT ON	F 428			6/10/14
		of each resident must be nce a month by a licensed				
	the attending physi	ust report any irregularities to cian, and the director of reports must be acted upon.				
	by:	NT is not met as evidenced				
	consultant pharma	v and document review, the cist failed to review blood e ranges to evaluate		F428 Drug Regimen Review, Re Irregular, Act On 1. R6 s Physician is aware of R		

Facility ID: 00021

If continuation sheet Page 22 of 30

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II TIC	PLE CONSTRUCTION	<u>OMB NO. 09</u> (X3) DATE SU		
	OF CORRECTION	IDENTIFICATION NUMBER:		B	COMPLET		
		245600	B. WING		05/01/2	2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE CO	(X5) MPLETIC DATE	
F 428	therapeutic effectiv concerns with low p (R6) reviewed for u received multiple a Findings include: R6's most recent p 4/22/14, indicated F diabetes, hypertens hypothyroidism, and disease. R6's most recent p 4/21/14, identified o (extended release) anti-hypertensive m pulse rate and redu contractions) 24 ho mouth daily for ess (an anti-hypertensiv orally twice a day fo Cardura (doxazosir daily for hypertensis R6's vital sign reco and April 2014, revi ten times, of these below 60, with a wa the electronic medi exceeded." Review readings for the sat systolic blood press millimeters of merco	eness and identify potential pulse rates for 1 of 5 residents innecessary drugs who nti-hypertensive medications. hysician's progress note, dated R6's diagnoses included sion, chronic pain, emia and chronic kidney hysician's order sheets, dated orders for metoprolol succinate ER tablet (an nedication that lowers the ices the force of heart our give 100 milligrams (mg) by ential hypertension, Cozaar ve medication) give 50 mg or essential hypertension and n mesylate) give two mg orally	F 428	 pressures and pulses. DNS discucurrent medications, pulses and by pressures with primary physician. staff are taking R6 s pulse prior metoprolol administration. Order, obtained to hold metoprolol for puthan 50. R6 s physician has revimedications, will have pharmacy consultant review and all recommendations will be acted up 2. All current and future residen signs will be provided to consultar pharmacist upon every facility vis will work with facility pharmacy control developed guidelines for expect normal parameters for pulse and pressure. Facility medical director review guidelines. Nursing staff will be educated necessity of providing proper mediations to resident physicians consultant pharmacist on an ongoing basis. Training will take place on 2014. Resident vital signs and consist pharmacist is addressing abnorm signs that may be related to media adverse effects. Findings will be presented to Quality assurance committee, committee will make frecommendations for ongoing au 4. Corrective action will be completed to adverse and the complete action will be completed to adverse action will be completed to action for a complete action for a complete action for a completed to action will be completed to adverse action will be completed to action will be completed to action will be completed to action for a complete action for a complete action for a complete action will be completed to action wil	blood Nursing to all s ilse less ewed all pon. t vital nt it. DNS onsultant tted blood r will I on the dical s and bing May 22, ultant ms will x sultant al vital cation		

Facility ID: 00021

If continuation sheet Page 23 of 30

	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	· · /	TE SURVEY MPLETED
	ST CORRECTION	IDENTIFICATION NOMBER.	A. BUILDII	NG		
		245600	B. WING			/01/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 428		age 23 nning over 180 mm Hg	F 4:	28		
	4/22/14, revealed a The progress notes physician (MD)-C n vitals were reviewe hypertension. No c R6's chart that the pressures or decre determine if the cur effective, or if paran metoprolol should b consultant docume	hysician progress notes, dated blood pressure of 199/74. s revealed R6's primary nade a comment that R6's d and listed a diagnosis of other evidence was noted on pattern of elevated blood ased pulses were evaluated to rrent drug regimen was meters for administration of the be defined. R6's pharmacy ntation was reviewed. No een identified for the previous				
	practical nurse (LF the metoprolol for a confirmed staff wer pulse prior to the a and confirmed this	5/01/14, at 9:15 a.m. licensed PN) -A said she would not give a pulse below 60 and re not routinely checking R6's dministration of the metoprolol was not indicated on R6's on administration record.				
	consultant pharmac hold metoprolol for voiced concern abo pulses and high bl cow" when R6's blo March and April we phone. The CP sta elevated blood pres review and stated in problems with resid typically have to as	a 5/1/14, at 9:30 a.m. the cist (CP) said he would usually a pulse less than 60. The CP but R6's consistently low ood pressures and stated "holy bod pressure readings for are reviewed at this time via ated staff needed to flag ssure readings for him to f staff did not tell him of dent vital signs, he would k in order to know if there were said every once in a while				

Facility ID: 00021

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	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CO	MPLETED
		245600	B. WING		05	/01/2014
NAME OF I	PROVIDER OR SUPPLIER		S			
GOOD S	AMARITAN SOCIETY	- BLACKDUCK		72 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 428	Continued From pa	age 24	F 428			
	but up until now ha computer and had information he nee confirmed he had r pressure readings. received access to resident electronic able to review this During interview or physician (MD-C) s were very difficult t compromised rena she had been work cardiology regardir unstable blood pre pulses would be m ambulatory and sh low pulses were a reviewed vital signs facility printed out a took them herself a stated she reviewe information during a printed report as	a 5/1/14, at 12:48 p.m. R6's stated R6's blood pressures o control due to R6's I function. MD-C also stated sing in conjunction with ag the treatment of R6's ssures. MD-C stated low ore of a concern if R6 was e is not so she did not feel the concern. MD-C said she s information at rounds as the a report for her and personally at clinic appointments. MD-C d resident vital signs rounds as the facility provided well as personally checking e reading herself during R6's				
F 441 SS=F	11/13, lacked guide parameters for pul	o for vital signs, last revised on elines for expected normal se or blood pressures. N CONTROL, PREVENT	F 441			6/10/14
	The facility must es Infection Control P	stablish and maintain an rogram designed to provide a comfortable environment and				

Facility ID: 00021

If continuation sheet Page 25 of 30

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
				NG	2.51	
		245600	B. WING _		05/	01/2014
	PROVIDER OR SUPPLIER	- BLACKDUCK		STREET ADDRESS, CITY, STATE, ZIP CODE 172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 441	 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. 		F 4	41		
	direct contact will tr (3) The facility mus hands after each d hand washing is ind professional practio	ransmit the disease. It require staff to wash their irect resident contact for which dicated by accepted				
		ndle, store, process and as to prevent the spread of				
	by: Based on interviev facility failed to ana	NT is not met as evidenced v and document review, the lyze patterns and trends of staff and residents. This had		F 441 Infection Control, prevent linens	spread ,	

