DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| | _ | - | _ | | ND TRANSMITT E SURVEY AGEN | | | ID: QBED Facility ID: 00322 | |
|---|--------------------|--|--|-------------------------------|---|----------------|--|--|------|
| MEDICARE/MEDICAID PROVIDER (L1) 245318 2.STATE VENDOR OR MEDICAID NO (L2) 004015100 | | 3. NAME AND ADDRESS OF FACILITY (L3) GOOD SAMARITAN SOCIETY - IN (L4) 2201 KEENAN DRIVE (L5) INTERNATIONAL FALLS, MN | | | NTERNATIONAL FALLS (L6) 56649 | | 4. TYPE OF ACTIO 1. Initial 3. Termination 5. Validation 7. On-Site Visit | 2. Recertification 4. CHOW 6. Complaint 9. Other | |
| 5. EFFECTIVE DATE CHANGE OF OV (L9) | VNERSHIP | 7. PROVIDER/SU 01 Hospital | JPPLIER CATEO 05 HHA | GORY 09 ESRD | 02 (L7) 13 PTIP 22 C | CLIA | 8. Full Survey After | | |
| 6. DATE OF SURVEY 03/19/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other | 015 (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 | I | FISCAL YEAR ENDII 12/31 | NG DATE: (L35) | |
| 11LTC PERIOD OF CERTIFICATION | | 10.THE FACILITY | ' IS CERTIFIED | AS: | | | | | |
| From (a): To (b): | | | nce With equirements e Based On: | | And/Or Approved Wa 2. Technical P 3. 24 Hour RN | Personnel | E Following Requirement 6. Scope of Sen 7. Medical Dir | rvices Limit | |
| 12.Total Facility Beds | 54 (L18) | 1. A | cceptable POC | | 4. 7-Day RN (5. Life Safety | (Rural SNF) | 8. Patient Room 9. Beds/Room | n Size | |
| 13.Total Certified Beds | 54 (L17) | | npliance with Pro ents and/or Appl | | * Code: A | (I | _12) | | |
| 14. LTC CERTIFIED BED BREAKDOW | N | | | | 15. FACILITY MEETS | | | | |
| 18 SNF 18/19 SNF 54 | 19 SNF | ICF | IID | | 1861 (e) (1) or 1861 (| (j) (1): | (L15) | | |
| (L37) (L38) | (L39) | (L42) | (L43) | | | | | | |
| 16. STATE SURVEY AGENCY REMAR | RKS (IF APPLICA | ABLE SHOW LTC CA | ANCELLATION | DATE): | | | | | |
| 17. SURVEYOR SIGNATURE | | Date : | | | 18. STATE SURVEY A | AGENCY AP | PROVAL | Date: | |
| Lyla Burkman, Unit Su | pervisor | | 03/19/2015 | (L19) | Mark Me | ath, Ei | nforcement Specia | 03/19/2013 | L20) |
| PART | II - TO BE | COMPLETED I | BY HCFA RI | EGIONAL | OFFICE OR SIN | GLE STA | TE AGENCY | | |
| DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to Part 2. Facility is not Eligible | | | IPLIANCE WIT HTS ACT: | H CIVIL | | nip/Control In | l Solvency (HCFA-257 terest Disclosure Stmt | | |
| 22. ORIGINAL DATE | 23. LTC AGREE | MENT 24 | 4. LTC AGREEI | MENT | 26. TERMINATION A | ACTION: | (| (L30) | |
| OF PARTICIPATION 06/01/1986 | BEGINNING | G DATE | ENDING DA | TE | VOLUNTARY 01-Merger, Closure | 00 | INVOLUN 05-Fail to I | NTARY Meet Health/Safety | |
| (L24) | (L41) | | (L25) | | 02-Dissatisfaction W/ R | | ent 06-Fail to I | Meet Agreement | |
| 25. LTC EXTENSION DATE: | | VE SANCTIONS n of Admissions: | a.m | | 03-Risk of Involuntary T 04-Other Reason for Wit | | OTHER 07-Provide 00-Active | er Status Change | |
| (L27) | B. Rescind S | uspension Date: | (L44) | | | | oo-Acuve | | |
| 28. TERMINATION DATE: | 29 |). INTERMEDIARY | (L45) CARRIER NO. | | 30. REMARKS | | | | |

(L31)

(L33)

DETERMINATION APPROVAL

00140

03/06/2015

32. DETERMINATION OF APPROVAL DATE

(L28)

(L32)

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245318

March 19, 2015

Mr. Adam Coe, Administrator Good Samaritan Society - International Falls 2201 Keenan Drive International Falls, Minnesota 56649

Dear Mr. Coe:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective March 4, 2015 the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 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 eNotice.

Sincerely,

Mont Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered March 19, 2015

Mr. Adam Coe, Administrator Good Samaritan Society - International Falls 2201 Keenan Drive International Falls, Minnsota 56649

RE: Project Number S5318025

Dear Mr. Coe:

On February 11, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 29, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On March 19, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 29, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 4, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 29, 2015, effective March 4, 2015 and therefore remedies outlined in our letter to you dated February 11, 2015, will not be imposed.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697 5318r15

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

| (Y1) Provider / Supplier / CLIA / Identification Number 245318 | (Y2) Multiple Construction A. Building B. Wing | | (Y3) Date of Revisit 3/19/2015 |
|--|--|--|-----------------------------------|
| Name of Facility | | Street Address, City, State, Zip Code | |
| GOOD SAMARITAN SOCIETY - INTER | RNATIONAL FALLS | 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | |

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

| (Y4) Item | | (Y5) Date | (Y4) Item | | (Y5) | Date | (Y4) | Item | | (Y5) | Date |
|----------------------------|--------------------------------|---------------------------------|----------------------------|------------------------------|--------|---------------------------------------|------|----------------------------|--------------------------|-------|---------------------------------|
| ID Prefix | - | Correction Completed 03/04/2015 | ID Prefix | | | Correction Completed 03/04/2015 | | ID Prefix | F0249 | | Correction Completed 03/04/2015 |
| Reg. # LSC | 483.15(a) | <u> </u> | Reg. # LSC | 483.15(f)(1) | | | | Reg. # LSC | 483.15(f)(2) | | |
| | F0279 483.20(d), 483.20(k | | ID Prefix Reg. # LSC | F0282 483.20(k)(3)(ii) | | Correction Completed 03/04/2015 | | Reg. # | F0314 483.25(c) | | Correction Completed 03/04/2015 |
| ID Prefix Reg. # LSC | F0322 483.25(g)(2) | Correction Completed 03/04/2015 | ID Prefix Reg. # LSC | F0329 483.25(I) | | Correction Completed 03/04/2015 | | Reg. # | | | |
| ID Prefix Reg. # LSC | | | ID Prefix Reg. # LSC | | | | | ID Prefix Reg. # LSC | | | |
| ID Prefix Reg. # LSC | | | ID Prefix Reg. # LSC | | | | | | | | |
| | | | | T | | | | | | | |
| Reviewed B | ByRevie | ewed By | Date: | Signature | of Sur | veyor: | | | | Date: | |
| State Agen | cy LB/ | /mm | 03/19/20 | 15 | 28 | 035 | | | | 03/ | 19/2015 |
| Reviewed E | By Revie | ewed By | Date: | Signature | of Sur | veyor: | | | | Date: | |
| Followup t | o Survey Complete 1/29/2015 | | | Check for any Uncorrected | | | | | Summary of the Facility? | YES | NO |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: QBED Facility ID: 00322

| | | | | | | - | |
|--|-----------------------|---|-------------------------------------|---------------------|--|--|----|
| MEDICARE/MEDICAID PROVID (L1) 245318 | | | IARITAN SOC | | TERNATIONAL FALLS | 4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification | |
| 2.STATE VENDOR OR MEDICAID (L2) 004015100 | NO. | (L4) 2201 KEEN . (L5) INTERNAT | | S. MN | (L6) 56649 | 3. Termination 4. CHOW 5. Validation 6. Complaint | |
| 5. EFFECTIVE DATE CHANGE OF (L9) | OWNERSHIP | 7. PROVIDER/SU | | | 02 (L7) 13 PTIP 22 CLIA | 7. On-Site Visit 9. Other 8. Full Survey After Complaint | |
| 6. DATE OF SURVEY 01/29 8. ACCREDITATION STATUS: | 9/2015 (L34) (L10) | 02 SNF/NF/Dual 03 SNF/NF/Distinct | 06 PRTF 07 X-Ray | 10 NF 11 ICF/IID | 14 CORF 15 ASC | FISCAL YEAR ENDING DATE: (L35) | _ |
| 0 Unaccredited 1 TJC 2 AOA 3 Other | | 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | 12/31 | |
| 11. LTC PERIOD OF CERTIFICATIO | N | 10.THE FACILITY | IS CERTIFIED | AS: | | | |
| From (a): | | A. In Complia | | | | f The Following Requirements: | |
| To (b): | | | equirements ee Based On: | | 2. Technical Personne 3. 24 Hour RN | 6. Scope of Services Limit 7. Medical Director | |
| 12.Total Facility Beds | 54 (L18) | 1. A | cceptable POC | | 4. 7-Day RN (Rural SI 5. Life Safety Code | NF) 8. Patient Room Size 9. Beds/Room | |
| 13.Total Certified Beds | 54 (L17) | X B. Not in Con Requirem | npliance with Progents and/or Appli | | * Code: B * | | |
| 14. LTC CERTIFIED BED BREAKDO | OWN | 1 | | | 15. FACILITY MEETS | | |
| 18 SNF 18/19 SNF | 19 SNF | ICF | IID | | 1861 (e) (1) or 1861 (j) (1): | (L15) | |
| 54 | | | | | | | |
| (L37) (L38) | (L39) | (L42) | (L43) | | | | |
| 16. STATE SURVEY AGENCY REM | IARKS (IF APPLICA | ABLE SHOW LTC CA | ANCELLATION 1 | DATE): | | | |
| 17. SURVEYOR SIGNATURE | | Date : | | | 18. STATE SURVEY AGENCY | Y APPROVAL Date: | |
| Teresa Ament, HFE | NEII | | 02/24/2015 | (L19) | Mark Meath | , Enforcement Specialist 03/04/2015 (L20 | 0) |
| PA | RT II - TO BE | COMPLETED I | BY HCFA RE | EGIONAI | L OFFICE OR SINGLE S | STATE AGENCY | |
| DETERMINATION OF ELIGIBIE 1. Facility is Eligible to I | | | IPLIANCE WITH HTS ACT: | H CIVIL | | ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) | |
| 2. Facility is not Eligible | e (L21) | | | | | ··· | |
| 22. ORIGINAL DATE | 23. LTC AGREE | MENT 24 | 4. LTC AGREEN | MENT | 26. TERMINATION ACTION | i: (L30) | |
| OF PARTICIPATION | BEGINNING | G DATE | ENDING DA | ГЕ | VOLUNTARY 0 | <u>INVOLUNTARY</u> | |
| 06/01/1986 | | | | | 01-Merger, Closure | 05-Fail to Meet Health/Safety | |
| (L24) | (L41) | | (L25) | | 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati | on | |
| 25. LTC EXTENSION DATE: | | VE SANCTIONS n of Admissions: | | | 04-Other Reason for Withdrawal | OTHER | |
| (7.25) | A. Suspension | ii oi Adillissiolis. | (L44) | | | 00-Active | |
| (L27) | B. Rescind St | uspension Date: | | | | | |
| | | | (L45) | | | | |
| 28. TERMINATION DATE: | 29 |). INTERMEDIARY | CARRIER NO. | | 30. REMARKS | | |
| | (L28) | 00140 | | (L31) | Posted 03/06/2015 C | 0. | |
| 31. RO RECEIPT OF CMS-1539 | 32 | 2. DETERMINATION | I OF APPROVAL | DATE | | | |
| | (1.22) | | | (L33) | DETERMINATION APP | POVAL | _ |
| | (L32) | | | (233) | DETERMINATION ALL | KO VAL | |



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered February 11, 2015

Mr. Adam Coe, Administrator Good Samaritan Society - International Falls 2201 Keenan Drive International Falls, Minnesota 56649

RE: Project Number S5318025

Dear Mr. Coe:

On January 29, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

<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, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: 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 March 10, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

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.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Good Samaritan Society - International Falls February 11, 2015 Page 4

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 29, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Good Samaritan Society - International Falls February 11, 2015 Page 5

Services that your provider agreement be terminated by July 29, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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 Health Regulation Division Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 02/24/2015 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | ATE SURVEY DMPLETED |
|--------------------------|--|--|---------------------|---|----------------------------|
| | | 245318 | B. WING _ | 0 | 1/29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | |
| (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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENT | rs | F 00 | 00 | |
| | as your allegation of Department's accepenrolled in ePOC, yat the bottom of the form. Your electror be used as verificated Upon receipt of an on-site revisit of you validate that substates | of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an our facility may be conducted to untial compliance with the en attained in accordance with | | | |
| F 241 SS=D | your verification. | AND RESPECT OF | F 24 | 11 | 3/4/15 |
| | manner and in an e enhances each res | omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality. | | | |
| | by: Based on observative review, the facility for treated in a dignification concerns for 1 of 1 reviewed for dignity Findings include: On 1/26/15, at 6:54 uncomfortable became the pants. R3 state her need to urinate | ion, interview and document ailed to honor the right to be d manner regarding toileting resident (R3) who was p.m. R3 stated she was ause she had just urinated in d when she informed staff of or have a bowel movement, go in the incontinent brief and | | To ensure dignity while toileting staff will honor R3 and all resident s requests to use the toilet if their care plan allows. If their care plan doesn t allow staff will explain this to the resident and let them know that their request will be communicated to the RN for further review. All household staff will be educated by DNS/designee to honor resident requests to use the toilet if care plan allows or to explain to the resident if toesn t currently allow and that it will be communicated to the RN for further | |
| ABORATORY | DIRECTOR'S OR PROVID | DER/SUPPLIER REPRESENTATIVE'S SIGN | JATURE | TITLE | (X6) DATE |

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

02/20/2015

Electronically Signed

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

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | LE CONSTRUCTION | | SURVEY PLETED |
|--------------------------|---|---|---------------------|---|------------------------------------|----------------------------|
| | | 245318 | B. WING | | 01/2 | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | : | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | , | , = 0.10 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 241 | unable to stand the with a mechanical I in the wheelchair, so bed in order to cleas sometimes her clot like. R3 added, "but One day I will get of sometimes she county have a bowel move they would say, "go you up." R3's Diagnosis Rep R3's diagnoses incoming inhalation of food of type 2 diabetes, particularly for person bed mobility, transforment and recone staff for person bed mobility, transforment of urine bowel. The MDS also indicincontinent of urine bowel. The MDS in toileting program to which could include voiding or bladder to indicated R3 was of toileting program to incontinence. R3's bladder inconting program to incontinence. R3's bladder inconting program to incontinence. | age 1 er up. R3 stated she was refore staff transferred her ift and when she was seated staff had to transfer her into an her up. R3 stated hes got wet which she did not to what can I do? I can't stand. In the toilet." R3 stated all feel the urge to urinate or ement but when she told staff to ahead and go and we'll clean cort dated 1/28/15, indicated luded pneumonia due to the romit, depression, anxiety, in and osteoarthrosis. The Data Set (MDS) dated a had moderate cognitive quired extensive assistance of hal hygiene and two staff for ers, dressing and toilet use. Cated R3 was frequently and always incontinent of dicated R3 was on a urinary of manage urinary continence as scheduled toileting, prompted training. The MDS further in an unidentified bowel of manage R3's bowel clinence care pan revised on the sincontinence was related to rege to void and refusals of lities of Daily Living (ADL) care, indicated R3 required total | F 241 | review. DNS/designee will audit to residents are toileted upon reques allowed by their individual care pla ensure dignity is maintained. Audit completed on random residents w for 4 weeks. Results will be forwar QA committee for further recommendation. | t as n to s will be eekly | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION ING | | | E SURVEY PLETED |
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| | | 245318 | B. WING | | | 01/2 | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP C 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 5 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | N SHOULD E APPROPF | BE | (X5) COMPLETION DATE |
| F 241 | The care plan indic consisted of having checked and chang In addition, the care benefits of refusals toilet substitutes had on 1/28/15, at 8:00 stated R3 did not us pan. NA-A stated the hours and she was also stated R3 did voided a large amowet. On 1/28/15, at 1:45 told her to go in her seldom used the be R3 stated "wetting y good to sit in wet pas sometimes tell whe a bowel movement tell her to go ahead would clean her up about it. I look at the so bad and I've new On 1/28/15, at 2:20 could at times tell shave a bowel moves she had never put I transferred. NA-A span and she did we asked R3 if she way verified staff would down her pants and with the mechanical states. | ransfer with a mechanical lift. ated R3's toileting schedule the incontinent product ged every three to four hours. It plan indicated the risk and of the toileting program and discussed. a.m. nursing assistant (NA)-A se the toilet but used the bed ey laid R3 down every two offered the bed pan. NA-A very well with the bed pan, unt and was also usually quite p.m. R3 again stated staff pants. R3 also stated she edpan because she hated it. Your pants is no good. It's no ants." R3 stated she can in she has to urinate and have but when she tells staff, they and go in her pants and they R3 stated "I don't feel good at toilet and I want to sit on it | F 2 | 41 | | | |

| | OF DEFICIENCIES DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | CONSTRUCTION | | E SURVEY IPLETED |
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| | | 245318 | B. WING | | | 01/ | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | 220 | REET ADDRESS, CITY, STATE, ZIP CODE 01 KEENAN DRIVE TERNATIONAL FALLS, MN 56649 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 241 | On 1/28/15, at 2:30 never put R3 on the unable to walk and lift to transfer. NA-C NA-C also stated si the bedpan. On 1/29/15, at 11:2 (RN)-B, stated R3 it toilet and the toileting to have her inconting changed. RN-B state pan. When asked it other resident to voincontinent product afterward, RN-B state on the bedpan. RN sling could be used toilet. RN-B also state sling but no longer. On 1/29/15, at 2:00 (DON) stated she care plan as long a line with the care plansked if it was appropriated they needed their pants and their the DON stated "Note that the state of the state of the poon stated they needed their pants and their the DON stated "Note that the state of the pants and their the DON stated "Note that the parts and their pants and the | ed there was a lift sling they son the toilet. I. p.m. NA-C stated she had toilet because she was utilized a full sling mechanical stated "we just change her." he had never assisted R3 onto he had never assisted R3 | | 241 | | | |
| | indicated the purpo of all residents. The for residents in a m that maintained or e | ent Dignity policy issued 2/13, se was to maintain the dignity e policy was to promote care anner and an environment enhanced each resident's in full recognition of his or her | | | | | |

| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS [KA] ID FREETY FACE BY THE PROVIDER OR SUPPLIED BY FULL FREED BY FULL FACE BY THE FEW FACE BY THE | | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | CONSTRUCTION | | E SURVEY PLETED |
|---|--------|---|--|---------|----|---|---|--------------------|
| 2201 KEENAN DRIVE INTERNATIONAL FALLS 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | | | 245318 | B. WING | | | 01/2 | 29/2015 |
| F241 Continued From page 4 individuality. F248 SS=E INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide activities to meet the individual interests for 4 of 4 residents (R43, R50, R26, R19) reviewed for activities. Findings include: R43 was not provided activities according to assessed need. R43's Admission Record dated 7/13/12, indicated diagnoses of blindness in both eyes, unspecified psychosis and major depressive disorder. R43's annual Minimum Data Set (MDS) dated 12/5/14, indicated R43 had severely impaired cognition, required extensive assistance of one staff with transfers and locomotion on the unit and had behaviors or hallucinations but none that were recently present. The MDS further indicated R43 felt tired or had little energy about haif or more of the reference period days, felt bad about herself or that she was a failure or had let there. | | | - INTERNATIONAL FALLS | | 22 | 201 KEENAN DRIVE | | |
| individuality. F 248 SS=E The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide activities to meet the individual interests for 4 of 4 residents (R43, R50, R26, R19) reviewed for activities. Findings include: R43's Admission Record dated 7/13/12, indicated diagnoses of blindness in both eyes, unspecified psychosis and major depressive disorder. R43's annual Minimum Data Set (MDS) dated 12/5/14, indicated R43 had severely impaired cognition, required extensive assistance of one staff with transfers and locomotion on the unit and had behaviors or hallucinations but none that were recently present. The MDS further indicated R43 felt tired or had little energy about half or more of the reference period days, felt bad about herself or that she was a failure or had let her | PRÉFIX | (EACH DEFICIENCY | / MUST BE PRECEDED BY FULL | PREFI | | (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR | BE | COMPLETION |
| she would be better off dead or of hurting herself | F 248 | individuality. 483.15(f)(1) ACTIV INTERESTS/NEED The facility must prof activities designed the comprehensive the physical, mental of each resident. This REQUIREMED by: Based on observative, the facility for meet the individual (R43, R50, R26, Rate) Findings include: R43 was not providual assessed need. R43's Admission Rate diagnoses of blindropsychosis and major R43's annual Minimal 12/5/14, indicated for cognition, required staff with transfers had behaviors or have recently present R43 felt tired or had more of the referent herself or that she of family down nearly | ITIES MEET OS OF EACH RES ovide for an ongoing program ed to meet, in accordance with assessment, the interests and all, and psychosocial well-being NT is not met as evidenced tion, interview and document ailed to provide activities to interests for 4 of 4 residents (19) reviewed for activities. ed activities according to ecord dated 7/13/12, indicated tiess in both eyes, unspecified or depressive disorder. num Data Set (MDS) dated (A43 had severely impaired extensive assistance of one and locomotion on the unit and allucinations but none that ent. The MDS further indicated d little energy about half or ce period days, felt bad about was a failure or had let her every day, had thoughts that | | | provided activities to meet their indivinterests. All residents will be review ensure they are being provided active to meet their individual interests. All household staff will receive education DAHL/designee on providing activities meet each resident is individual interests. All household staff will receive education DAHL/designee on providing activities meet each resident is individual interestivities are being provided that meresidents individual needs by auditing random residents weekly for 4 week Results will be forwarded to QA | ved to vities on by es to erests. eet ng cs. | 3/4/15 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPLIER/CLIA

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
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| | | 245318 | B. WING _ | | 01 | /29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP COD 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 5664 | E | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 248 | activities of interest - to have books, ne read - listen to music - be around animals - do things with gro - go outside to get f was good - participate in relig R43's care plan lac individualized and / be of interest to R4 R43 was observed On 1/26/15, at 5:00 television in the day Channel on, not actively ending television or radio of On 1/27/15, at 11:3 in front of the televinot actively engage On 1/28/15, at 1:23 watching the Weath engaged. R43's activity docurattended / participal activities in 12/14, at 12/ | tified R43 felt the following were very important to her: wspapers and magazines to s such as pets ups of people resh air when the weather ious services or practice ked identification of or group activities that would 3. the following times: p.m. sitting in front of the room with the Weather tively engaged. a.m. sitting in her room, no on. 6 a.m. sitting in the day room sion on the Weather Channel, d. p.m. sitting in day room her Channel, not actively mentation indicated R43 had ted in 10 activities in 1/14, 13 and 10 activities in 1/15. | F 24 | 48 | | |
| | R50 was not provid assessed need. | ed activities according to | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL ⁻ A. BUILDI | TIPLE CONSTRUCTION | | DATE SURVEY COMPLETED |
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| | | 245318 | B. WING | | | 01/29/2015 |
| | PROVIDER OR SUPPLIER | 7 - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 248 | Continued From page | age 6 | F 2 | 48 | | |
| | | Record dated 12/12/14, es of chronic obstructive airway sion and anxiety. | | | | |
| | R50 was cognitive | MDS dated 12/25/14, indicated ly intact and required minimal staff with transfers, ambulation the unit. | | | | |
| | | dicated R50 had felt the y important or somewhat | | | | |
| | do favorite activitlisten to musickeep up with thego outside to getwas good | | | | | |
| | and stated activities she would like, income weekends. R50 state provided much in that more activities | 4 p.m. R50 was interviewed as were not offered as often as luding on evenings and ated the facility had not the way of activities and if they s, she would go. R50 further is usually consisted of bingo | | | | |
| | | cked individualized and group d be of interest to R50. | | | | |
| | director (HL)-A war facility gathered re dislikes for activitie accommodate the | 6 p.m. the household life s interviewed and stated the sidents individual likes and es and then tried to resident's preferences. If a le to state what their | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | FIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
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| | | 245318 | B. WING | | 01 | /29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIF 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN | CODE | |
| (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 ACTIVE CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 248 | individualized prefebring them to an ad like bingo, music of further stated that rand many were spoidentify spontaneous from 1/26/15, through the nursing assistate individual resident activities the resident either assist them to activity. When asked the actual time to incresidents, HL-A state lack of an activities for R43 and Con 1/29/15, at 8:13 was interviewed an activities was limited and from an organi not have time to do residents as their was unaware if reswere on the care platime to look at the comprehensive assiphysical, mental an each resident. | erences were, the facility may extivity that may stimulate them is smaller group activities. HL-A not all activities were organized entaneous. HL-A was unable to us activities that had occurred 1/28/15. HL-A also stated into were to utilize the the care plans to identify what ents were interested in, and to the activity or initiate an ed if the nursing assistants had initiate activities with the sted probably not. HL-A verified ity care plan and a lack of ind R50. It a.m. nursing assistant (NA)-I did stated his involvement in ed to transporting residents to zed activity. NA-I stated he did is spontaneous activities with vere only two nursing esidents. NA-I further stated he ident individual preferences lan because he doesn't have | F 2 | 48 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245318 | B. WING | | 01/2 | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | : | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE NTERNATIONAL FALLS, MN 56649 | · | |
| (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 CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 248 | 11/3/14, indicated Fimpairment and wardisease and osteodindicated R26 was totally dependent upon and off the unit. R26's Activities Cardated 2/21/14, indice participation due to acute/chronic health and chronic health incontinence or pair activities would be R26's undated cardependent on staff cognitive stimulation care plan directed seedside/in-room visuand stimulation and include woodworking spouse, lawn work The care plan also music, or book on this room or laying of the control of the control of the whee At 5:30 p.m. NA-Fimeal. On 1/27/15, at 10:1 (FM)-B stated staff | nimum Data Set (MDS) dated R26 had severe cognitive is diagnosed with Alzheimer's arthrosis. The MDS also non-ambulatory and was pon one person for locomotion are Area Assessment (CAA) cated R26 had reduced activity physical disability, unstable the problems, cognitive deficits conditions such as n. The CAA indicated addressed on the care plan. The CAA indicated addressed on the care plan. The cate of the provide 1:1 sits to promote socialization of identified topics of interest to ng, R26's grandchildren and or keeping busy in the garage. directed staff to turn on TV, tape in room when R26 was in down. 2 p.m. R26 was observed lichair at the dining room table, was observed feeding R26 his 5 a.m. R26's family member did not encourage or bring M-B stated they "never did | F 248 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION | | TE SURVEY MPLETED |
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| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, 2 2201 KEENAN DRIVE INTERNATIONAL FALLS, MI | ZIP CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 248 | On 1/27/15, at 3:1 laying in bed. A ke place in the fellows without music, telev | ige 9 I p.m. R26 was observed no activity was currently taking hip hall. R26's room was vision or book on tape in use. 9 a.m. R26 was observed in | F 2 | 248 | | |
| | bed with the TV on 8:09 a.m. at which his left side and the remained the same R26 was observed wheelchair in the di At 8:59 a.m. R26 h was observed to re | R26 remained the same until time R26 was positioned on TV remained on. R26 until 8:21 a.m. At 8:47 a.m. dressed and seated in the ning room being fed breakfast ad completed his meal and main seated at the dining 3 a.m. At 9:56 a.m. R26 was | | | | |
| | facility did not do at FM-B stated she we group activities suc | p.m. FM-B again stated the nything with R26 for activities. buld, at times, bring R26 to h as bingo but stated she had visiting 1:1 or assisting R26 y kind. | | | | |
| | they were not awar | p.m. NA-D and NA-E stated e of any activities done for they would put his TV on but d. | | | | |
| | would take him to be stated R26 required could not tolerate s | p.m. NA-F stated R26's wife bingo at times. NA-F also d repositioning frequently and itting up for long periods so he any group activities. | | | | |
| | bed with the TV qui | 0:06 a.m. R26 was observed in letly on. No radio or tape ed in the room. The activity | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | ` ' | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
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| | | 245318 | B. WING | | 01/2 | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 248 | on 1/29/2015, at 10 have a player that it would occasionally do this once a wee activity they usually TV on. On 1/29/2015, at 10 was supposed to hassistants or home also taken to group at times so he coul Documentation Sumonths of Novemb January 2015 was revealed the follow -November 2014 - events (documentation sumonths of November 2014 - eve | a church service was 0 a.m. 0:08 a.m. NA-H stated R26 did read stories to him that they use. NA-H stated they might k or so. NA-H stated the only did for R26 was to leave the 0:12 a.m. HL-B stated R26 ave 1:1 visits with the nursing makers. HL-B stated R26 was activities in the fellowship hall d listen in. R26's rvey Report for activities for the per 2014, December 2014 and reviewed with HL-B and ing: documentation of 4 activity ation lacked name of activity documentation of 0 activity cumentation of 0 activity | F 248 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | CONSTRUCTION | | E SURVEY PLETED |
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| | | 245318 | B. WING | | | 01/2 | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | 220 | REET ADDRESS, CITY, STATE, ZIP CODE D1 KEENAN DRIVE TERNATIONAL FALLS, MN 56649 | • | |
| (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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 248 | admissions and ho | e plan. p.m. the director of usehold life (AHL) indicated | F 2 | 48 | | | |
| | ensure activities we there was no document:1 visits as directed | coordination with HL-B to ere provided. AHL verified mentation R26 had received ed on the care plan and ould have received 1:1 visits as | | | | | |
| | R19 was not provid assessed need. | ded activities according to | | | | | |
| | was diagnosed with The MDS also indicted and encouragement indicated R19's dail were identified as Finvolvement in care | dated 1/13/15, indicated R19 in dementia and depression. Cated R19 had severe int and required staff reminders int to attend activities. The MDS ily and activity preferences R19 enjoyed family e discussions, doing things with and participating in favorite | | | | | |
| | R19's activity goals | A dated 1/13/15, indicated were being met and this care ed as R19 had been included ctivities. | | | | | |
| | 1/20/15, indicated I included discussion newspapers, huntineasy listening musi | est Data Collection Tool dated his current leisure interests h/reminisce, magazines, ng/fishing, camping, listening to ic, he played the harmonica, tary service, animals/pets and | | | | | |