If continuation sheet Page 26 of 30

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE	0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:		IG		PLETED
		245600	B. WING _		05/0	1/2014
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SOOD S	AMARITAN SOCIETY	- BLACKDUCK				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 441	Continued From pa	ige 26	F 44	11		
	the potential to affe in the facility.	ct all 32 residents who resided		1. Aprils Staff absences related to have been recorded on monthly inf	fection	
	Findings include:			surveillance reports. Resident mon infection surveillance reports were	-	
	Review of the facilit	ty's infection control program		reviewed and compared to employ monthly infection surveillance repo		
		which lacked a surveillance		Written report has been completed		
		ng analysis and interpretation		tabulating and assessing data colle		
		fection risks. The Monthly Infections in Center for 01/14,		Rates were calculated and trends established, results will be reported		
		04/14, revealed only infections		committee.		
t		ibiotics were tracked. The		2. Reports found in infection cont		
		stem lacked trending of		manual, monthly Report of Resider		
		ntibiotics. In addition, a employee infections and		Infections in Center, Monthly Repo Staff Infections in Center, Infection		
		lance between resident and		Surveilance Report, Montly Infection		
		had not been established.		Control Report are all being utilized		
	On $5/1/14$ at 11.42	a.m. the facility infection		infection control policy/procedure.3. DNS to provide education at new	urcoc	
		is reviewed with the director of		meeting on 5-22-14 on providing in		
		ON indicated all residents who		surveillance reports on all resident		
		antibiotic were entered onto a		illnesses with and without need for		
		by the floor nurse. Upon veillance reports were sent to		antibiotics. All facility supervisors h been educated on the proper proce		
		I the information onto the		for report their employee illnesses,		
	Monthly Report of F	Resident Infections in Center.		education conducted on 5-21-14.		
		d on the Monthly Report of		4. Infection control reports to be a		
		in Center included: resident ed, site of infection, culture		by Quality Coordinator or designee per month for 3 months Findings		
		jent, antibiotic treatment,		presented to Quality assurance		
	cautionary measure	es, isolation and if center		committee, committee will make fu		
		o stated she was notified by		recommendations for ongoing aud		
		dent infections not requiring she reviewed monthly but did		5. Corrective action will be compl 6-10-2014	elea by	
		monthly report. DON indicated				
	she reported direct	ly from the monthly reports at				
		nce and Assessment (QAA) net quarterly. In addition, DON				
		viously created similar monthly				

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· /	E SURVEY
	JF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3		<i>I</i> PLETED
		245600			05	/01/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 441	••••••••••••••••••••••••••••••••••••••	age 27 e infections but no longer did	F 44′	1		
	this. The DON ind employee call in sh stated the last com	icated she retained each leet and reviewed them. DON pleted monthly report of /infections available was dated				
	analysis of residen	5 p.m. DON confirmed no t infection trends with ployee infections/illnesses was				
	2003, directs the in investigate and ass	rol Nurse Procedure dated July fection control nurse to sist with employee health recording employee infection ation.				
	2003, identified the surveillance to include	eillance procedure dated July procedure for disease ude: "4. Tabulate and assess alculate rates, b. establish results"				
F 466 SS=C	contained the follow forms, as reference dated July 2003: "N Infections in Cente Infections in Cente Report, Monthly Inf 483.70(h)(1) PROC	rol Policies/Procedures manual wing disease surveillance ed in the Table of Contents Aonthly Report of Resident r, Monthly Report of Staff r, Infection Surveillance fection Control Report." CEDURES TO ENSURE LITY	F 466	6		6/10/14
	that water is availa	stablish procedures to ensure ble to essential areas when ormal water supply.				

Facility ID: 00021

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	05/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245600	B. WING _		05/0	01/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 466	Continued From pa	ge 28	F 46	6		
	by: Based on interview emergency water pe estimated water new was established and for storage and dist had been identified affect all 32 residen Findings include: The facility's EMER AND PROCEDURE store bottled water would be provided f lacked indication of was allocated to the 2 gallons of water w shift employees. The of the average amo each day to determ of water covered th amount of staff per be allocated for the for meals or a meth of the water to mee hygiene. The policy sanitary services we Drilling company in supplier) on a daily supply was reestab identified the method	NT is not met as evidenced and record review the facility olicy failed to ensure the eds for dietary and staff use d failed to ensure the method ribution of non-potable water This had the potential to its residing in the facility. GENCY WATER POLICY reviewed 2/4/10, indicated in the amount of 2 gallons for the facility staff. The policy how the 2 gallons of water employees per shift or if the vas for a 24 hour period for all is policy also lacked indication ount of employee's that worked ine if the amount of 2 gallons e needs for the average day, how much water would dietary department to provide od for storage and distribution t the needs for employee hand indicated water for essential puld be obtained from a Well Blackduck (bulk water basis until the facility's normal lished. The policy had not of for storage or distribution of stimated calculated water for		 F 466 Procedures to Ensure Wate Availability 1. Facility procedure for Emergen Water has been revised to state the gallons of water will be allocated to employee per 8 hour shift (2 quarts drinking and food preparation, 2 qu and 1 gallon for employee sanitation hand hygiene). Procedure also rea- jugs of water will be transported to the Dietary & Nursing departments Maintenance Director or designee gallon jug of water with a hand pun be placed in each utility room and f kitchen for employee hand hygiene hand hygiene jugs will be replaced necessary. All employees have reviewed the revised procedure This procedure will be reviewee updated as determined necessary annual basis. Corrective action will be compl 6-10-2014 	cy at 2 each for larts in and ads that both by the to be e. A 3 np will acility c. The as he d and on an	

Facility ID: 00021

If continuation sheet Page 29 of 30

		AND HUMAN SERVICES				FORM	05/20/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245600	B. WING			05/	01/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- BLACKDUCK			72 SUMMIT AVENUE WEST LACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 466	Continued From pa	ige 29	F4	66			
	The director of envi interviewed on 5/1/ confirmed there we	ironmental services was 14, at 11:15 p.m. and are area's of the facility olicy that needed clarification.					

Facility ID: 00021

	MENT OF HEALTH			FS	600073	Printed: 05/05/201 FORM APPROVEI OMB NO, 0938-039	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIF	PLE CONSTRUCTION 3 01 - MAIN BUILDING 01	(X3) DATE SI COMPLE	
		245600		B. WING		04/2	9/2014
	ROVIDER OR SUPPLIER				STATE, ZIP CODE NUE WEST		
00000		T - DEACKDOOK		DUCK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000		·	
	FIRE SAFETY						
	01 Main Building						
	Minnesota Departm Marshal Division. Ai Samaritan Society E was found in substa requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 10 Chapter 19 Existing Good Samaritan So building built at three major portion of the 1-story with a basen	at 42 CFR, Subpart ty from Fire, and the fire Protection Assoc 01, Life Safety Code Health Care. ciety Blackduck is a e different times. The building was built in nent and was detern	State fire yey, Good Building h the 2000 diation (LSC), 1-story e first and 1970, is hined to				
	be Type I(332) cons room/ PT addition w the original building. a basement and wa (111) construction. In	truction. In 1996 a c vas constructed to th . This addition is 1-st s determined to be t n 2009 a connecting	lining e north of ory, with ype II link and				
	activities addition wa the dining room. It is barrier, 1-story, no b construction facility with 30-minute fire b	s separated with a 2- pasement , Type V(1 is divided into 3 smo	hour fire 11)				
	The facility has a co sprinkler system with installed in accordar Standard for Installa 1999 edition. The fa which includes smol corridor system and is installed in accord	h quick response he nce with NFPA 13 Th tion of Sprinkler Sys acility has a fire alarr ke detection through in all common areas	ads, ie tems n system out the s, which				
LABORATOR	AY DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESE	NTATIVE'S SIGN	ATURE	TITLE		(X6) DATE