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| | | 245318 | B. WING _ | | 01/ | /29/2015 |
| | PROVIDER OR SUPPLIER | / - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIF 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN | CODE | |
| (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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 248 | Continued From page | age 12 | F 2 | 48 | | |
| | | plan lacked a focus area and identified R19's activity s. | | | | |
| | laying in his bed. F | D p.m. R19 was observed R19 did not attend the Keno in the fellowship hall. | | | | |
| | indicated there wa game scheduled. | O p.m. the activity calendar s a social hour with a card At this time, R19 was observed and did not participate in this | | | | |
| | R19's Documentat indicated the follow | ion Survey Report for activities ving: | | | | |
| | event (documental event) -November 2014 - event (documental event) -December 2014 - events (one being -January 2015- R1 | 19 participated in one activity tion lacked name of the activity R19 participated in one activity tion lacked name of the activity R19 participated in two activity the holiday potluck on 1/19/14) 9 participated in 9 activity bingo, small group, ball toss, | | | | |
| | On 1/28/15, at 10:0 homemakers were the fellowship hall. scheduled the home | B a.m. NA-E stated R19 did not ties. O4 a.m. HL-B stated the responsible for the activities in When an activity was nemakers were supposed to go sure the residents who wanted | | | | |

| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION IG | | TE SURVEY MPLETED |
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| | | 245318 | B. WING _ | | 01 | /29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP OF 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 5 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE |
| F 248 | to attend the activit stated the nursing responsible for cochowever they did a residents to the activity calendar the however nobody knexample, on 1/4/15 "couch potato" liste there was no time what this activity m On 1/28/15, at 1:50 no documentation participated in befoleoks pretty pathetic looks pretty pathetic on 1/29/15, at 1:25 director of admission were interviewed. Were normally iden plan. The HL-B corn R19's activity goals thought he had meadmitted she had redocumentation with had actually attend activity area of focus confirmed R19 had and that some of the more appropriate for listening to music, show in his room and harmonica. HL-B coleisure interest evalon 1/20/15, the interest on 1/20/15, the interest evalon 1/20/15, t | by got to the activity. She assistants were not ordinating the activities; ssist in transporting the tivities. O a.m. NA-E stated on the ey will have something listed, nows what it means. For 5, the activity calendar had ed as a scheduled activity, designated and nobody knows eans. O p.m. HL-B confirmed she had of what activities R19 had are 11/30/14. HL-B stated "it c." 5 p.m. the HL-B and the ons and household life (AHL) The AHL confirmed activities tified on each residents care afirmed she had just resolved son his care plan because she this goals; however the HL-B | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | | E SURVEY MPLETED |
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| | | 245318 | B. WING | | 01/ | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 249 SS=E | offered or participated. The Activity Program the facility would proprogram designed to physical, mental an each resident. In a focus on the cognitic community, social a individual resident. The Non-Traditional dated 6/12, indicated would be reflected and self-directed and self-directed and self-directed activity director wouresponse of the activities programalified professional who is applicable, by the Seligible for certificated specialist or as an arecognized accredition, 1990; or has 2 years or recreational program in a health occupational therapeter. | m policy dated 1/15, indicated ovide an ongoing activity to meet the interests and the d psychosocial well-being of ddition, the activities would tive, physical, spiritual, and creative needs of each and creative needs of each are settings and Activities policy at the residents interests in the planned, spontaneous ctivities offered. Also, the all monitor and evaluate the ivity program to determine if a of the resident have been all who is a qualified on specialist or an activities licensed or registered, if that in which practicing; and is it in as a therapeutic recreation activities professional by a ting body on or after October pars of experience in a social gram within the last 5 years, 1 the in a patient activities in a qualified obist or occupational therapy impleted a training course | F 2 | | | 3/4/15 |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | | E SURVEY IPLETED |
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| | | 245318 | B. WING | | 01/ | 29/2015 |
| | PROVIDER OR SUPPLIER | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP (2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 5 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE |
| F 249 | by: Based on intervier facility failed to end directed by a quali was responsible for implementation, suevaluation of the at This had the potent residing on 2 of 3 of the facility's Quali policy and proceduractivity program who fa social or recreatifive years, one of vactivities program On 1/27/15, at 9:00 admissions and hoshe had worked further years, but has not department for any verified she did no required per facility director. On 1/27/15, at 9:40 spent approximate activities and was admissions, referred. | INT is not met as evidenced w and document review, the sure the activity program was fied activity professional who or directing the development, apervision and ongoing ctivities program, as required. Itial to effect all residents units. Ifications of Activity Director are dated 6/12, indicated the ould be directed by a qualified and two years of experience in onal program within the last which was full-time in a patient within a health care setting. In a.m. the director of ousehold life (AHL)-C stated at the facility for three worked full time in the activity of those three years. DAHL-C thave the qualifications of policy to be an activities. In a.m. the AHL-C stated she also responsible for also responsible for als, discharge planning, social | F 2 | · | nas proper is a change in es the review the to ensure they ults will be | |
| | On 1/27/15, at 9:43 spent approximate activities and was admissions, referra services, volunteer management. | ly 25-30% of her time on also responsible for | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION G | (X3) DATE COMF | PLETED |
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| | | 245318 | B. WING | | 01/2 | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | | |
| (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 APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 249 | department as has administrator also v 30% of her time to 483.20(d), 483.20(k) | ked full time in the activity had multiple roles. The rerified AHL-C was allotted spend on activities. (1) DEVELOP | F 249 | | | 3/4/15 |
| SS=E | to develop, review a comprehensive plan for each reside objectives and time medical, nursing, an needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident's §483.10, including the under §483.10(b)(4) This REQUIREMENT by: Based on observative review, the facility facomprehensive car activity needs for 3 R19) reviewed for a second review of the rev | the results of the assessment and revise the resident's of care. It velop a comprehensive care ent that includes measurable tables to meet a resident's of mental and psychosocial tified in the comprehensive It describe the services that are train or maintain the resident's physical, mental, and eing as required under ervices that would otherwise exactly but are not provided as exercise of rights under the right to refuse treatment on the provided in the residence of the right to refuse treatment on the right to refuse treatment on, interview and document | | R43, R50 and R19 will have care printerventions developed to meet the activity needs. R43, R6, R29 and R have care plan interventions developed include the use of psychotropic medications. All residents will be re | eir 47 will oped to | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245318 | B. WING | | 01/ | 29/2015 | |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIF 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN | PCODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 279 | medications for 4 o R29) reviewed for u Findings include: R43's care plan wa individualized activi R43's Admission R diagnoses of blindin psychosis and majo R43's annual Minim 12/5/14, indicated R cognition, required staff with transfers had behaviors or ha were recently prese R43 felt tired or had more of the referen herself or that she v family down nearly she would be better in some way nearly The MDS also iden activities of interest - to have books, ne read - listen to music - be around animals - do things with gro - go outside to get f was good | f 5 residents (R43, R6, R47, innecessary medications. s not developed to include ty preferences and needs. ecord dated 7/13/12, indicated less in both eyes, unspecified or depressive disorder. num Data Set (MDS) dated R43 had severely impaired extensive assistance of one and locomotion on the unit and allucinations but none that ent. The MDS further indicated dittle energy about half or ce period days, felt bad about was a failure or had let her every day, had thoughts that off dead or of hurting herself every day. tified R43 felt the following were very important to her: wspapers and magazines to | F 2 | interventions developed to activity needs and to inclup psychotropic medications Leaders will be educated DAHL/designee on develointerventions to meet resign RN is will be educated by on developing care plan in monitor the side effects of DAHL/designee will audit care plans weekly for 4 with care plans are developed activity needs. DNS/design random resident care plans weeks to ensure care plandeveloped to monitor side medications. Results will apply QA committee for further recommendation. | ide the use of s. Household by oping care plan dent s needs. DNS/designeenterventions to f medications. random resident eeks to ensure to meet their mee will audit his weekly for 4 ns are effects of | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | IPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
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| | | 245318 | B. WING _ | | 0- | 1/29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP COD 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 5664 |)E | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 279 | individualized activity R50's Admission Ridentified diagnoses disease, hypertensing R50's admission M R50 was cognitively assistance of one sand locomotion on R50's MDS also incomposed following were very important to her: - do favorite activiticalisten to musicalisten to musicalisten to musicalisten to musicalisten to get for was good On 1/28/15, at 2:16 director (HL)-A state residents individual and then tried to accomprese to example activity or initiate and R50's care plantactivity or initiate and R50's care plantactivity care planta | s not developed to include ty preferences and needs. ecord dated 12/12/14, so of chronic obstructive airway ion and anxiety. DS dated 12/25/14, indicated y intact and required minimal staff with transfers, ambulation the unit. dicated R50 had felt the important or somewhat es news fresh air when the weather p.m. the household life ed the facility gathered each likes and dislikes for activities | F 27 | 79 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245318 | B. WING | | 01/2 | 29/2015 | |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | | | | |
| (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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE | |
| F 279 | Continued From pa | age 19 | F 279 | | | | |
| | | as not developed to include dress his activity needs. | | | | | |
| | was diagnosed with The MDS also indiccognitive impairme and encouragemer indicated R19's dail were identified as ecare discussions, opeople and particip | dated 1/13/15, indicated R19 in dementia and depression. Cated R19 had severe int and required staff reminders int to attend activities. The MDS and activity preferences enjoying family involvement in doing things with groups of pating in favorite activities. | | | | | |
| | R19's activity goals | A dated 1/13/15, indicated were being met and this care ed as R19 had been included ctivities. | | | | | |
| | 1/20/15, indicated I included discussion newspapers, huntineasy listening musi | est Data Collection Tool dated nis current leisure interests n/reminisce, magazines, ng/fishing, camping, listening to ic, he played the harmonica, tary service, animals/pets, and | | | | | |
| | director of admission were interviewed. Were normally iden plan. The HL-B corn R19's activity goals thought he had me admitted she had redocumentation with | 5 p.m. the HL-B and the ons and household life (AHL) The AHL confirmed activities tified on each residents care nfirmed she had just resolved son his care plan because she this goals; however the HL-B not checked R19's regards to what activities R19 ed prior to her resolving R19's | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 245318 | B. WING | | 01/2 | 29/2015 |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS | | | : | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY) | D BE | (X5) COMPLETION DATE |
| F 279 | confirmed R19 had and that some of the more appropriate for listening to music, as box in his room, an harmonica. HL-B coleisure interest eval on 1/20/15, the interest or match up with the offered or participate. The Care Plan policing resident would have comprehensive care achieving and main medical, nursing, premotional, psychose. The Comprehensive Conferences procedure plan would be | s on his care plan. HL-B severe cognitive impairment e activities which would be or R19 would be 1:1 visits, spending time with the tinker d encouraging him to play his onfirmed according to R19's fuation that had been reviewed rests R19 had identified did he activities R19 had been sed in. by dated 9/12, indicated each e plan directed toward taining each resident's optimal hysical, functional, spiritual, ocial and educational needs. e Care Plan and Care dure dated 6/14, specified the comprehensive and the ed would meet the resident's | F 279 | | | |
| | risperdal (an antips or behavioral interv R43's Medication R was diagnosed with physician's orders of order for risperdal (mouth) twice a day | deview Report indicated R43 a unspecified psychosis. R43's dated 1/20/15, identified an 0.125 milligrams (mg) po (by for psychosis, and may 125 mg in the a.m. and 0.25 | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|--|---|--------------|-------------------------------|--|
| | | 245318 | B. WING | | 01/29 | 9/2015 | |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | 1 01/25/2010 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| F 279 | had severely impain hallucinations, but present. The MDS or had little energy felt bad about hers had let her family of thoughts that she whurting herself in som MDS documented hallucinations/delusibehaviors were should be hallucinations/behaviors/behaviors/behaviors/siteractions if R43 | dated 12/5/14, indicated R43 red cognition, had behaviors or none that were recently further identified R43 felt tired about half or more of the days, elf or that she was a failure or lown nearly every day, and had would be better off dead, or of ome way nearly every day. The R43 had behaviors of sions, however it indicated no own. | F 27 | 9 | | | |
| | Seroquel (an antiper behaviors nor behaviors nor behaviors nor behaviors nor behaviors nor behaviors may be a diagnoses that included 12/15 po three times a day 25 mg as needed up between midnight at the included trouble asleep, or sleeping having little energy | not address the use of sychotic medication), avioral interventions. eview Report indicated uded senile dementia, and paranoia. R6 's physician's 1/14, directed Seroquel 25 mg ay, 75 mg po at bedtime, and up to two times in 24 hours and 4:00 a.m. for paranoia. So dated 10/24/14, indicated R6 act, and had mood problems le falling asleep or staying too much, and feeling tired or nearly every day. The MDS 6 had no hallucinations or | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|---|---|-------------------------------|----------------------------|
| | | 245318 | B. WING _ | | 01 | /29/2015 |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS | | | | STREET ADDRESS, CITY, STATE, ZIP C 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56 | ODE | |
| (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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 279 | paranoia, staff inte | not address behaviors of rventions with paranoia, use of otential side effects of the | F 27 | 79 | | |
| | Seroquel. 01/29/15, at 9:46 a was interviewed ar risperdal on the ca Seroquel on the ca | .m. registered nurse (RN)-A nd verified the lack of the use of re plan for R43, and the lack of the plan for R6. | | | | |
| | expect nursing star what to include on R47's care plan lad | ewed and stated she would ff to follow the facility policy on the care plan. cked interventions regarding nticoagulation medication | | | | |
| | R47 was cognitived anticoagulation metworks to prevent the R47's undated Adriad diagnoses that (quivering or irregulated compandid the related to one vertical half | OS dated 12/2/14, indicated y intact and received edication (medication that he clotting of the blood) daily. Inission Record indicated R47 to included atrial fibrillation elar heartbeat that can lead to heart failure and other edications), rheumatoid arthritis, tion and hemiplegia (paralysis of the body) Review Report dated 1/19/15, | | | | |
| | included orders for | warfarin sodium give 2 mg by day every Sunday, Monday, | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 245318 | B. WING | | 01/ | 29/2015 | |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | | | | |
| (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 SHOUNDER CROSS-REFERENCED TO THE APPRINT DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | |
| F 279 | Continued From pa | age 23 | F 279 |) | | | |
| | Tuesday, Thursday | y, Friday and Saturday and give ery Wednesday related to atrial | | | | | |
| | | Administration (FDA) black box varfarin sodium can cause ding. | | | | | |
| | | rent care plan did not address ntial side effects of warfarin. | | | | | |
| | (RN)-B verified that | :48 p.m. registered nurse t monitoring of warfarin was he current care plan. | | | | | |
| | nursing (DON) stat and procedures we DON confirmed the | 2:23 p.m. the director of ed her expectation was policy are to be followed at the facility. It is facility policy directed staff to swith black box warnings on | | | | | |
| | Conference policy of interdisciplinary teal was comprehensive included physicians were currently bein | re Care Plan and Care dated 6/14, indicated the am would ensure the care plan e by incorporating items that s' orders and diagnoses that g treated, and adverse "black box" warnings for | | | | | |
| | monitoring interven effects related to th antipsychotic) and | I not address appropriate ations for potential adverse se use of Zyprexa (an Remeron (an antidepressant). | | | | | |
| | K29's physician's o | orders dated 11/18/14, included | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---|--|------------------------------|-------------------------------|--|
| | | 245318 | B. WING | | 01 | /29/2015 | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 279 | Continued From pa | ge 24 | F 2 | 79 | | | |
| | Zyprexa 5 mg in the for dementia with L | e evening, starting on 8/15/14, ewy Bodies and Remeron 15 starting on 8/15/14, for | | | | | |
| | R48 had impaired of behaviors, R29 rejectivity during the assessment | S dated 12/18/14, identified cognition, had no psychosis or ected cares one to three days nent period and had received ntidepressant medication | | | | | |
| | indicated R29's dia | is Report dated 1/29/15, gnoses included dementia with ehavioral disturbances and | | | | | |
| | 11:00 a.m. to 1:45 peyes or talk when s | ly observed on 1/27/15, from o.m., R29 would not open her poken to until the staff then R29 opened her eyes, | | | | | |
| | awake and eating be However, one the s | a.m. R29 was observed breakfast with staff assistance. Same day, during the lunch t open her eyes or eat any | | | | | |
| | care plan did not ac potential risks or sic the Remeron. The book and should kr | 7 a.m. RN-B confirmed R29's ddress monitoring for the de effects of the Zyprexa or RN stated the staff had a drug now the side effects of buld be a standard of care, | | | | | |
| | The facility policy a | nd procedure on Care Plan | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | IPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---------------------|--|-------------------------------------|--|
| | | 245318 | B. WING _ | | 01/29/2015 | |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 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) | D BE COMPLÉTION | |
| F 279 F 282 SS=D | dated 9/12, directed individualized comp will include measur directed toward ach resident's optimal infunctional, spiritual, educational needs. 483.20(k)(3)(ii) SEF PERSONS/PER CATThe services provided by the services pro | d each resident will have an orehensive plan of care that able goals and timetables nieving and maintaining the nedical, nursing, physical, emotional, psychosocial and RVICES BY QUALIFIED | F 25 | | 3/4/15 | |
| | by: Based on observat review, the facility for repositioning intervery plan for 1 of 3 resid pressure ulcers. The activity intervention for 1 of 4 residents Findings include: R63 was not reposit directed by her care R63's Diagnosis Re R63's diagnoses as neck of the femur (leg), dementia, righ (wound with full this subcutaneous fat mere) | entions as directed by the care ents (R63) reviewed for the facility also failed to provide is as directed by the care plan (R26) reviewed for activities. | | R63 is being repositioned per their plan and R26 s care plan interver for activities are being followed. All residents receiving repositioning a activities were identified to ensure care plans are being followed. All household staff will be educated b DNS/designee on following reside plans. DNS/designee will audit repositioning weekly for 4 weeks to ensure care plans are being follow DAHL/designee will audit activity interventions weekly for 4 weeks to ensure care plans are being follow Results will be forwarded to QA committee for further recommendations. | ntions I nd their y nt care o ved. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|------------------------|---|-------------------------------|----------------------------|
| | | 245318 | B. WING | | 01. | /29/2015 |
| | PROVIDER OR SUPPLIER | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP (2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 5 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE |
| F 282 | R63's care plan dat R63 had a pressure immobility and directurning/repositionin. On 1/28/15, at 7:00 in bed, positioned on ursing assistant (Norom and proceeds brief. R63 was brief rolled to her right si required changing. was wet. While R63 opened the brief and of the brief under the slightly off of her back for n NA-E and NA-D att pillow between R63 again on her back. positioned on her beffective offloading hour). On 1/28/15, at 10:1 (RN)-C stated repoeither assisting her wheelchair, or turned her back. RN-C coconsider R63 to be change if R63 had than one minute wheelchair or minute wheelchair one minute | ge 26 ysema (a chronic respiratory decrease in lung function). ged 12/16/14, identified that e ulcer related to her cted staff to assist her with g at least every two hours. a.m. R63 was observed lying on her back. At 8:15 a.m. NA)-E and NA-D entered R63's ed to change her incontinent fly (less than ten seconds) de to determine if the brief NA-D confirmed R63's brief 3 remained on her back, NA-D and NA-E tucked the right sides he resident. NA-E rolled R63 and NA-D removed the wet of the new brief (R63 was not no more than 30 seconds). The ached the new brief, placed a cteres and positioned R63 R63 was observed to remain ack without repositioning or assistance until 10:00 a.m. (3) 7 a.m. registered nurse sitioning for R63 included out of her bed into her ed from side to side, including infirmed she would not repositioned during a brief not been offloaded for greater hile her brief was being infirmed she expected the staff | F 2 | 82 | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | TIPLE CONSTRUCTIONS | | | E SURVEY MPLETED | |
|--|--|--|---------------------|---------------|---|---------------------|----------------------------|
| | | 245318 | B. WING | | | 01/ | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | 2201 KEENAN D | SS, CITY, STATE, ZIP CODE DRIVE IAL FALLS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH (| VIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU REFERENCED TO THE APPRO DEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| F 282 | confirmed three ho R63 being reposition On 1/28/15, at 11:2 confirmed R63 had position and not off minute when they of On 1/29/15, at 9:10 (DON) verified staff R63 every two hour The Skin Assessment Prevention policy down | urs was too long to go without | F 2 | 82 | | | |
| | R26's undated cardependent on staff cognitive stimulatio care plan directed shedside/in-room vis and stimulation and include woodworkin spouse, lawn work The care plan also music, or book on this room or laying of On 1/26/15, at 5:22 seated at a table in | e plan indicated R26 was and family for activities, n, and social interaction. The staff to provide 1:1 sits to promote socialization didentified topics of interest to ng, R26's grandchildren and or keeping busy in the garage. directed staff to turn on TV, ape in room when R26 was in | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | LE CONSTRUCTION | | E SURVEY PLETED | |
|---|---|--|---------------------|---|--------------------|----------------------------|
| | | 245318 | B. WING | | 01/: | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | : | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE NTERNATIONAL FALLS, MN 56649 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 282 | Continued From pa | nge 28 5 a.m. R26's family member | F 282 | | | |
| | (FM)-B stated staff | did not encourage or bring M-B stated they "never did | | | | |
| | laying in bed. A ker place in the fellows | 1 p.m. R26 was observed no activity was currently taking hip hall. R26's room was vision or book on tape in use. | | | | |
| | bed with the TV on 8:09 a.m. at which his left side and the a.m. R26 was obse the wheelchair in th breakfast. At 8:59 meal and was obse dining room table up | 9 a.m. R26 was observed in R26 remained the same until time R26 was positioned on TV remained on. At 8:47 erved dressed and seated in the dining room being fed a.m. R26 had completed his erved to remain seated at the Intil 9:23 a.m. At 9:56 a.m. in bed with the TV on. | | | | |
| | facility did not do at FM-B stated she w group activities suc | p.m. FM-B again stated the nything with R26 for activities. ould, at times, bring R26 to the as bingo but stated she had visiting 1:1 or assisting R26 y kind. | | | | |
| | they were not awar | p.m. NA-D and NA-E stated e of any activities done for they would put his TV on but d. | | | | |
| | R26's wife would ta stated R26 required could not tolerate s | p.m. NA-F stated at times, lke him to bingo. NA-F also d repositioning frequently and itting up for long periods so he I any group activities. | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | TIPLE CONSTRUCTION ING | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|------------------------|--|-----------------------------------|----------------------------|
| | | 245318 | B. WING | | 01. | /29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, Z 2201 KEENAN DRIVE INTERNATIONAL FALLS, MM | IP CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 282 | On 1/29/2015, at 10 laying in bed with the tape player was obsactivity calendar incomplete scheduled for 10:00 on 1/29/2015, at 10 have a player that roccasionally use. Nonce a week or so, they usually did for On 1/29/2015, at 10 (HL)-B stated R26 was activities in the fellocould listen in. R26's Documentation for the months of N2014 and January 2 and revealed the formulation of the months of N2014 and January 2 and revealed the formulation of N2014 and January 2 and revealed the formulation of N2014 and January 2 and revealed the formulation of N2014 and January 2 and revealed the formulation of N2014 and January 2015 and revents. HL-B indicated the formulation of N2014 and January 2015 and revents. HL-B indicated the formulation of N2014 and January 2015 and revealed R26 attention of N2014 and R26 attention of R26 attentio | 2:00:06 a.m. R26 was observed elevision quietly on. No radio or served in the room. The dicated a church service was 0 a.m. 2:08 a.m. NA-H stated R26 did ead stories to him they would NA-H stated they might do this NA-H stated the only activity R26 was to leave the TV on. 2:12 a.m. household leader was supposed to have 1:1 ng assistants or homemakers. as also taken to group whip hall at times so he 2:015 was reviewed with HL-B llowing: documentation of 4 activity tion lacked name of activity documentation of 0 activity cumentation of 0 activity e were additional activity | F 2 | 282 | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---|--|------|-------------------------------|--|
| | | 245318 | B. WING _ | | 01/ | 29/2015 | |
| _ | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | • | | |
| (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) COMPLETION DATE | |
| F 282 F 314 SS=D | on 12/31/14,1/6/15 there were no other documented for R2 have had 1:1 visits. expected staff to pr directed by the care On 1/29/15, at 2:44 admissions and hor she worked in coord activities were proving documentation of directed on the care should have received. The Comprehensive Conferences proce resident-specific cate to meet the physical The Care Plan polic resident would have comprehensive car and maintain the re physical, and nursing 483.25(c) TREATM PREVENT/HEAL P Based on the comp resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoida pressure sores received. | and 1/7/15. HL-B verified ractivities and no 1:1 activities 6 and confirmed R26 should HL-B stated she would have ovide 1:1 activities for R26 as a plan. p.m. the director of usehold life (AHL) indicated dination with HL-B to ensure ided. AHL verified there was R26 had received 1:1 visits as a plan and confirmed R26 and 1:1 visits as directed. e Care Plan and Care dure dated 6/14, indicated a re plan should be developed all, needs of the resident. by dated 9/12, indicated each an individualized e plan developed to achieve sident's optimal medical, and needs. ENT/SVCS TO RESSURE SORES brehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that a healing, prevent infection and the healing, prevent infection and | F 28 | | | 3/4/15 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | , , | PLE CONSTRUCTION G | | E SURVEY PLETED |
|--|--|---|---------------------|---|--|----------------------------|
| | | 245318 | B. WING _ | | 01/2 | 29/2015 |
| | PROVIDER OR SUPPLIEF | Y - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZII 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 314 | by: Based on observareview, the facility and repositiong for identified with an arequired every two Findings include: R63's Diagnosis FR63 was diagnose the neck of the fer lower leg), demen hip stage 3 (wound tissue, subcutaned tendon or muscle tunneled) pressure emphysema (a chocausing a decrease R63's care plan day had a pressure und directed staff to as repositioning at least R63's Positioning at least R63's Admission R63's a | age 31 ENT is not met as evidenced ation, interview and document failed provide timely turning r 1 of 3 residents (R63) active pressure ulcer and hour turning and repositioning. Report dated 12/16/14, indicated ed with a pathologic fracture of mur (bone of the thigh, upper tia, anxiety, panic disorder, right d with full thickness loss of ous fat may be visible but bone, are not exposed, may be elucer, arthritis, and ronic respiratory disease te in lung function). Acted 12/16/14, indicated R63 cer related to immobility and test every two hours. Assessment and Evaluation dicated R63 was unable to hanges in position without to her weakness and bilateral ractures. In addition, a ram should be implemented. Minimum Data Set (MDS) dated d R63 had moderate cognitive equired extensive assist with offerring, toileting and personal | F 31 | | d per plan their e. All residents ere identified to being followed. aff was educated esitioning icare. epositioning sure care plans ts will be | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , | LE CONSTRUCTION | | E SURVEY MPLETED |
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| | | 245318 | B. WING | | 01/ | /29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE NTERNATIONAL FALLS, MN 56649 | | |
| (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 SHOUNDERSON CROSS-REFERENCED TO THE APPRINTED DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 314 | Continued From pa | _ | F 314 | | | |
| | and had an existing | | | | | |
| | 12/23/14, indicated repositioning in bed also indicated R63 pressure ulcer with plan which included | ssessment (CAA) dated I R63 required assistance with d and wheelchair. The CAA had an existing stage 3 a recommended treatment d a pressure relief mattress, in place and a scheduled dule. | | | | |
| | predicting risk for p dated 1/13/15, ider development of a p intervention guide i | e Assessment (tool for pressure sore development) of the pressure ulcer and the precommended R63 should be and have a planned turning | | | | |
| | | ord revealed the following with of wound measurement: | | | | |
| | - width, 0.8 cm - de -12/24/14 - 1.5 cm cm-depth. Comme the perimeter of the perimeter came in causing tissue dam increased in length instructed to ensure the wound bed. -1/2/15 - 0.9 cm - le depth | timeters (cm) - length, 0.5 cm epth length, 0.5 cm - width, 0.8 ent indicated that the outside of e wound, most probable the contact with the dressing, hage to good skin and causing a. As an intervention, staff was e the dressing only contacted ength, 0.5 cm - width, 1.2 cm - length, 0.4 cm - width, 1.0 cm | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | LE CONSTRUCTION | | E SURVEY PLETED | |
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| | | 245318 | B. WING | | 01/: | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE NTERNATIONAL FALLS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 314 | - depth On 1/28/15, at 7:00 | length, 0.4 cm - width, 0.8 cm a.m. R63 was observed lying on her back, twisted at the | F 314 | | | |
| | waist with her legs chest and left side. (NA)-E and NA-D e proceeded to change (less than ten seconder to determine NA-D confirmed Reference on the seconder to determine NA-D confirmed Reference on the seconder to determine NA-E tucked the resident. NA-E back, NA-D remove new brief and return was not off of her beseconds). NA-E are and placed a pillow R63 positioned on with her legs bent to left side. R63 was con her back without offloading until 10:00 | bent upwards towards her At 8:15 a.m. nursing assistant entered R63's room and ge her brief. R63 was briefly nds) rolled to her right side in if the brief required changing. 33's brief was wet. While R63 ack, NA-D opened the brief ne right sides of the brief under rolled R63 slightly off of her ed the wet brief, positioned the ned R63 onto her back (R63 ack for no more than 30 and NA-D fastened the new brief between R63's knees and left ther back, twisted at the waist upwards towards her chest and observed to remain positioned to repositioning or effective 30 a.m. (3 hours). | | | | |
| | was observed to coulcer's daily dressin ulcer was observed area with minimal odressing when rem wound were pink, toss of tissue and so be tunneled. LPN-0 | sed practical nurse (LPN)-C onduct R63's right hip pressure of change. R63's pressure I to be located on her right hip drainage observed on the oved. The margins of the he wound had full thickness kin, however didn't appear to C did not reposition the uring or after conducting the | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|---|------------------------------------|----------------------------|
| | | 245318 | B. WING | | 0. | 1/29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, 2201 KEENAN DRIVE INTERNATIONAL FALLS, M | ZIP CODE | |
| (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 | CTION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 314 | entered R63's roon They gathered thei positioned on to he was observed. R63 from open areas ho coccyx area were of her back had a rais stated was much in On 1/28/15, at 10:1 (RN)-C stated repo- either out of her be turned from side to RN-C confirmed sh be repositioned dur R63 had not been of minute while her br confirmed she expert plan with regards to hours. In addition I was too long to go or offloaded. On 1/28/15, at 11:2 confirmed R63 had position and not off minute when they of On 1/29/15, at 9:10 (DON) verified staf- R63 every two hour The Positioning As policy dated 3/2008 determine an indivi | and name of a na | F3 | 14 | | |