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

STATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIERCULA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING 01 AAN BUILDING 01 A BUILDING 0		MENT OF HEALTH					FORM	: 05/05/2014 APPROVED). 0938-0391
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	K 000	National Fire Alarm sleeping rooms hav operated smoke de have automatic fire the Minnesota State fire alarm system is department notifical The facility has a ca census of 31 at the The requirement at	Code" 1999 edition. e single station batter tectors and hazardou detection in accorda e Fire Code 2007 edi monitored for autom tion. pacity of 32 beds ha time of the survey.	ery us areas nce with tion. The natic fire id a	K 000			

	MENT OF HEALTH			Ŧ	5600023	FORM	05/05/2014 APPROVED 0.0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA	1	PLE CONSTRUCTION G 02 - ACTIVITIES ADDITION	(X3) DATE S COMPLE	URVEY
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K 000	INITIAL COMMENT	S		K 000			
	FIRE SAFETY						
	02 Connecting Link	Activities					
		Survey was conducte ent of Public Safety,					
	Fire Marshal Divisio	n. At the time of this ciety Blackduck 01 I	survey,				
		in substantial compli					
	Medicare/Medicaid		2000				
	edition of National F (NFPA) Standard 10	ire Protection Assoc	iation				
	Chapter 19 Existing		(200),				
	Good Samaritan So						
	building built at three major portion of the	building was built in	1970, is				
	1-story with a basen be Type I(332) cons	truction. In 1996 a c	lining				
	room/ PT addition w the original building.						
	a basement and was (111) construction. In						
	activities addition wa the dining room. It is	as constructed to the	north of				
	barrier, 1-story, no b	asement , Type V(1	11)				
	construction facility i with 30-minute fire b		ke zones				
	The facility has a col			1997 (1998) (1997)			
	sprinkler system with installed in accordar						
	Standard for Installa 1999 edition. The fa						
	which includes smol						
	corridor system and is installed in accord	in all common areas	s, which				
	Y DIRECTOR'S OR PROVID			ATURE	TITLE		(X6) DATE

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

STATEMENT OF DEPREVENTS X11 DEMONDRAUMBER X245600 X245600<			AND HUMAN SERV & MEDICAID SERV				FORM	05/05/2014 APPROVED . 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - BLACKDUCK STREET ADDRESS, CITY, STATE, ZIP CODE 172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630 172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (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) COMPLETION DATE K 000 Continued From page 1 National Fire Alarm Code" 1999 edition. All sleeping rooms have single station battery operated smoke detectors and hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system is monitored for automatic fire department notification. K 000 The facility has a capacity of 32 beds had a census of 31 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is							(X3) DATE SU	JRVEY
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	Nat slea ope hav the fire dep The cen	tional Fire Alarm eping rooms have arated smoke def re automatic fire Minnesota State alarm system is partment notificat a facility has a ca usus of 31 at the a requirement at	Code" 1999 edition. e single station batte tectors and hazardou detection in accorda Fire Code 2007 edi monitored for autom ion. pacity of 32 beds ha time of the survey.	ery us areas nce with tion. The natic fire d a	K 000			

Page 20



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted May 8, 2014

Ms. Angel Normandin, Administrator Administrator Good Samaritan Society - Blackduck 172 Summit Avenue West Blackduck, Minnesota 56630

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5600023

Dear Ms. Normandin:

The above facility was surveyed on April 28, 2014 through May 1, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Good Samaritan Society - Blackduck May 8, 2014 Page 2

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman by email: lyla.burkman@state.mn.us, or phone: (218) 308-2104.

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

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

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

Sincerely, Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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2 000	Initial Comments		2 00	00			
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER	2				
	144A.10, this correct pursuant to a surver found that the defice herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has be	ued , it is ed lation nce e of een ow. to ered oon e will e item				
	that may result from orders provided that the Department wit	hearing on any assess n non-compliance with th t a written request is ma hin 15 days of receipt of ent for non-compliance.	nese ade to				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	participate in the electr nsure orders consistent artment of Health in 14-01, available at tate.mn.us/divs/fpc/profi e licensing orders are	with				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTAT	IVE'S SIGNATUR	E	TITLE		(X6) DATE 05/19/14

Electronically Signed

If continuation sheet 1 of 32

TATEMENT OF DEFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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you elect is necess enter the text. You State lice completi corrected Minneso On 4/28 surveyor above pr orders a electroni reviewed they will Minneso the State federal s	ronically. sary for St word "con must ther ensure pro on date, th d prior to e ta Departr /14, 4/29/ s of this D ovider and re issued. c plan of c these orc be comple ta Departr Licensing oftware. T	Alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available fo indicate in the electronic cess, under the heading he date your orders will be electronically submitting to the nent of Health. 14, 4/30/14, and 5 /1/14, epartment's staff, visited the d the following correction Please indicate in your correction that you have lers, and identify the date whe eted. nent of Health is documenting g Correction Orders using ag numbers have been sota state statutes/rules for	n			
column e statute/r "Summa and repla correction findings after the evidence are the S Time per PLEASE FOURTH	gned tag r entitled "IE ule out of o ry Statemo aces the "" n order. T which are statement by." Follo Suggested iod for Co DISREGA I COLUMI	number appears in the far left O Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection. ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY IPLETED
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	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 265	MN Rule 4658.008 Resident Health Sta	5 Notification of Chg in atus	2 265			5/20/14
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for:				
		involving the resident which I has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ation in health, mental, or in either life-threatening al complications;				
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				
	D. a decision t resident from the n	o transfer or discharge the ursing home; or				