| TIPLE CONSTRUCTION ING | (X3) DATE SURVEY COMPLETED | |
|---|--|--|
| | 01/29/2015 | |
| STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | | |
| X (EACH CORRECTIVE ACTION SHOULD | BE COMPLÉTION | |
| | 3/4/15 | |
| | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
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| | | 245318 | B. WING | | 01/2 | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 201 KEENAN DRIVE NTERNATIONAL FALLS, MN 56649 | | |
| (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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 322 | Continued From pa | ge 36 | F 322 | | | |
| | by: Based on observatoreview, the facility of gastrostomy tube (of the stomach for foot medication administ (R48) observed for through a G-tube. Findings include: R48's Diagnosis Resultant R48's diagnoses in swallowing) due to pulmonary (lungs) is recurrent pneumon R48's care plan data required a tube fee mouth). On 1/28/15, at 11:5 (LPN)-C was obsert of R48's Baclofen 1 G-tube. The LPN with medication, crushed dissolved the medic milliliters (ml) of water and attached an extended and extended and extended in approximation. | tion, interview and document ailed to check placement of a G-tube, a tube which goes into a dand or medications) prior to stration for 1 of 1 residents medication administration eport dated 1/28/15, indicated cluded dysphagia (difficulty cerebrovascular disease, nsufficiency and a history of ia. ted 10/3/14, indicated R48 ding and was NPO (nothing by 5 a.m. licensed practical nurse ved during the administration 0 milligrams (mg) via the rashed her hands, obtained the dathe medication and then cation in approximately 20 ter. The LPN donned gloves tension tube to a port near a. The LPN then attached the ringe to the extension tube and rately 15 cc of water, poured in the owed by approximately 15 cc of | | R48 s G-tube placement is being verified prior to administration of medication. All residents with a g-tube identified to ensure placement is verified prior to administration of medication. All licensed nurses will educated by DNS/designee on verig-tube placement prior to administration. DNS/designee will aud times a week for 4 weeks that g-tubplacement is being verified prior to administration of medication. Resulbe forwarded to QA committee for frecommendation. | be fying ation of it three be | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | | | TE SURVEY MPLETED | |
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| | | 245318 | B. WING | B. WING | | 01/29/2015 | |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (X5) COMPLETION DATE | |
| F 322 | water and then put the syringe pushing tube. LPN-C did no G-tube prior to adm medication. LPN-C always gave R48's for placement of the short peg that goes On 1/29/15, at 8:30 reviewed the facility checked placement medication. On 1/29/15, at 2:00 (DON) stated she was care plan and "if the then they should." Twould expect staff to | the plunger into the barrel of air in to clear the extension to check for placement of the inistering the water and stated that was the way she medication and did not check to G-tube because R48 had a into the stomach. a.m. LPN-C stated she had a policy and should have to prior to administering R48's p.m. the director of nursing would expect staff to follow the exact plan directed to do so the DON also stated she of follow the policy. | F 3. | 22 | | | |
| F 329 SS=D | policy revised 11/13 checked for placem administering media staff to check pater use a syringe and in aspirate gastric corn in the stomach. 483.25(I) DRUG REUNNECESSARY DEACH resident's druunnecessary drugs drug when used in duplicate therapy); without adequate mindications for its use | ation Administration Via Tube 8, indicated the tube should be nent and patency prior to cation. The policy directed acy and position of the tube, nject 5-10 ml of air then attents to ensure the tube was eGIMEN IS FREE FROM RUGS g regimen must be free from and An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of aces which indicate the dose | F 3. | 29 | | 3/4/15 | |

| - | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM | | , , | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 245318 | B. WING | | | 01/29/2015 | | |
| _ | PROVIDER OR SUPPLIER | Y - INTERNATIONAL FALLS | | 22 | REET ADDRESS, CITY, STATE, ZIP CODE 201 KEENAN DRIVE ITERNATIONAL FALLS, MN 56649 | <u> </u> | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 329 | combinations of the Based on a compresident, the facility who have not use given these drugs therapy is necess as diagnosed and record; and resided drugs receive graph behavioral interversidents. | rehensive assessment of a ty must ensure that residents d antipsychotic drugs are not unless antipsychotic drug ary to treat a specific condition documented in the clinical ents who use antipsychotic dual dose reductions, and ntions, unless clinically an effort to discontinue these | F3 | 329 | | | | |
| | by: Based on intervier facility failed to en were monitored, in was identified for reviewed for unner Findings include: R6 did not have a attempted nor just for use identified for Seroquel (an antiput R6's Medication For diagnoses that including insomnia, anxiety orders dated 12/1 | ew and document review, the sure antipsychotic medications nanaged and justification of use 2 of 5 residents (R6, R43) cessary medications. gradual dose reduction tification / adequate indications or the continued use of psychotic medication). Review Report indicated cluded senile dementia, and paranoia. The physician's 5/14, directed Seroquel 25 of (by mouth) three times a day, | | | R6 s Seroquel and R43 s risperd be reviewed for appropriate use and necessary action will be taken to en they are free from unnecessary medications in accordance with our and procedure. All residents receiving antipsychotic medications will be reviewed for appropriate use and necessary will be taken to ensure they are free unnecessary mediations in accordance with our policy and procedure. All licentary and procedure and procedure and psychopharmacological medications policies and procedures. DNS/design will also educate all household staff appropriately care planning and documenting mood/behaviors. | policy ng viewed action from nce censed signee | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245318 | B. WING | | | 01/2 | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONAL FALLS | | 22 | REET ADDRESS, CITY, STATE, ZIP CODE 201 KEENAN DRIVE ITERNATIONAL FALLS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | X | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 329 | two times in 24 hou a.m. for paranoia. R6's quarterly Minii 10/24/14, indicated had mood problem asleep or staying a and feeling tired or every day. The MD hallucinations or de R6's care plan did paranoia, staff interepisodes, use of Seffects of the Serod On 1/29/15, at 9:46 was interviewed an addressed on the owere no behaviors. reduction had been not successful and attempted since that R43 was not monit justification/adequarisperdal (an antips R43's Medication Fdiagnoses that incl The physician's ordan order for risperodiagnosis of psycholo.125 mg in the a.r. hallucinations returns the results of the production of the physician's ordan order for risperodiagnosis of psycholo.125 mg in the a.r. hallucinations returns the parameter of the param | mum Data Set (MDS) dated R6 was cognitively intact and s that included trouble falling sleep, or sleeping too much having little energy nearly S further identified R6 had no elusions. The address behaviors of trentions for paranoid eroquel nor potential side quel. To a.m. registered nurse (RN)-A ad stated if behaviors were not eare plan, it was because there RN-A stated a gradual dose attempted on 8/13, but was a reduction had not been at time. The address before the complete of the com | F3 | 29 | DNS/designee will randomly audit antipsychotic medications to ensure residents are free from unnecessal medications. Audits will be done we for 4 weeks. Results will be forward QA committee for further recommendation. | y eekly | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ' | FIPLE CONSTRUCTION NG | | TE SURVEY MPLETED | |
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| | | 245318 | B. WING | ····· | 01 | /29/2015 |
| | PROVIDER OR SUPPLIER | - INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP C 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 5 | CODE | |
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| F 329 | hallucinations, but present. The MDS or had little energy felt bad about hers had let her family of thoughts that she whurting herself in s MDS documented hallucinations/delu behaviors were she R43's care plan did hallucinations/beha hallucinations / del risperdal or potention on 1/29/15, at 9:28 and stated R43's cabehaviors because behaviors at this time monitoring had not On 1/29/15, at 1:08 (DON) was intervise expect staff to follo dose reduction of promitoring of side justification/adequate psychotropic medical The facility policy a Psychopharmalogi Sedative/Hypnotics and behavior, side effective indicate the behavior, side effective indicate the sentence of | red cognition, had behaviors or none that were recently further identified R43 felt tired about half or more of the days, elf or that she was a failure or down nearly every day, and had would be better off dead or of ome way nearly every day. The R43 had behaviors of sions, however it indicated no own. If not address behaviors of aviors, staff interventions with usions / behaviors, use of al side effects of the risperdal. If a.m. RN-A was interviewed are plan and monitoring lacked are plan and monitoring lacked are R43 was not having any me. RN-A verified side effect been done. If p.m. the director of nursing ewed and stated she would by the policy regarding gradual psychotropic medications, effects, and monitoring for ate indication for use of cation. | F 3. | 29 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION IG | (X3) DAT | TE SURVEY MPLETED | |
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| | 245318 | B. WING _ | | 01/ | /29/2015 | |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - | INTERNATIONAL FALLS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 5664 | | | |
| PRÉFIX (EACH DEFICIENCY I | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| | | | | | | |

Good Samaritan Society International Falls, MN January 29, 2015

241 - D

Based on observation, interview and document review the facility failed to ensure dignity was maintained during toileting for 1 of 1 resident (R3) reviewed for incontinence

248 - E

Based on observation, interview and document review the facility failed to provide activities to meet the individual interests for 4 of 4 residents (R43, R50, R26, R19) reviewed for activities.

249 - E

Based on interview and document review the facility failed to provide a qualified activity director. This had the potential to affect 2 of 3 households in the facility.

279 - E

Based on observation, interview and document review the facility failed to develop care plan interventions to meet the activity needs of 3 of 4 residents (R43, R50, R19) reviewed for activities. In addition, the facility failed to develop care plan interventions to monitor the side effects of medications for 4 of 5 residents (R43, R6, R29, R47) whose medications were reviewed.

282 - D

Based on observation, interview and document review the facility failed to ensure care plan interventions for repositioning were followed 1 of 3 residents (R63) reviewed for pressure ulcers. The facility also failed to ensure care plan interventions for activities were followed for 1 of 4 residents (R26) reviewed for activities.

314 - D

Based on observation interview and document review the facility failed to ensure a repositioning and turning program had been followed for 1 of 3 residents (R63) identified with a pressure ulcer.

322 - D

Based on observation, interview and document review the facility to ensure gastrostomy (G-tube) placement was verified prior to administration of medications for 1 of 1 resident (R48) who received medications via G-tube.

329 - D

Based on observation, interview and document review, the facility failed to ensure psychotropic medications were monitored and managed appropriately for 2 of 5 residents (R43, R6) whose medication regimens were reviewed. State Licensing:

4658.0810 -

Based on interview and document review the facility failed to ensure 4 of 5 residents (R3, R16, 50, R63) received tuberculin skin testing (TST) according to the CDC guidelines. In addition, the facility failed to ensure 1 of 5 new employees received TST according to the CDC guidelines.

144.6503 -

Based on interview and document review the facility failed to ensure Alzheimer's training was provided for employees. In addition, the facility failed to provide consumers with written information regarding the Alzheimer's training program.

F5318024

Printed: 01/29/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 03 - 2013 BUILDING

(X3) DATE SURVEY COMPLETED

245318

B. WING

01/28/2015

NAME OF PROVIDER OR SUPPLIER

GOOD SAMARITAN SOCIETY - INTERNATION

STREET ADDRESS, CITY, STATE, ZIP CODE

2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

| | INTER | NATIONAL | FALLS, MN 56649 | |
|--------------------------|--|---------------------|---|----------------------------|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| K 000 | INITIAL COMMENTS | K 000 | | |
| | FIRE SAFETY | | | |
| | 03 2013 Building | | | |
| | A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Good Samaritan Society International Falls 03 2013 Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancy. | | | |
| | The Good Samaritan Society International Falls is a new 1-story building, no basement, and was determined to be Type V (111) construction. The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition) with quick response sprinkler heads. The building is separated from the new assisted living building with a 2-hour fire barrier. | | | |
| | The facility has automatic smoke detectors that are on the fire alarm system, throughout the corridor system, in all areas open to the corridor and in all sleeping rooms. It is installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition) and the Minnesota State Fire Code 2007 edition. The fire alarm system is monitored for automatic fire department notification. | | | |
| | The building is divided into 3 smoke compartments by 1-hour smoke barriers and 2-hour fire barriers. | | | |
| LABORATOR | RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG | NATURE | TITLE | (X6) DATE |

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

(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.

Printed: 01/29/2015 FORM APPROVED OMB NO. 0938-0391

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE | R/CLIA //BER: | | PLE CONSTRUCTION G 03 - 2013 BUILDING | (X3) DATE S COMPL | (X3) DATE SURVEY COMPLETED | |
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| | | 245318 | | B. WING_ | NG 01/28 | | | |
| | PROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | | | |
| GOODS | SAMARITAN SOCIE | TY - INTERNATION/ | | EENAN DE IATIONAL | RIVE .FALLS, MN 56649 | | | |
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| | census of 54 at the | | | | | | | |
| | The facility was sur | veyed as one buildin | g. | | | | | |
| | The requirement at are MET. | 42 CFR, Subpart 48 | 3.70(a) | | | | 32 | |
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Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted February 11, 2015

Mr. Adam Coe, Administrator Good Samaritan Society - International Falls 2201 Keenan Drive International Falls, Minnesota 56649

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5318025

Dear Mr. Coe:

The above facility was surveyed on January 26, 2015 through January 29, 2015 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

Good Samaritan Society - International Falls February 11, 2015 Page 2

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

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

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

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 at (218) 308-2104 or email: lyla.burkman@state.mn.us.

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

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

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 Health Regulation Division Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

5318s15lic

PRINTED: 02/24/2015 FORM APPROVED

(X6) DATE

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE COMP | SURVEY | |
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| | | 00322 | | B. WING | | 01/2 | 9/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | 5 | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
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| 2 000 | Initial Comments | | | 2 000 | | | |
| | ****ATTE | NTION***** | | | | | |
| | NH LICENSING | CORRECTION ORDE | R | | | | |
| | 144A.10, this correct pursuant to a surve found that the deficit herein are not corrected shall I | Minnesota Statute, section order has been is y. If, upon reinspection iency or deficiencies ciected, a fine for each vibe assessed in accordines promulgated by reartment of Health. | sued n, it is ited iolation ance | | | | |
| | 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 | nether a violation has becompliance with all rule provided at the table number indicated bens several items, failure the items will be consided to Lack of compliance uny item of multi-part rument of a fine even if turing the initial inspections. | ng elow. e to dered ipon ile will he item | | | | |
| | that may result from orders provided tha the Department with | hearing on any assess n non-compliance with t a written request is m nin 15 days of receipt on t for non-compliance. | these nade to of a | | | | |
| | receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st | participate in the elect nsure orders consister artment of Health in 14-01, available at tate.mn.us/divs/fpc/pro e licensing orders are | nt with | | | | |

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

Electronically Signed 02/20/15

TITLE

STATE FORM 6899 QBED11 If continuation sheet 1 of 51

| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INTERNATIONA (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG CONTINUED FROM THE ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" 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. On January 26th, 27th, 28th and 29th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have | | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | o. ` ′ | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: | | |
|--|---------|--|--|--|---|--------------------------------------|--------------------------|
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INTERNATIONA (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CONtinued From page 1 Department of Health orders being submitted to you electronically. 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. On January 26th, 27th, 28th and 29th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have | | | | A. BOILDIN | u | | |
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| PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 000 Continued From page 1 Department of Health orders being submitted to you electronically. 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. On January 26th, 27th, 28th and 29th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have | GOOD S | SAMARITAN SOCIETY | '-INTERNATIONA | | | | |
| Department of Health orders being submitted to you electronically. 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. On January 26th, 27th, 28th and 29th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have | PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE AC CROSS-REFERENCED TO | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETE DATE |
| reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS | 2 000 | Department of Heavou electronically. is necessary for Steenter the word "cortext. You must then State licensure procompletion date, the corrected prior to employ the Minnesota Department on January 26th, surveyors of this Deabove provider and orders are issued. electronic plan of creviewed these ordered they will be compled Minnesota Department the State Licensing federal software. To assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned tag in column entitled "Its statute/rule out of complete the statement evidence by." Follower the Suggested Time period for Country Column perio | alth orders being submitte Although no plan of corrected Statutes/Rules, please rected" in the box available indicate in the electronic cess, under the heading lee date your orders will be electronically submitting to ment of Health. 27th, 28th and 29th, 2015 epartment's staff, visited in the following correction. Please indicate in your correction that you have lers, and identify the date elect. In ent of Health is document of Deficien Orders using ag numbers have been sota state statutes/rules for the ent of Deficiencies column for Comply" portion of the his column also includes the in violation of the state state, "This Rule is not met as wing the surveyors finding Method of Correction and rection. ARD THE HEADING OF TARD THE HEADING OF TAR | ed to ection e le le for control e le fo | | | |

Minnesota Department of Health

STATE FORM G899 QBED11 If continuation sheet 2 of 51

| | ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | | | SURVEY PLETED |
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| | | 00322 | | B. WING | | 01/2 | 29/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
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| 2 000 | Continued From pa | age 2 | | 2 000 | | | |
| | THIS WILL APPEA | R ON EACH PAGE. | | | | | |
| | THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | | | | | | |
| 2 302 | MN State Statute 144.6503 Alzheimer's disease or related disorder train | | | 2 302 | | | 2/9/15 |
| | ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 | | | | | | |
| | Alzheimer's disease or related of segregated or gene care staff | lity serves persons we disorders, whether in eral unit, the facility's ars must be trained in | n a direct | | | | |
| | related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequent topics covered. | of Alzheimer's diseas activities of daily living with challenging be | ng; haviors; ers in of the oloyees ne basic | | | | |
| | This MN Requirem | ent is not met as ev | idenced | | | | |

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP | | | SURVEY LETED |
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| 2 302 | Continued From pa | ge 3 | 2 302 | | | |
| | facility failed to ens in a written or elect facility staff training dementia/Alzheime frequency of trainin | | | corrected | | |
| | Findings include: | | | | | |
| | verified there was r | a.m., the administrator no information regarding the residents or resident's nilies. | | | | |
| | administrator or desimplement policies required Alzheimer requirements. The | quality assessment and ee could perform random | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |
| 2 560 | MN Rule 4658.0409 Plan of Care; Conte | 5 Subp. 2 Comprehensive ents | 2 560 | | | 3/4/15 |
| | comprehensive pla objectives and time long- and short-terr and mental and psy | of plan of care. The n of care must list measurable stables to meet the resident's m goals for medical, nursing, ychosocial needs that are apprehensive resident | | | | |

Minnesota Department of Health

STATE FORM 6899 QBED11 If continuation sheet 4 of 51

| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2201 KEENAN DRIVE | |
|--|---|
| 2201 KEENAN DRIVE | |
| GOOD SAMARITAN SOCIETY - INTERNATIONA INTERNATIONAL FALLS, MN 56649 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMBINED CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | PREFIX |
| assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan to include individualized activity needs for 3 of 4 residents (R43, R50, R19) reviewed for activities. In addition, the facility failed to develop a comprehensive care plan to include the use of psychotropic medications for 4 of 5 residents (R43, R6, R47, R29) reviewed for unnecessary medications. Findings include: R43's care plan was not developed to include individualized activity preferences and needs. R43's Admission Record dated 7/13/12, indicated diagnoses of blindness in both eyes, unspecified psychosis and major depressive disorder. R43's annual Minimum Data Set (MDS) dated 12/5/14, indicated R43 had severely impaired cognition, required extensive assistance of one staff with transfers and locomotion on the unit and had behaviors or hallucinations but none that were recently present. The MDS further indicated R43 felt tired or had little energy about half or more of the reference period days, felt bad about herself or that she was a failure or had let her family down nearly every day, had thoughts that she would be better off dead or of hurting herself in some way nearly every day. | an res TbErecaFfapnF F Fir Fdp F1cshwFnhfas |

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Minnesota Department of Health STATE FORM

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP | | | SURVEY LETED |
|---------------|--|---|---|---|--------|------------------|
| | | 00322 | B. WING | | 01/2 | 9/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | 1 01/2 | 0,2010 |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | NAN DRIVE | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID ID | .LS, MN 56649 PROVIDER'S PLAN OF CORRECTI | ON | (X5) |
| PREFIX TAG | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | COMPLETE DATE |
| 2 560 | Continued From pa | ge 5 | 2 560 | | | |
| | activities of interest | were very important to her: | | | | |
| | read - listen to music - be around animals - do things with gro - go outside to get f was good | | | | | |
| | R50's care plan was not developed to include individualized activity preferences and needs. | | | | | |
| | | ecord dated 12/12/14, s of chronic obstructive airway ion and anxiety. | | | | |
| | R50's admission MDS dated 12/25/14, indicated R50 was cognitively intact and required minimal assistance of one staff with transfers, ambulation and locomotion on the unit. | | | | | |
| | | dicated R50 had felt the important or somewhat | | | | |
| | do favorite activitie listen to music keep up with the r go outside to get f was good | | | | | |
| | director (HL)-A state residents individual and then tried to ac | p.m. the household life ed the facility gathered each likes and dislikes for activities commodate those also stated the nursing | | | | |

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X) A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|-------------------------|--|-------------------------------|--------------------------|
| | | 00322 | B. WING | | 01/29/2015 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | NAN DRIVE FIONAL FAL | LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 2 560 | assistants were to utilize the individual resident care plans to identify what activities the residents were interested in, and either assist them to the activity or initiate an activity. HL-A verified R43 and R50's care plans lacked identification of an activity care plan and lack of preferred activities. On 1/29/15, at 8:13 a.m. nursing assistant (NA)-I stated he was unaware if resident individual preferences were identified on the care plans because he did not have time to look at the care plan. | | 2 560 | | | |
| | interventions to add R19's annual MDS was diagnosed with The MDS also indic cognitive impairment and encouragement indicated R19's dail were identified as ecare discussions, di people and particip R19's Activities CA R19's activity goals area had be resolve in all appropriate act R19's Activity Interes 1/20/15, indicated hincluded discussion newspapers, huntin easy listening music | s not developed to include dress his activity needs. dated 1/13/15, indicated R19 in dementia and depression. Eated R19 had severe into an activities and required staff reminders into attend activities. The MDS by and activity preferences enjoying family involvement in oing things with groups of atting in favorite activities. A dated 1/13/15, indicated were being met and this care end as R19 had been included extivities. Set Data Collection Tool dated his current leisure interests had conference in agazines, ag/fishing, camping, listening to conference, animals/pets, and activity needs. | | | | |

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Minnesota Department of Health STATE FORM

PRINTED: 02/24/2015 FORM APPROVED

Minnesota Department of Health

| AND DIAN OF CODDECTION IDENTIFICATION NUMBER | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
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| | | | | | | | |
| | | 00322 | | B. WING | | 01/2 | 29/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | | | , , | STATE, ZIP CODE | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | | NAN DRIVE TIONAL FAL | LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM | / FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| 2 560 | Continued From page 7 | | | 2 560 | | | |
| | director of admission were interviewed. Were normally iden plan. The HL-B corn R19's activity goals thought he had me admitted she had no documentation with had actually attend activity area of focus confirmed R19 had and that some of the more appropriate for listening to music, show in his room, and harmonica. HL-B coleisure interest eva on 1/20/15, the interest eva on 1/20/15, the interest eva on the care Plan policy resident would have comprehensive carachieving and main medical, nursing, pemotional, psychos. The Comprehensive care plan would be | regards to what acted prior to her resolves on his care plan. It is severe cognitive implementations and the activities which was a severe cognitive implementation of the activities which the activities is severe cognitive implementation of the activities is severe to a severe an individualized replan directed toward and and education of the activities is severe plan and capture dated 6/14, special and education of the activities is severe plan and capture dated 6/14, special and education of the activities is severe plan and capture dated 6/14, special and education of the activities is severe plan and capture dated 6/14, special and education of the activities is severe plan and capture dated 6/14, special and education of the activities is severe plan and capture dated 6/14, special and education of the activities is severe plan and capture dated 6/14, special and education of the activities is severe plan and capture dated 6/14, special and education of the activities is severe plan and capture dated 6/14, special and education of the activities is severe plan and capture dated 6/14, special and education of the activities is severe plan and capture dated 6/14, special and education of the activities is severe plan and capture dated 6/14, special and education of the activities is severe plan and capture dated 6/14, special and education of the activities is severe plan and capture dated 6/14, special and captu | fe (AHL) activities ints care resolved cause she the HL-B tivities R19 ving R19's HL-B pairment buld be visits, ne tinker o play his to R19's n reviewed iffied did d been ated each ard nt's optimal piritual, al needs. re ecified the I the | | | | |
| | | I not address the use sychotic medication), | | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 00322 | | B. WING | | 01/3 | 29/2015 |
| NAME OF | PROVIDER OR SUPPLIER | • | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | · | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | | NAN DRIVE ΓΙΟΝΑL FAL | LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIE: Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| 2 560 | Continued From pa | age 8 | | 2 560 | | | |
| | or behavioral interv | rentions. | | | | | |
| | was diagnosed with physician's orders of order for risperdal (mouth) twice a day | Review Report indicated unspecified psychological dated 1/20/15, identifulated 1/25 milligrams (mg for psychosis, and material 125 mg in the a.m. allucinations return. | sis. R43's ied an) po (by nay | | | | |
| | had severely impair hallucinations, but in present. The MDS or had little energy felt bad about herse had let her family dithoughts that she will hurting herself in so MDS documented | dated 12/5/14, indicated cognition, had be none that were recent further identified R43 about half or more of elf or that she was a down nearly every day would be better off deceme way nearly every R43 had behaviors of sions, however it indicates. | haviors or tly felt tired f the days, failure or r, and had ad, or of r day. The f | | | | |
| | hallucinations/beha interactions if R43 i | I not address aviors, staff intervention in the responding to the responding to the respondent of the respondent of the respondent in the | al, staff ns or | | | | |
| | Seroquel (an antips | not address the use of sychotic medication), avioral interventions. | | | | | |
| | diagnoses that inclinsomnia, anxiety a orders dated 12/15 | eview Report indicate uded senile dementia and paranoia. R6 ' s p /14, directed Seroque ay, 75 mg po at bedtir | a, ohysician's el 25 mg | | | | |