Minneso	ta Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
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2 265	Continued From pa	ige 3	2 265			
	E. expected an	nd unexpected resident deaths.				
	by:	ent is not met as evidenced		Operated		
	facility failed to notif oxygen saturations, blood pressures in consult the physicia administration for 1	and document review, the fy the physician of a decline in , elevated temperature and a timely manner and failed to an for parameters for oxygen of 3 residents (R6) reviewed hanges who experienced falls s.		Corrected		
	Findings include:					
	indicated R6 had m	num Data Set dated 1/23/14, oderate cognitive impairment sive staff assistance for all ing.				
	4/22/14, indicated a diabetes, hypertens	hysician's progress note, dated an active diagnoses of sion, chronic pain, depression, emia and chronic kidney				
	R6's nursing progre following informatio	ess notes revealed the n:				
	floor in another resi hit her head during listed as within norr pressure of 179/76, R6's physician and Follow up neuro che	5 p.m. R6 was found on the ident's room. R6 said she had the fall, neuro checks were nal limits and an initial blood, pulse 78. The note indicated family were notified of the fall. eck information, per the neuro ter the incident revealed the				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
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2 265	Continued From pa	age 4	2 265			
	following informatic	on:				
	- At 8:30 p.m. 3/21/ 192/89	/14, R6's blood pressure was				
	- At 10:30 p.m. on 3 was 259/84	3/21/14, R6's blood pressure				
	- At 12:30 a.m. on 3 was 239/93	3/22/14, R6's blood pressure				
	- At 2:30 a.m. on 3/ was 190/80	/22/14, R6's blood pressure				
	- The final blood pressure recording for R6 on 3/22/14, at 7:00 p.m. was 193/73. The note indicated R6 was alert with normal hand grasps and upper body movement and her pupils were equal in size and reactive to light.					
	note revealed R6's normal limits after H of consciousness) a (within normal limits monitor. The medi that the significantly excess of 200 milling	37 a.m. the nursing progress neuro checks were within her fall on 3/21/14. LOC (level and orientation were WNL s) as well. Continue to cal record lacked evidence y elevated blood pressures in meters of mercury (mm Hg) or were reported to a physician.				
	vital signs included 227/97, a temp of 1 saturations of 85-89 R6 had vomited the At 9:30 a.m. R6's b and was 202/60, te 67 with oxygen satu PRN (as needed) of	5 a.m. the note indicated R6's an elevated blood pressure of 100.0, a pulse of 91 an oxygen 9%. The note also indicated erefore was kept in her room. blood pressure was rechecked imp of 100.8 degrees, pulse of urations dipping to 78-85% and oxygen was applied at two liters emperature was rechecked	f d			

	ta Department of He IT OF DEFICIENCIES	ealth (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE		(X3) DATE	SURVEY
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2 265	Continued From pa	age 5	2 265			
	increased to 96% v note further indicat pain or discomfort	ees, oxygen saturations with the oxygen at 2 liters. The ed R6 was not complaining of and had stopped vomiting. tified of this incident via an				
	4/1/14, was not uni a routine weekly ch recording of 176/58 (tympanic), pulse 5	d vital sign information after til 4/5/14, four days later when neck revealed a blood pressure 3, temperature of 97.1 51 (regular) and respirations of aturation was recorded as 94%				
	dated 4/15/14, and checked and clean lacked documentar notified regarding F 4/1/14, and evider	d nursing progress note was indicated R6 had her ears ied. R6's medical record tion that R6's physician was R6's change of condition on ince of any additional or vital signs being taken to tion.				
	indicated R6 was s nursing home roun R6's oxygen satura	e visit note dated 4/22/14, seen by her physician during ids. The note also indicated ations were recorded at 93% or s 66 and R6's blood pressure /74.	1			
		n 04/30/14, at 12:34 p.m., NA)-A said R6 was in a had "Given up."				
	registered nurse (F nurse (LPN)-A stat over 200 mm Hg w require a recheck of	n 5/1/14, at 10:03 a.m., both RN) -A and licensed practical ed blood pressure readings yould be concerning and would of the blood pressure to see if i	t			
Inesota De	epartment of Health VI		⁶⁸⁹⁹ O	76Z11	If continua	tion sheet 6 o

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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X4) ID REFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 265	Continued From pa	age 6	2 265			
	259 after a fall with definitely concernin oxygen saturations concern, both verifi fax the doctor with During interview or director of nursing had been an intesti facility on 4/1/14, a "personally called t blood pressures no from 3/22/14. She have been reviewe on rounds but was documentation to t remembered receive on the day of her fa was doing. The DO follow up oxygen sa taken once a shift i abnormal with sym identified she may call a doctor unless	his effect. The DON ving a call from R6's daughter all wanting to know how she ON stated she would expect aturations and vitals to be if they were noted to be ptoms of an illness. The DON not necessarily expect staff to s temperatures were over 101 ident had been running a low				
	the DON stated R6 order for oxygen us incident and the fac staff to first apply th then were expected guidance. The DO	view on 5/1/14, at 10:50 a.m. 6 did not have a physician's se at the time of the 4/1/14, cility medical director preferred he oxygen when needed and d to call a doctor for further N stated the facility did not				
	against corporate p a previous order fo	ers for oxygen as this was policy and also stated R6 had r as needed oxygen that had due to lack of clear				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00021	B. WING		05/	01/2014
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE	1	
GOOD S	AMARITAN SOCIETY		IMIT AVENUE V DUCK, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 265	Continued From pa	age 7	2 265			
	physician (MD-C) s were very difficulty compromised rena she had been work cardiology regardir unstable blood pre- facility definitely sh R6's temperature a saturations on 4/1/ "unfortunate" that t she reviewed R6's facility rounds as th report as well as pe checking R6's blood during R6's clinic a The facility policy, e in Resident Status, indicated the center all caps) inform the (except in a medica is incompetent), an physician and, if kr family or legal repri- cases: -1. Resident accid a potential for requi- -2. Significant cha mental or psychoso -3. Need to alter tr	entitled Notification of Change revised February 2005, in will IMMEDIATELY (written in a resident, if appropriate al emergency or when resident's nown, notify the resident's nown, notify the resident's esentative in the following ent which results in injury with iring physician intervention. nge in the resident's physical,				
	ongoing document notification for a su	ncluded a flow chart including ation, monitoring and physiciar spected resident illness. The d staff should continue				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00021	B. WING		05/	01/2014
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		MIT AVENUE DUCK, MN 566			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 265	Continued From pa	age 8	2 265			
	policy/procedure, b frequency of the m Additionally, the po revised 11/13, were entitled Temperature oral temperature of	ent according to center but lacked guidelines for onitoring or reassessment. licies for vital signs, last e reviewed and the policy re defined a fever as a single f greater than 100 degrees beated oral temperature of ove sheit.	r			
	work with the medi to update policies a notify the physician and consulting the resident needs. Th staff. The DON or audits of resident r	sing (DON) or designee could				
	Time Period for Co days.	rrection: Twenty-one (21)				
2 560	MN Rule 4658.040 Plan of Care; Cont	5 Subp. 2 Comprehensive ents	2 560			5/20/14
	comprehensive pla objectives and time long- and short-tern and mental and ps identified in the corr assessment. The must include the in	of plan of care. The in of care must list measurable stables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plar sota Statutes, section 626.557, agraph (b).	n			

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00021	B. WING		05/	01/2014
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		MIT AVENUE OUCK, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 560	Continued From pa	age 9	2 560			
	This MN Requirem by: Based on interview facility failed to ensincluded appropriat a resident receiving of fluid due to a flui responsible for more where the resident them, location of the the frequency of me emergency intervent of an emergency at held on the days the	ent is not met as evidenced and document review, the pure the written care plan te interventions for the care of g dialysis related to delineation d restriction, persons nitoring daily fluid intake, dialyzes and how to contact re residents fistula, directive or onitoring of the fistula, ntions, who to contact in case nd which medications were e resident received dialysis for) in the sample who received		Corrected		
	Findings include:					
	received hemodialy renal failure. The c staff to not draw ble readings in the left document / report t needed and to repo bleeding, hemorrha signs and symptom site such as rednes drainage and to mo blood makes as it r care plan lacked id vascular access R HeRO graft), where placed, how often t for a Bruit or feel for over an artery and flow), the delineation	ed 4/8/14, indicated R5 ysis three times a week due to are plan interventions directed ood or take blood pressure grafted arm, to monitor and to R5's health care provider as ort signs and symptoms of age, bacteremia, septic shock, as of infection to the access as, swelling, warmth or onitor for a bruit (the sound moves through arteries). R5's entification of the type of 5 had (i.e. fistula, Dacron graft, e 5's vascular access was o check the vascular access or a thrill (a vibration that is felt caused by turbulent blood on of fluid related to how much etary was going to provide and				

	IT OF DEFICIENCIES OF CORRECTION	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DPLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00021	B. WING		05/	01/2014
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
OOD S	AMARITAN SOCIETY		MIT AVENUE DUCK, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 560	Continued From pa	age 10	2 560			
	daily fluid intake. T indication of which on dialysis days an where R5 dialyzed, to do or who to cor related emergency accessing R5's new On 4/30/14, at 11:3 (LPN)-C stated R5 medications held o succinate ER 50 m 60 mg). LPN-C cor identified which me on dialysis days. On 4/30/14, at 1:03 confirmed R5's write	ble for monitoring R5's total he care plan also lacked of R5's medication were held ad also lacked indication of , how to contact them and wha ntact in case of a dialysis (i.e. excess bleeding from wly placed fistula). 30 a.m. licensed practical nurse had two blood pressure on dialysis days (metopropolol ng (milligrams) and Imdur ER nfirmed R5's care plan had not edications were not given to R5 3 p.m. registered nurse (RN)-C tten care plan lacked the ents as listed above.				
	could review policie the development or These policies coul facility nurse's coul policies and procee could be audited for these audits being Quality Assessment ensure on-going co	sing and/or their designee es and procedures related to f comprehansive plans of care ld be revised as necessary. A ld be re-educated on these dures. Resident care plans or content, with the results of shared with the facility's nt and Assurance committee, to				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			5/20/14

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00021			05/	01/2014
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE	00/	01/2014
GOOD S	AMARITAN SOCIETY	- BLACKDUCK 172 SUM	MIT AVENUE	WEST		
	SUMMA DV STA	TEMENT OF DEFICIENCIES	UCK, MN 56	630 PROVIDER'S PLAN OF (
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 11	2 830			
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on id preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident bed.				
	by: Based on observati review, the facility f physician of a decli elevated temperatu timely manner and for parameters for of 3 residents (R6) rev change who experi illness. Additionally	ent is not met as evidenced ion, interview and document ailed to monitor and notify the ne in oxygen saturations, irre and blood pressures in a failed to consult the physician oxygen administration for 1 of viewed for notification of enced falls and an acute , the facility failed to monitor 1 resident (R5) who received in a fluid restriction.		corrected		
	indicated R6 had m	mum Data Set dated 1/23/14, noderate cognitive impairment sive staff assistance for all ing.				
		hysician's progress note, datec an active diagnoses of				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00021		B. WING		01/2014
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		IMIT AVENUE DUCK, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 12	2 830			
	diabetes, hyperten hypothyroidism, an disease.	sion, chronic pain, emia and chronic kidney				
	R6's nursing progra following information	ess notes revealed the on:				
	floor in another res hit her head during listed as within nor pressure of 179/76 R6's physician and Follow up neuro ch	5 p.m. R6 was found on the ident's room. R6 said she had the fall, neuro checks were mal limits and an initial blood b, pulse 78. The note indicated family were notified of the fall. heck information, per the neuro fter the incident revealed the price.				
	192/89 - At 10:30 p.m. on was 259/84 - At 12:30 a.m. on was 239/93 - At 2:30 a.m. on 3 was 190/80 - The final blood pr 3/22/14, at 7:00 p.r indicated R6 was a	/14, R6's blood pressure was 3/21/14, R6's blood pressure 3/22/14, R6's blood pressure /22/14, R6's blood pressure ressure recording for R6 on m. was 193/73. The note alert with normal hand grasps by ement and her pupils were eactive to light.				
	note revealed R6's normal limits after of consciousness) (within normal limit monitor. The medi that the significantl excess of 200 milli	37 a.m. the nursing progress neuro checks were within her fall on 3/21/14. LOC (level and orientation were WNL s) as well. Continue to ical record lacked evidence y elevated blood pressures in meters of mercury (mm Hg) or were reported to a physician.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	00021			B. WING		05/04/2014	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE. ZIP CODE	05/01/201		
	AMARITAN SOCIETY			WEST			
		BLACK	OUCK, MN 566				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
2 830	Continued From pa	age 13	2 830				
	vital signs included 227/97, a temp of 1 saturations of 85-8 R6 had vomited an 9:30 a.m. R6's bloc and was 202/60, te 67 with oxygen satu PRN (as needed) of per minute. R6's te and was 99.5 degre increased to 96% v note further indicate pain or discomfort a R6's family was not email. - The next recorded 4/1/14, was not unt routine weekly chear recording of 176/58 (tympanic), pulse 5	5 a.m. the note indicated R6's an elevated blood pressure of 100.0, a pulse of 91 an oxygen 9%. The note also indicated d was kept in her room. At od pressure was rechecked mp of 100.8 degrees, pulse of urations dipping to 78-85% and oxygen was applied at two liters emperature was rechecked ees, oxygen saturations with the oxygen at 2 liters. The ed R6 was not complaining of and had stopped vomiting. tified of this incident via an d vital sign information after il 4/5/14, four days later at a ck revealed a blood pressure 3, temperature of 97.1 i1 (regular) and respirations of					
	on room air. -R6's next recorded	aturation was recorded as 94% d nursing progress note was indicated R6 had her ears					
	checked and clean lacked documentat notified regarding F 4/1/14, and eviden	ed. R6's medical record tion that R6's physician was R6's change of condition on the of any additional or vital signs being taken to					
	doctor per a physic dated 4/22/14. R6' recorded at 93% or	ursing home rounds by her ian nursing home visit note is oxygen saturations were n room air, pulse was 66 and e recording was 199/74.					