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------------|---|-------------------------------|--------------------------|
| | | | A. BOILDING. | | | |
| | | 00322 | B. WING | | 01/2 | 29/2015 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| GOOD S | AMARITAN SOCIETY | ' - INTERNATIONA | ENAN DRIVE ATIONAL FAL | LS, MN 56649 | | |
| (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 SHOT CROSS-REFERENCED TO THE APPROPRIES OF T | ULD BE | (X5) COMPLETE DATE |
| 2 560 | 25 mg as needed uperween midnight at R6's quarterly MDS was cognitively inta that included troubl asleep, or sleeping having little energy further identified R6 delusions. R6's care plan did a paranoia, staff inter Seroquel nor the post Seroquel. 01/29/15, at 9:46 a was interviewed an risperdal on the car Seroquel on the c | up to two times in 24 hours and 4:00 a.m. for paranoia. 6 dated 10/24/14, indicated R6 act, and had mood problems le falling asleep or staying too much, and feeling tired or nearly every day. The MDS 6 had no hallucinations or not address behaviors of rventions with paranoia, use of otential side effects of the and verified the lack of the use of the plan for R43, and the lack of the plan for R6. 9 p.m. the director of nursing ewed and stated she would fit to follow the facility policy on | f | DEFICIENCY) | | |
| | had diagnoses that | t included atrial fibrillation lar heartbeat that can lead to | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | X3) DATE SURVEY COMPLETED | |
|--|---|------------------------------|---|------------|
| | 00322 | B. WING | | 01/29/2015 |
| NAME OF PROVIDER OR SUPPL | ETY - INTERNATIONA 2201 KE | ENAN DRIVE | STATE, ZIP CODE | |
| PREFIX (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | |
| heart-related comacular degen on one vertical R47's Medicatic included orders mouth one time Tuesday, Thurs 3 mg by mouth fibrillation. The Federal Driwarning indicating major or fatal by R47's undated monitoring for properties of the content of the content of the content of the conference polinterdisciplinary was comprehent included physic were currently lives and restricted in the care plan. | oke, heart failure and other omplications), rheumatoid arthritis, eration and hemiplegia (paralysis half of the body) on Review Report dated 1/19/15, for warfarin sodium give 2 mg by a day every Sunday, Monday, day, Friday and Saturday and give every Wednesday related to atrial ug Administration (FDA) black boxed warfarin sodium can cause | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X2) | | | SURVEY LETED | |
|---|--|---|-------------------------|--|------------------|--------------------------|
| | | 00322 | B. WING | | 01/29/2015 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | . 2 - · <u> </u> | - |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | NAN DRIVE TIONAL FAL | LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 2 560 | Continued From pa | ge 11 | 2 560 | | | |
| | monitoring interventeffects related to the antipsychotic) and FR29's physician's or Zyprexa 5 mg in the for dementia with Lemg in the evening statementia with Lewy R29 s quarterly MD R48 had impaired to behaviors, R29 reject during the assessmentipsychotic and a daily. R29's The Diagnost indicated R29's diagrams and the same an | not address appropriate tions for potential adverse e use of Zyprexa (an Remeron (an antidepressant). rders dated 11/18/14, included e evening, starting on 8/15/14, ewy Bodies and Remeron 15 starting on 8/15/14, for a Bodies. S dated 12/18/14, identified cognition, had no psychosis or exted cares one to three days ment period and had received antidepressant medication is Report dated 1/29/15, gnoses included dementia with ehavioral disturbances and | | | | |
| | 11:00 a.m. to 1:45 peyes or talk when sassisted with eating ate but did not talk. On 1/28/15, at 9:50 awake and eating behowever, one the smeal R29 would no lunch. On 1/29/15, at 11:10 care plan did not acpotential risks or side | ly observed on 1/27/15, from o.m., R29 would not open her poken to until the staff of then R29 opened her eyes, a.m. R29 was observed breakfast with staff assistance, ame day, during the lunch of topen her eyes or eat any 7 a.m. RN-B confirmed R29's of the defects of the Zyprexa or RN stated the staff had a drug | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|-------------------------|---|------|--------------------------|
| | | 00322 | B. WING | ···· | 01/2 | 9/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | NAN DRIVE TIONAL FAL | LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 560 | book and should kn medications. "It sho they're licensed." The facility policy ar dated 9/12, directed individualized comp will include measura directed toward ach resident's optimal m | ge 12 now the side effects of build be a standard of care, and procedure on Care Plan deach resident will have an orehensive plan of care that able goals and timetables sieving and maintaining the nedical, nursing, physical, emotional, psychosocial and | 2 560 | | | |
| | The Director of Nurdevelop, review, an procedures to ensuall residents. The Director of Nurdeducate all appropriocedures. The Director of Nurdevelop monitoring compliance. TIME PERIOD FOR | THOD OF CORRECTION: sing or designee could d/or revise policies and re a care plan is developed for sing or designee could iate staff on the policies and sing or designee could systems to ensure ongoing | | | | |
| 2 565 | Plan of Care; Use Subp. 3. Use. A co | 5 Subp. 3 Comprehensive omprehensive plan of care personnel involved in the | 2 565 | | | 3/4/15 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | , , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
|--|--|--|--|-------------------------------|--|-------|--------------------------|
| | | 00322 | | B. WING | | 01/2 | 9/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONA | 2201 KEE | NAN DRIVE | STATE, ZIP CODE LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 565 | Continued From pa | ge 13 | | 2 565 | | | |
| | by: Based on observati review, the facility for repositioning interve plan for 1 of 3 resid pressure ulcers. The activity interventions for 1 of 4 residents Findings include: R63 was not reposi directed by her care R63's Diagnosis Re R63's diagnoses as neck of the femur (I leg), dementia, righ (wound with full thic subcutaneous fat m | entions as directed be lents (R63) reviewed the facility also failed is as directed by the (R26) reviewed for a litioned every two house | cument by the care I for to provide care plan activities. urs as , identified of the oper lower re ulcer , ne, tendon | | corrected | | |
| | | ysema (a chronic res decrease in lung fund | | | | | |
| | R63 had a pressure immobility and direct | ted 12/16/14, identifice ulcer related to her cted staff to assist he g at least every two l | er with | | | | |
| | in bed, positioned on nursing assistant (Norom and proceeded brief. R63 was brief rolled to her right sirequired changing. | a.m. R63 was obse on her back. At 8:15 a NA)-E and NA-D ente ed to change her inco fly (less than ten sec de to determine if the NA-D confirmed R6 B remained on her ba | a.m. ered R63's continent conds) e brief 63's brief | | | | |

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Minnesota Department of Health STATE FORM

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | | ` , | E CONSTRUCTION | | SURVEY PLETED |
|--------------------------|---|--|--|-------------------------|--|------------------------------|--------------------------|
| | | 00322 | | B. WING | | 01/2 | 29/2015 |
| NAME OF | PROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | | NAN DRIVE ΓΙΟΝΑL FAL | LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| 2 565 | of the brief under the slightly off of her back for many positioned off of her back for many pillow between R63 again on her back, positioned on her beffective offloading hour). On 1/28/15, at 10:1 (RN)-C stated repositioned repositioned on her back, and the same positioned on her back. RN-C consider R63 to be change if R63 had than one minute who changed. RN-C consider R63 to be change if R63 had than one minute who changed. RN-C consider R63 had the positioning every confirmed three hore R63 being reposition. On 1/28/15, at 11:2 confirmed R63 had position and not off minute when they confirmed the position and not off minute when they confirmed R63 had position and not off minute when they confirmed R63 every two hours. The Skin Assessment Prevention policy dwho were unable to the slightly of the skin Assessment Prevention policy dwho were unable to the slightly of the skin Assessment Prevention policy dwho were unable to the slightly of the skin Assessment Prevention policy dwho were unable to the slightly of the skin Assessment Prevention policy dwho were unable to the slightly of the skin Assessment Prevention policy dwho were unable to the slightly of the | and NA-E tucked the rine resident. NA-E rollack and NA-D removed the new brief (R63 no more than 30 sectorached the new brief, B's knees and position R63 was observed to back without reposition assistance until 10:00 assistance u | led R63 ed the wet was not onds). placed a ned R63 o remain ning or 00 a.m. (3 rse uded her including ot a brief or greater ng d the staff on RN-C no without -D n the same n one 3:15 a.m. nursing nd turn care plan. cer residents res | 2 565 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|---------------------------|--|-------|--------------------------|
| | | 00322 | B. WING | | 01/2 | 9/2015 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY, S | STATE, ZIP CODE | • | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | ENAN DRIVE ITIONAL FAL | LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 565 | Continued From pa | ge 15 | 2 565 | | | |
| | Program as directed R26's undated care dependent on staff cognitive stimulation care plan directed s bedside/in-room vis and stimulation and include woodworkin spouse, lawn work The care plan also | e plan indicated R26 was and family for activities, n, and social interaction. The staff to provide 1:1 sits to promote socialization I identified topics of interest to ng, R26's grandchildren and or keeping busy in the garage. directed staff to turn on TV, ape in room when R26 was in | | | | |
| | seated at a table in | 2 p.m. R26 was observed the dining room waiting for n. R26 was being fed his meal | | | | |
| | (FM)-B stated staff | 5 a.m. R26's family member did not encourage or bring M-B stated they "never did | | | | |
| | laying in bed. A ken place in the fellows | p.m. R26 was observed o activity was currently taking hip hall. R26's room was vision or book on tape in use. | | | | |
| | bed with the TV on. 8:09 a.m. at which this left side and the a.m. R26 was obsethe wheelchair in th | 9 a.m. R26 was observed in R26 remained the same until time R26 was positioned on TV remained on. At 8:47 rved dressed and seated in e dining room being fed a.m. R26 had completed his | | | | |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|---|---------------------|--|-------------------|--------------------------|
| | | 00322 | B. WING | ····· | 01/2 | 9/2015 |
| | PROVIDER OR SUPPLIER | - INTERNATIONA 2201 KEE | NAN DRIVE | STATE, ZIP CODE | | |
| | AMARITAN GOOLTT | INTERNA | TIONAL FAL | LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 565 | Continued From pa | ge 16 | 2 565 | | | |
| | dining room table u | erved to remain seated at the ntil 9:23 a.m. At 9:56 a.m. in bed with the TV on. | | | | |
| | facility did not do ar FM-B stated she we group activities suc | p.m. FM-B again stated the nything with R26 for activities. ould, at times, bring R26 to h as bingo but stated she had visiting 1:1 or assisting R26 y kind. | | | | |
| | they were not awar | p.m. NA-D and NA-E stated e of any activities done for they would put his TV on but d. | | | | |
| | On 1/28/15, at 2:42 p.m. NA-F stated at times, R26's wife would take him to bingo. NA-F also stated R26 required repositioning frequently and could not tolerate sitting up for long periods so he did not often attend any group activities. | | | | | |
| | laying in bed with te tape player was obs | 0:06 a.m. R26 was observed elevision quietly on. No radio or served in the room. The dicated a church service was 0 a.m. | | | | |
| | have a player that r occasionally use. Nonce a week or so. | 0:08 a.m. NA-H stated R26 did read stories to him they would NA-H stated they might do this NA-H stated the only activity R26 was to leave the TV on. | | | | |
| | (HL)-B stated R26 visits with the nursin HL-B stated R26 was | 0:12 a.m. household leader was supposed to have 1:1 ng assistants or homemakers. as also taken to group owship hall at times so he | | | | |

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|---------------------|--|------|--------------------------|
| | | 00322 | B. WING | | 01/2 | 9/2015 |
| | PROVIDER OR SUPPLIER | - INTERNATIONA 2201 KEE | NAN DRIVE | STATE, ZIP CODE LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 565 | • | ge 17 on Survey Report for activities | 2 565 | | | |
| | | ovember 2014, December 2015 was reviewed with HL-B llowing: | | | | |
| | events (documenta event) -December 2014 - o events. | documentation of 4 activity tion lacked name of activity documentation of 0 activity | | | | |
| | events. | cumentation of 0 activity e were additional activity | | | | |
| | attendance sheets homemakers for ac December 2014 an revealed R26 attend 12/25/14, a group a on 12/31/14,1/6/15 there were no other documented for R2 have had 1:1 visits. | completed by the stivities for the months of d January 2015. These ded present opening on activity on 12/26/14, and bingo and 1/7/15. HL-B verified activities and no 1:1 activities 6 and confirmed R26 should HL-B stated she would have ovide 1:1 activities for R26 as | | | | |
| | admissions and houshe worked in coordactivities were proving documentation Figure directed on the care | p.m. the director of usehold life (AHL) indicated dination with HL-B to ensure ided. AHL verified there was R26 had received 1:1 visits as a plan and confirmed R26 ed 1:1 visits as directed. | | | | |
| | Conferences proceresident-specific ca | e Care Plan and Care dure dated 6/14, indicated a re plan should be developed Il, needs of the resident. | | | | |

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| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|---|---------------------|---|-------------------|--------------------------|
| | | 00322 | B. WING | | 01/2 | 9/2015 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | • | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | NAN DRIVE | LS, MN 56649 | | |
| (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 APPRODEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 2 565 | Continued From pa | ge 18 | 2 565 | | | |
| | resident would have comprehensive car | e plan developed to achieve sident's optimal medical, | | | | |
| | The Director of Nur develop, review, an procedures to ensu care plan. The Director of Nur educate all appropr procedures. The Director of Nur | THOD OF CORRECTION: sing or designee could d/or revise policies and re the implementation of the sing or designee could iate staff on the policies and sing or designee could systems to ensure ongoing | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |
| 2 900 | MN Rule 4658.0529 Ulcers | 5 Subp. 3 Rehab - Pressure | 2 900 | | | 3/4/15 |
| | comprehensive res of nursing services | sores. Based on the ident assessment, the director must coordinate the ursing care plan which | | | | |
| | without pressure so pressure sores unle condition demonstr | o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and | | | | |
| | B. a resident w | ho has pressure sores | | | | |

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| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|---|-------------------------|---|-------------------|--------------------------|
| | | 00322 | B. WING | | 01/2 | 9/2015 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | NAN DRIVE TIONAL FAL | LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 900 | promote healing, pr new sores from dev | y treatment and services to revent infection, and prevent | 2 900 | | | |
| | Based on observati review, the facility f and repositiong for identified with an ad | on, interview and document ailed provide timely turning 1 of 3 residents (R63) stive pressure ulcer and hour turning and repositioning. | | corrected | | |
| | Findings include: | | | | | |
| | R63 was diagnosed the neck of the fem lower leg), dementi hip stage 3 (wound tissue, subcutaneou tendon or muscle a tunneled) pressure | onic respiratory disease | | | | |
| | had a pressure ulce | red 12/16/14, indicated R63 er related to immobility and sist R63 with turning and st every two hours. | | | | |
| | dated 12/16/14, ind make significant ch assistance related thip and knee contra | ssessment and Evaluation icated R63 was unable to anges in position without to her weakness and bilateral actures. In addition, a am should be implemented. | | | | |
| | | inimum Data Set (MDS) dated R63 had moderate cognitive | | | | |

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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|--|-------------------------|--|-------------------|--------------------------|
| | | | | | | |
| | | 00322 | B. WING | | 01/2 | 9/2015 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | NAN DRIVE TIONAL FAL | LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 900 | bed mobility, transfinggiene. In additional risk for the devel and had an existing ulcer on her right his treatment plan inclure positioning programs. R63's Care Area As 12/23/14, indicated repositioning in bed also indicated R63 pressure ulcer with plan which included wheelchair cushion repositioning scheol repositioning scheol reductions risk for plan development of a plan program of the perimeter of the perimeter of the perimeter of the perimeter came in causing tissue damincreased in length | quired extensive assist with erring, toileting and personal n, R63 had been identified as opment of a pressure ulcer gunhealed stage 3 pressure ip. The MDS indicated the uded a turning and am. ssessment (CAA) dated R63 required assistance with d and wheelchair. The CAA had an existing stage 3 a recommended treatment d a pressure relief mattress, in place and a scheduled dule. e Assessment (tool for pressure sore development) atified R63 was at risk for the pressure ulcer and the recommended R63 should be and have a planned turning ard revealed the following with of wound measurement: timeters (cm) - length, 0.5 cm | 2 900 | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---|---------------------|--|-----------------------------------|--------------------------|
| | | 00322 | | B. WING | | 01/ | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONA | 2201 KEE | NAN DRIVE | STATE, ZIP CODE LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | ΓΙΟΝ SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| 2 900 | depth -1/12/15 - 0.9 cm - 1 - depth -1/26/15 - 0.7 cm - 1 - depth On 1/28/15, at 7:00 in bed, positioned of waist with her legs If the chest and left side. (NA)-E and NA-D exproceeded to change (less than ten second order to determine) | ge 21 length, 0.4 cm - widt length, 0.4 cm - widt a.m. R63 was obse in her back, twisted a bent upwards toward At 8:15 a.m. nursing ntered R63's room a ge her brief. R63 was nds) rolled to her righ if the brief required of | rved lying at the ds her grassistant and s briefly ht side in changing. | 2 900 | DEI IOILING | | |
| | remained on her ba and NA-E tucked th the resident. NA-E in back, NA-D remove new brief and return was not off of her b seconds). NA-E and and placed a pillow R63 positioned on h with her legs bent un left side. R63 was of | ick, NA-D opened the right sides of the kerolled R63 slightly of the wet brief, positived R63 onto her back for no more thanked NA-D fastened the between R63's kneed her back, twisted at the pwards towards her observed to remain part repositioning or effective results. | e brief brief under f of her tioned the ck (R63 n 30 e new brief es and left the waist chest and positioned | | | | |
| | was observed to co ulcer's daily dressin ulcer was observed area with minimal d dressing when removed wound were pink, the loss of tissue and see tunneled. LPN-C | sed practical nurse (Induct R63's right hip of change. R63's preto be located on he rainage observed or oved. The margins one wound had full this kin, however didn't at did not reposition the ring or after conduction. | o pressure essure r right hip n the of the ockness appear to ne | | | | |