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00021	B. WING		05/	01/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
GOOD SA	AMARITAN SOCIETY		MIT AVENUE V UCK, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 14	2 830			
		04/30/14, at 12:34 p.m., NA)-A said R6 was in a had "Given up."				
	registered nurse (R nurse (LPN)-A said 200 mm Hg would require a recheck of	5/1/14, at 10:03 a.m., N)-A and licensed practical blood pressure readings over be concerning and would of the blood pressure to see if i				
	259 after a fall with definitely concernin oxygen saturations concern, both verifi	confirmed a blood pressure of a potential head injury was g. Both LPN-A and RN-A said in the 70's would also be a ed they would definitely call or something like that.				
	director of nursing (had been an intesti facility on 4/1/14, an "personally called th	5/1/14, at 10:20 a.m. the (DON) said she thought there nal flu going through the nd said she would have he doctor" with the elevated				
	from 3/22/14. She have been reviewer on rounds but was documentation to th	nis effect. The DON				
	on the day of her fa was doing. The DC follow up oxygen sa taken once a shift it	ving a call from R6's daughter all wanting to know how she DN stated she would expect aturations and vitals to be f they were noted to be				
	identified she may call a doctor unless	ptoms of an illness. The DON not necessarily expect staff to a temperatures were over 101 ident had been running a low for several days.				
		oximately 10:30 a.m. R6 was her room in a chair. R6 was				

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00021	B. WING		05/	/01/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- BLACKDUCK	MIT AVENUE V UCK, MN 566				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ge 15	2 830				
		nable to answer basic w she felt or how long she had ty.					
	DON stated R6 did for oxygen use at th and the facility med first apply the oxyge call a doctor for furt stated the facility di oxygen as this was also stated R6 had	5/1/14, at 10:50 a.m. the not have a physician's order he time of the 4/1/14, incident lical director preferred staff to en and then were expected to ther guidance. The DON d not have standing orders for against corporate policy and a previous order for as t was discontinued due to lack s for use.					
	physician (MD-C) s were very difficult to compromised renal she had been work cardiology regardin unstable blood pres facility definitely sho R6's temperature a saturations on 4/1/ ⁷ "unfortunate" that th she reviewed reside during facility round printed report as we	5/1/14, at 12:48 p.m. R6's tated R6's blood pressures o control due to R6's function. MD-C also stated ing in conjunction with g the treatment of R6's ssures. MD-C confirmed the buld have called and reported nd decreased oxygen 14, and stated it was his did not happen. MD-C said ent vital signs information Is as the facility provided a ell as personally checking R6's ding herself during R6's clinic					
	in Resident Status, indicated the center all caps) inform the (except in a medica is incompetent), an	entitled Notification of Change revised February 2005, r will IMMEDIATELY (written in resident, if appropriate al emergency or when resident d consult with the resident's own, notify the resident's					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00021		B. WING		05/01/2014	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
GOOD SA	AMARITAN SOCIETY		IMIT AVENUE V DUCK, MN 566				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
2 830	Continued From pa	age 16	2 830				
	family or legal repr cases:	esentative in the following					
	a potential for requ -2. Significant cha mental or psychos -3. Need to alter to -4. Decision to tra from the center.	reatment significantly. nsfer or discharge the resident					
	ongoing document notification for a su flow chart indicated monitoring a reside policy/procedure, b frequency of the m Additionally, the por revised 11/13 were entitled Temperature oral temperature o	ncluded a flow chart including ration, monitoring and physiciar uspected resident illness. The d staff should continue ent according to center but lacked guidelines for nonitoring or reassessment. blicies for vital signs, last e reviewed and the policy re defined a fever as a single f greater than 100 degrees beated oral temperature of ove nheit.					
		cubic centimeter (cc) daily fluid daily total fluid intake was not	t				
		S dated 4/10/14, indicated R5 n and was independent with					
	diagnoses included	RECORD indicated R5's d end stage renal disease nodialysis and type II diabetes					
		24 a.m. RN-B confirmed R5 laily fluid restriction which					

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00021	B. WING		05/	01/2014
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OOD S	AMARITAN SOCIETY		IMIT AVENUE DUCK, MN 566			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLE DATE
2 830	Continued From pa	age 17	2 830			
	started day R5 had her first dialysis treatment on 9/4/14.					
		ers dated 3/19/14, did not r a restricted fluid intake.				
	on a daily fluid rest and directed staff t giving R5 any fluid document all fluids lacked identification fluid restriction amo	ed 4/23/14, indicated R5 was riction due to renal disease o see the charge nurse before s between meals and to provided. The care plan n of the amount of the daily ount and did not delineate how n meals and medication pwed.				
	responsible for the know how much flu during the medicat would give R5 no r med pass during th directions or care p identified how muc the med pass. LPN no more than 400 of passes in 24 hours was responsible for	20 a.m. LPN-C, who was care of R5, stated she did not uid she was allotted to give R5 ion pass. LPN-C stated she nore than 100 cc of fluid for the be day shift but there were no olan interventions which h fluid LPN-C was allotted for I-C stated R5 would be given cc of fluid for all of the med and she did not know who r monitoring R5's total daily ire that R5 was staying within estriction amount.				
	stated R5 was prove each meal which we daily. The dietary me plan did not deline allotted with meals allotted during me responsible to more	05 p.m. the dietary manager vided 360 cc of fluid during vas a total of 1080 cc of fluid manager confirmed R5's care ate how much fluid R5 was and how much fluid R5 was d pass, and who was hitor R5's total daily fluid manager verified there was no				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00021	B. WING		05/	01/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY		MIT AVENUE V JCK, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 18	2 830			
	daily because the f not account for the with each med pass the residents total Review of the facili sheets from the Di intake was not con residents. Many of "Not Available" and recorded between Review of R5's Me indicated fluid intak passes had not be through 4/24/14. O staff had begun to each med pass an between 210 cc ar On 4/30/14, at 1:03 was no planned de	ch total fluid intake R5 received facility's computer system did a amount of fluid R5 was given ss, and nobody was monitoring fluid intake each day. ity's fluid intake monitoring nning Report revealed fluid usistently recorded for all the entries were identified as d R5's dietary fluid intake was 240 cc to 1080 cc daily. edication Administration sheets ke provided during the med en recorded from 9/4/13, 0n 4/25/14, the MAR identified record R5's fluid intake with d indicated R5 was provided and 240 cc fluid daily. 3 p.m. RN-C confirmed there elineation for fluids for nursing le R5. RN-C verified R5's total				
	daily fluid intake wa Suggested Method The director of nur could review and re related to the ident residents and for re obtaining physiciar nursing could prov The director of nur monitoring program interventions are b	as not being monitored. d of Correction: sing and/or their designee evise policies and procedures ification of the clinical needs of eporting resident status and hs orders. The director of ide training to involved staff. sing could establish a n to assure appropriate care				

Minneso	ta Department of He	alth	-			_
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00021	B. WING		05/0	1/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BLACKDUCK	MIT AVENUE UCK, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Program Subpart 1. Infection home must establis	D Subp. 1 Infection Control; on control program. A nursing th and maintain an infection signed to provide a safe and nt.	21375			5/20/14
	by: Based on interview facility failed to ana infections for both s	ent is not met as evidenced and document review, the lyze patterns and trends of staff and residents. This had ct all 32 residents who resided		corrected		
	revealed a system of program with ongoi of infections and inf Report of Resident 02/14, 03/14, and 0 with prescribed anti- facility's tracking sy- infections without a tracking system for comparison surveill employee illnesses On 5/1/14, at 11:42 control program wa nursing (DON). DC	y's infection control program which lacked a surveillance ng analysis and interpretation fection risks. The Monthly Infections in Center for 01/14, 4/14, revealed only infections biotics were tracked. The stem lacked trending of ntibiotics. In addition, a employee infections and ance between resident and had not been established. a.m. the facility infection s reviewed with the director of DN indicated all residents who				
	surveillance report completion, the sur	antibiotic were entered onto a by the floor nurse. Upon veillance reports were sent to the information onto the				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00021	B. WING		05/	01/2014	
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
GOOD S	AMARITAN SOCIETY		IMIT AVENUE V DUCK, MN 566	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21375	Continued From pa	age 20	21375				
Resident Infections in name, date admitted taken, causative age cautionary measures acquired. DON also nursing staff of resid an antibiotic which s not include on the m she reported directly the Quality Assurand committee which me stated she had previous reports of employee this. The DON indice employee call in she stated the last comp		ad on the Monthly Report of s in Center included: resident ed, site of infection, culture gent, antibiotic treatment, es, isolation and if center so stated she was notified by ident infections not requiring she reviewed monthly but did monthly report. DON indicated thy from the monthly reports at nce and Assessment (QAA) net quarterly. In addition, DON viously created similar monthly e infections but no longer did icated she retained each neet and reviewed them. DON upleted monthly report of s/infections available was dated	,				
	analysis of resident	5 p.m. DON confirmed no t infection trends with bloyee infections/illnesses was					
	2003, directs the in investigate and ass	rol Nurse Procedure dated July fection control nurse to sist with employee health recording employee infection ation.					
	2003, identified the surveillance to inclu	eillance procedure dated July e procedure for disease ude: "4. Tabulate and assess alculate rates, b. establish results"					
		rol Policies/Procedures manua wing disease surveillance	I				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00021	B. WING	B. WING		05/01/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- BLACKDUCK	MIT AVENUE V DUCK, MN 566	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21375	forms, as reference dated July 2003: "N Infections in Cente Infections in Cente	age 21 ed in the Table of Contents Monthly Report of Resident r, Monthly Report of Staff r, Infection Surveillance fection Control Report."	21375				
	review and revise p to components of t and develop a syst patterns and trends and analyzed. The	l of Correction: sing and/or designee could policies and procedures related he infection control program em of auditing, to ensure s for infections are monitored e quality assurance committee dit records to ensure					
	Time Period For Co days.	orrection: Twenty one- (21)					
21426	Prevention And Co (a) A nursing home maintain a compre- infection control pre- current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide	A.04 Subd. 4 Tuberculosis ntrol e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance ntation of the guidelines.	21426			5/20/14	

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00021	B. WING		05/0	1/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		IIT AVENUE JCK, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 22	21426			
	(b) Written complia be maintained by th	ance with this subdivision must an nursing home.				
	by: Based on interview facility failed to ens received the require (TST) for 3 of 5 en (NA)-D, NA-E, and reviewed, for tubero	ent is not met as evidenced and document review, the ure all health care workers ed two-step tuberculin skin test ployees (nursing assistant laundry assistant (LA)-A) culin skin testing. This had the II 32 residents who resided in		corrected		
	Findings include:					
	indicated they were tuberculosis (TB) so 2/22/14. However,	for nursing assistant NA-D hired on 2/22/14, and a creening was completed on the record lacked completion of the first and				
	hired on 2/20/14, an was administered p However, the recor	for NA-E indicated they were nd revealed the first step TST rior to employment on 7/9/13. d lacked documentation step was completed.				
	hired on 2/6/14, and was administered of lacked documentat was completed.	for LA-A, indicated they were d revealed the first step TST in 2/6/14. However, the record ion indicating a second step				
Ainnesota D	epartment of Health					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE				
OOD S	AMARITAN SOCIETY		IMIT AVENUE V DUCK, MN 566	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21426	Continued From pa	age 23	21426				
	(DON) confirmed the documentation that completed for NA-E confirmed the facilit testing fluid availabi it for these employed indicated she had a tuberculin testing fl pharmacy, though s The Tuberculin Ski Screening Health C identified the presc pre-employment sc and directed the act (TST) test per MDF Health] recommend Suggested Method The director of nurs policies and proced	reening for healthcare worker Iministration of the two-step I [Minnesota Department of dations.	5				
	audit the implement procedures to ensu- Nursing staff could requirements for tu	tation of those policies and ire on-going compliance. be re-educated on the berculin skin testing.	L				
21525	MN Rule 4658.130 Consultation	5 A.B.C Pharmacist Service	21525			5/20/14	
	services of a pharn Board of Pharmacy	ust employ or obtain the nacist currently licensed by the v who: nsultation on all aspects of the					

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
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GOOD S	AMARITAN SOCIETY		IMIT AVENUE DUCK, MN 56	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21525	Continued From pa	age 24	21525				
	home; B. establishes and disposition of a detail to enable an C. determines	acy services in the nursing a system of records of receipt all controlled drugs in sufficient accurate reconciliation; and that drug records are ned and that an account of all maintained.					
	by: Based on interview consultant pharma pressure and pulse therapeutic effectiv concerns with low p (R6) reviewed for u	ent is not met as evidenced and document review, the cist failed to review blood e ranges to evaluate reness and identify potential pulse rates for 1 of 5 residents innecessary drugs who nti-hypertensive medications.		corrected			
	Findings include:						
	4/22/14, indicated diabetes, hyperten	hysician's progress note, date R6's diagnoses included sion, chronic pain, emia and chronic kidney	t l				
	4/21/14, identified of (extended release) anti-hypertensive m pulse rate and reduced contractions) 24 ho mouth daily for ess (an anti-hypertensi orally twice a day for	nedication that lowers the uces the force of heart our give 100 milligrams (mg) by ential hypertension, Cozaar ve medication) give 50 mg or essential hypertension and n mesylate) give two mg orally	> /				

	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
good s	AMARITAN SOCIETY		MIT AVENUE V DUCK, MN 566				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21525	Continued From pa	ige 25	21525				
	and April 2014, reve ten times, of these below 60, with a wa the electronic medi exceeded." Review readings for the sat systolic blood press millimeters of merce recordings. Addition information was reve months and revealed documented pulses	rdings for the months of March ealed R6's pulse was taken recordings eight of ten were arning notation generated by cal record "Low of 60.0 v of R6's blood pressure me time period revealed sures in excess of 180 oury (mm Hg) five out of 11 onal blood pressure and pulse viewed for the previous six ed a consistent pattern of s in the 50's per minute and nning over 180 mm Hg	n				
	4/22/14, revealed a The progress notes physician (MD)-C n vitals were reviewe hypertension. No c R6's chart that the pressures or decre determine if the cur effective, or if parar metoprolol should to consultant docume irregularities had be 10 month period.	hysician progress notes, dated blood pressure of 199/74. s revealed R6's primary nade a comment that R6's d and listed a diagnosis of other evidence was noted on pattern of elevated blood ased pulses were evaluated to rrent drug regimen was meters for administration of the be defined. R6's pharmacy ntation was reviewed. No een identified for the previous 5/01/14, at 9:15 a.m. licensed PN) -A said she would not give	o e d				
	the metoprolol for a confirmed staff wer pulse prior to the a and confirmed this	a pulse below 60 and re not routinely checking R6's dministration of the metoprolo was not indicated on R6's on administration record.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21525	Continued From pa	age 26	21525				
	consultant pharmachold metoprolol for voiced concern abore pulses and high bl cow" when R6's blo March and April we phone. The CP state elevated blood press review and stated in problems with reside typically have to as concerns. The CP someone would pri but up until now hat computer and had	n 5/1/14, at 9:30 a.m. the cist (CP) said he would usually a pulse less than 60. The CP out R6's consistently low ood pressures and stated "holy ood pressure readings for ere reviewed at this time via ated staff needed to flag ssure readings for him to f staff did not tell him of dent vital signs, he would k in order to know if there were said every once in a while int a vital sign report for him d not had access to the difficulty getting the ded for the drug reviews, and					
	confirmed he had r pressure readings. received access to resident electronic able to review this i	the vital signs portal in records and would now be					
	physician (MD-C) s were very difficult to compromised rena she had been work cardiology regardin unstable blood pres	stated R6's blood pressures o control due to R6's I function. MD-C also stated sting in conjunction with the treatment of R6's ssures. MD-C stated low ore of a concern if R6 was					
	ambulatory and she low pulses were a c reviewed vital signs facility printed out a took them herself a	e is not so she did not feel the concern. MD-C said she s information at rounds as the a report for her and personally at clinic appointments. MD-C d resident vital signs					
nesota D	information during a printed report as	rounds as the facility provided well as personally checking e reading herself during R6's					

Minneso	ota Department of He	alth			FORM	APPROVED
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	SURVEY PLETED
		00021	B. WING		05/01/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		IMIT AVENUE DUCK, MN 566	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21525	Continued From pa	ge 27	21525			
	clinic appointments					
	11/13, lacked guide	for vital signs, last revised on lines for expected normal se or blood pressures.				
	Pharmacist could e that blood pressure reviewed for therap for administration a could randomly auc	sing (DON) and the Consulting stablish a system to monitor is and pulse ranges are outic ranges and parameters re established. The DON dit the system to ensure ping addressed and report to				
	Time Period For Co days.	prrection: Twenty one- (21)				
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary ral	21535			5/20/14
	must be free from u unnecessary drug is A. in excessive therapy; B. for excessive C. without adec D. in the prese which indicate the c discontinued. In addition to the d part 4658.1310, the with provisions in th Code of Federal Re 483.25 (1) found in	al. A resident's drug regimen unnecessary drugs. An s any drug when used: dose, including duplicate drug e duration; quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required ir e nursing home must comply he Interpretive Guidelines for egulations, title 42, section Appendix P of the State , Guidance to Surveyors for				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY,	STATE, ZIP CODE		01/2014	
GOOD S	AMARITAN SOCIETY		MIT AVENUE DUCK, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21535	Continued From pa	ige 28	21535				
	Department of Hea Health Care Finance This standard is inc available through th	acilities, published by the Ith and Human Services, sing Administration, April 1992 corporated by reference. It is the Minitex interlibrary loan the Law Library. It is not change.					
	by: Based on observat review the facility fa were reviewed with address potential c adverse reactions a elevated blood pres to evaluate the effe antihypertensive m beta-blocker (a class hypertension that m heart muscle contra	ent is not met as evidenced ion, interview and document ailed to ensure low pulse rates the physician in order to oncerns with medication and failed to demonstrate ssures were reviewed in order activeness of multiple edications including a ss of medications used to trea educes the rate and force of action) for 1 of 5 residents unnecessary drugs.		corrected			
	indicated R6 had m	mum Data Set dated 1/23/14, noderate cognitive impairment sive staff assistance for all ing.					
	dated 4/22/14 ident diabetes, hypertens	hysician's progress notes, iffied active diagnoses of sion, chronic pain, emia and chronic kidney					
	4/21/14, identified (extended release)	hysician's order sheets, dated orders for metoprolol succinate ER tablet (a beta-blocker) 24 grams (mg) by mouth daily for	e				

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
21535	Continued From pa	age 29	21535				
	twice a day for ess. Cardura (doxazosin daily for hypertensi R6's vital sign reco and April 2014 reve times, of those reco 60, with a warning electronic medical exceeded." Review readings for the sa systolic blood press millimeters of mero recordings. Additio information was rev months and reveal documented pulses	edication) give 50 mg orally ential hypertension and n mesylate) give two mg orally	1				
	4/22/14, revealed a The progress notes physician (MD)-C r vitals were reviewe hypertension. No c R6's chart which in blood pressures or evaluated to determ regimen was effect	hysician progress notes, dated a blood pressure of 199/74. Is revealed that her primary nade a comment that R6's ad and listed a diagnosis of other evidence was noted on dicated the pattern of elevated decreased pulses was nine if the current drug tive, or if parameters for he metoprolol should be					
	practical nurse (LP the metoprolol for a confirmed staff was pulse prior to the a	n 5/01/14, at 9:15 a.m. licensed N)-A said she would not give a pulse below 60 and s not routinely checking R6's dministration R6's metoprolol us not indicated on R6's	1				

	ta Department of He	ealth (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00021	B. WING		05/	01/2014
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S/	AMARITAN SOCIETY		MIT AVENUE	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 30	21535			
	electronic medicati	on administration record.				
	consultant pharmachold metoprolol for was concerned abo and high blood pre- when R6's blood pre- and April were revie On 5/1/14, at appro- observed resting in pale in color and we	n 5/1/14, at 9:30 a.m. the cist (CP) said he would usually a pulse less than 60. The CP but the consistently low pulses ssures and stated "holy cow" ressure readings for March ewed at this time via phone. Distinct of the state of the state of the room in a chair. R6 was a line room in a chair. R6 was as unable to answer basic ow she felt or how long she had ty.				
	stated R6's blood p control due to R6's MD-C also stated s conjunction with ca treatment of R6's u MD-C stated low p concern if R6 was a therefore she was n irregular pulse. M resident vital signs rounds as the facili well as personally of	a 5/1/14, at 12:48 p.m. MD-C pressures were very difficult to compromised renal function. she had been working in indiology regarding the instable blood pressures. ulses would be more of a ambulatory and she was not not concerned with R6's D-C said she reviewed information during facility ty provided a printed report as checking R6's blood pressure ing R6's clinic appointments.				
	succinate ER from Services Business 2/2011, revealed by common side effect	s package insert for metoprolo McKesson Packaging Unit of McKesson, revised radycardia (slow pulse) was a et of metoprolol and that e contraindicated in a patient ardia.				
		for vital signs, revised on				
nesota De	epartment of Health		6899	76Z11	If continucti	on sheet 31 c

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY		IMIT AVENUE V DUCK, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
21535	Continued From page 31 11/13, lacked guidelines for expected normal parameters for pulse or blood pressures.		21535			
	could review and re related to monitorin effects and medica staff could be re-ea procedures. An au with results being s assessment and as ongoing compliance	sing and/or their designee evise policies/procedures ing medications for adverse ation effectiveness. All nursing ducated on these policies and uditing tool could be developed shared with the facility's quality ssurance committee, to ensure	,			
nesota De	epartment of Health					