Minnesota Department of Health

STATE FORM G899 QBED11 If continuation sheet 22 of 51

| | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|--|--|--|------------------------------|--|-----------------------------------|--------------------------|
| | | 00322 | | B. WING | | 01/ | 29/2015 |
| | PROVIDER OR SUPPLIER | - INTERNATIONA | 2201 KEE | NAN DRIVE | STATE, ZIP CODE LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT | ULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| 2 900 | dressing change. On 1/28/15, at 11:4 entered R63's room They gathered their positioned on to he was observed. R63 from open areas he coccyx area were of her back had a rais stated was much in On 1/28/15, at 10:1 (RN)-C stated repositioned dur R63 had not been of minute while her broonfirmed she expensioned she expensioned dur R63 had not been of minute while her broonfirmed she expensioned she expensioned dur R63 had not off minute when they or offloaded. On 1/28/15, at 11:2 confirmed R63 had position and not off minute when they or on 1/29/15, at 9:10 (DON) verified staff R63 every two hour. The Positioning Asspolicy dated 3/2008 determine an individual control of the positioning and the positioning and policy dated 3/2008 determine an individual control of the positioning and policy dated 3/2008 determine an individual control of the positioning and policy dated 3/2008 determine an individual control of the positioning and policy dated 3/2008 determine an individual control of the positioning and policy dated 3/2008 determine an individual control of the positioning and policy dated 3/2008 determine an individual control of the positioning and policy dated 3/2008 determine an individual control of the policy dated 3/2008 determine an individual control of the policy dated 3/2008 determine an individual control of the policy dated 3/2008 determine an individual control of the policy dated 3/2008 determine an individual control of the policy dated 3/2008 determine an individual control of the policy dated 3/2008 determine an individual control of the policy dated 3/2008 determine an individual control of the policy dated 3/2008 determine an individual control of the policy dated 3/2008 determine an individual control of the policy dated 3/2008 determine an individual control of the policy dated 3/2008 determine an individual control of the policy dated 3/2008 determine an individual control of the policy dated 3/2008 determine an individual control of the policy dated 3/2008 determine an individual control o | 1 a.m. NA-E and NA- n to change her brief a r supplies, and while F r right side her bottom 's bottom was observ owever; R63's left but observed very reddenced, red rash in which | again. R63 was a area ed free ttock and ed and NA-E se ided or ack. R63 to brief if han one d. RN-C 63's care wo hours positioned D the same one :15 a.m. aursing d turn care plan. | 2 900 | | | |

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STATE FORM

QBED11 If continuation sheet 23 of 51

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) D (X3) D | | | |
|--|--|--|--|--|---------|--------------------------|
| | | 00322 | B. WING | | 01/2 | 29/2015 |
| | PROVIDER OR SUPPLIER | - INTERNATIONA 2201 KEI | ENAN DRIVE | STATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| 2 900 | resident assessment The Mobility Suppo procedure dated 11 individualized repost and on observation period of time. The Positioning Data 3/2008, defined offl from an area for at The Skin Assessment Prevention dated 6/2 are unable to repost independently should by their care plan. SUGGESTED MET The Director of Nurdevelop, review, an procedures to ensure and residents who are receiving the proper promote healing, procedures to ensure under the Director of Nurdeducate all approprince procedures. The Director of Nurdevelop monitoring compliance. | rt and Positioning: Positioning /13, indicated an sitioning schedule was ed on evaluation of risk factors of the resident's skin over a ta Collection Tool dated oading as removing pressure least one minute. ent and Pressure Ulcer /14, indicated residents who sition themselves ald be repositioned as directed d/or revise policies and re residents do not develop a ss it is clinically unavoidable, do have pressure ulcers are r care and services needed to revent infection and promote | | | | |
| | (21) days. | , | | | | |

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QBED11 If continuation sheet 24 of 51

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|---|---------------------|---|-------------------|--------------------------|
| | | 00322 | B. WING | | 01/2 | 9/2015 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | • | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | NAN DRIVE | LS, MN 56649 | | |
| (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 APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 930 | Continued From pa | ge 24 | 2 930 | | | |
| 2 930 | MN Rule 4658.0529 Nasogastric, Gastro | 5 Subp. 7 B. Rehab - ostomy tubes | 2 930 | | | 3/4/15 |
| | and feeding syringes. Based o assessment, a nurs B. a resident w gastrostomy tube o appropriate treatme aspiration pneumor dehydration, metab | ric tubes, gastrostomy tubes, in the comprehensive resident sing home must ensure that: who is fed by a nasogastric or reding syringe receives the ent and services to prevent nia, diarrhea, vomiting, olic abnormalities, and leers and to restore, if eding function. | | | | |
| | by: Based on observati review, the facility for gastrostomy tube (0 the stomach for foo medication adminis | ent is not met as evidenced on, interview and document ailed to check placement of a G-tube, a tube which goes into id and or medications) prior to tration for 1 of 1 residents medication administration | | corrected | | |
| | R48's Diagnosis Re R48's diagnoses in swallowing) due to pulmonary (lungs) i recurrent pneumon R48's care plan dat | eport dated 1/28/15, indicated cluded dysphagia (difficulty cerebrovascular disease, nsufficiency and a history of ia. ed 10/3/14, indicated R48 ding and was NPO (nothing by | | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|--|---------------------|---|----------------------------------|--------------------------|
| | | 00322 | | B. WING | | 01/ | 29/2015 |
| | PROVIDER OR SUPPLIER | - INTERNATIONA | 2201 KEE | NAN DRIVE | STATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| 2 930 | mouth). On 1/28/15, at 11:5 (LPN)-C was obser of R48's Baclofen 1 G-tube. The LPN w medication, crushed dissolved the medication, crushed and attached an ex R48's stomach area barrel of a large syrpoured in approximathe medication followater and then put the syringe pushing tube. LPN-C did no G-tube prior to adminedication. LPN-C always gave R48's for placement of the short peg that goes On 1/29/15, at 8:30 reviewed the facility checked placement medication. On 1/29/15, at 2:00 (DON) stated she we care plan and "if the then they should." Twould expect staff to the cked paternadministering medistaff to check paternadministering medistaff to check paternal checked for placemadministering medistaff to checked paternal checked for placemadministering medistaff to checked for pl | 5 a.m. licensed practived during the admit 0 milligrams (mg) via shed her hands, old the medication and cation in approximater. The LPN donnetension tube to a poar. The LPN then attainge to the extension ately 15 cc of waters wed by approximate the plunger into the pair in to clear the extension at the plunger into the pair in to clear the extension at the medication and did as G-tube because R into the stomach. a.m. LPN-C stated of policy and should he prior to administering the care plan directed for the DON also stated. | nistration a the obtained the dithen ely 20 digloves rt near ached the nitube and poured in ely 15 cc of barrel of ktension ely 15 cc of barrel of ktension ely 16 ktension ely 18 ktension el el ely 18 ktension el ely | 2 930 | | | |

Minnesota Department of Health

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|-------------------------|--|-------------------------------|--------------------------|
| | | | A. BUILDING: | | | |
| | | 00322 | B. WING | | 01/2 | 9/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | NAN DRIVE TIONAL FAL | LS, MN 56649 | | |
| (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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 930 | aspirate gastric cor in the stomach. SUGGESTED MET The Director of Nur develop, review, an | THOD OF CORRECTION: sing or designee could d/or revise policies and | 2 930 | | | |
| | are monitored for p feeding tube. The Director of Nur educate all appropr procedures. The Director of Nur develop monitoring compliance. | re resident with feeding tubes roper placement of that sing or designee could iate staff on the policies and sing or designee could systems to ensure ongoing | | | | |
| 21426 | TIME PERIOD FOR CORRECTION: Twenty-one (21) days. MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control | | 21426 | | | 3/4/15 |
| | maintain a comprehinfection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control plaunpaid employees, residents, and volumelith shall provide regarding implements. | e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines of States Centers for Disease ation (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines. | | | | |

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| | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION : | (X3) DATE COMP | SURVEY PLETED |
|--------------------------|--|---|---------------------|--|-------------------|--------------------------|
| | | 00322 | B. WING | | 01/2 | 29/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | | DDRESS, CITY, | STATE, ZIP CODE | • | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | | LS, MN 56649 | | |
| (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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 21426 | Continued From pa | ge 27 | 21426 | | | |
| | be maintained by th | ne nursing home. | | | | |
| | by: Based on interview facility failed to ensi R50, R63) received according to the Ce Prevention (CDC) g facility failed to ensi | and document review, the ure 4 of 5 residents (R3, R16, I tuberculin skin testing (TST) enters for Disease Control & guidelines. In addition, the ure 1 of 5 new employees ST according to the CDC | | corrected | | |
| | Findings include: | | | | | |
| | RESIDENT TST: | | | | | |
| | medical record indicates of her TST on read as negative 0 10/3/14. R3 receive on 10/8/14, results | the facility on 10/1/14. R3's cated she received the first 10/1/14, and this test was millimeters (mm) induration or ed the second step of her TST were read on 10/10/14, as documentation of induration). | 1 | | | |
| | R16's medical reco first step of her TST and results were re induration on 12/17 later). R16 received on 12/22/14, and th | to the facility on 12/15/14. Indicated she received the T on 12/16/14, at 5:54 a.m. and as negative - 0 mm Indicated she received the T on 12/16/14, at 5:59 p.m. (36 hours of the second step of her TST he results were read on the second documented as negative | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---|-----------------|--|-------------------------------|--------------------------|
| | | 00322 | B. WI | NG | | 01/2 | 9/2015 |
| | PROVIDER OR SUPPLIER | - INTERNATIONA 220 | 1 KEENAN I | DRIVE | TATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PRI | D EFIX AG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21426 | R50's medical recofirst step of her TST were read as negat 12/15/14. R50 rece TST on 12/22/14, reas "negative" (lacker induration). R63 was admitted to R63's medical recofirst step of her TST lacked documentation read and the results step of her TST on 12/26/15, as "negation induration). On 1/27/15, at 3:25 confirmed R50's medical recomposition of ir second TST, and it induration. On 1/27/15, at 3:29 - R3's medical recomposition in the second TST in the results are reasonal results ar | o the facility on 12/12/14. rd indicted she received the on 12/13/14, and the resive - 0 mm induration on ived the second step of he sults were read on 12/25 and documentation of the facility on 12/16/14. rd indicated she received on 12/16/14. The record on 12/16/14. The record on of when the first step via the second of the second the second received the second received (lacked documentation). The results were read in the results of should have indicated p.m. RN-C confirmed: ord lacked documentation econd step TST as read too early. RN-C do be 48-72 hours before the results of the results. It is not the results of the results o | sults er /14, the was id d on on of N)-A the of | 26 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--|---------------------|--|-----------------------------------|--------------------------|
| | | 00322 | | B. WING | | 01/ | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONA | 2201 KEE | NAN DRIVE | STATE, ZIP CODE LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| 21426 | indicated NA-C recon 11/14/14. This to a negative - 0 mm resecond step of her later), results were negative - 0 mm resecond step of her later), results were negative - 0 mm resecond step of her later), results were negative - 0 mm resecond step of her later. If the first TS step would be computed administer admission, which we later. If the first TS step would be computed be read 48 to administered. | eived the first step of est was read on 11/1 result. NA-C received TST on 12/11/14 (27 read on 12/13/14, wisult. a.m. the director of sher expectation that is policy and the stands to tuberculosis scribure. a.m. the DON confiner second step of heek (21 days) guideles (21 days) | 16/14, with of the days ith a nursing at staff adards of reening, rmed her TST ines per ulosis w. This upon 2 hours second reeks after ond test is CTION: hee could accedures process. | 21426 | | | |
| | TIME PERIOD FOR | R CORRECTION: To | wenty (21) | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|-------------------------|---|------|--------------------------|
| | | 00322 | B. WING | | 01/2 | 9/2015 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | _ | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | NAN DRIVE TIONAL FAL | LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T | D BE | (X5) COMPLETE DATE |
| 21426 | Continued From pa | ge 30 | 21426 | | | |
| | days | | | | | |
| 21435 | MN Rule 4658.0900 Recreation Program | O Subp. 1 Activity and n; General | 21435 | | | 3/4/15 |
| | home must provide recreation program. based on each individed strengths, and need meet the physical, right well-being of each right comprehensive resistant and the strengths and the strength of the strength | al requirements. A nursing an organized activity and . The program must be vidual resident's interests, ds, and must be designed to mental, and psychological resident, as determined by the ident assessment and n of care required in parts 58.0405. Residents must be ies to participate in the opment of the activity and . | | | | |
| | by: Based on observatireview, the facility fameet the individual | on, interview and document ailed to provide activities to interests for 4 of 4 residents 19) reviewed for activities. | | corrected | | |
| | Findings include: | | | | | |
| | R43 was not provide assessed need. | ed activities according to | | | | |
| | diagnoses of blindn | ecord dated 7/13/12, indicated less in both eyes, unspecified or depressive disorder. | | | | |
| | 12/5/14, indicated F | num Data Set (MDS) dated R43 had severely impaired extensive assistance of one | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | | |
|--|---|---|---|---------------------|--|------------------------------|--------------------------|--|
| | | 00322 | | B. WING | | 01/2 | 01/29/2015 | |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONA | 2201 KEE | NAN DRIVE | STATE, ZIP CODE | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE | |
| 21435 | staff with transfers a had behaviors or hawere recently prese R43 felt tired or had more of the reference herself or that she was family down nearly she would be better in some way nearly. The MDS also identicativities of interest to have books, neare and a listen to music be around animals do things with group outside to get f was good participate in religional R43's care plan lactindividualized and be of interest to R43's care plan lactindividualized and be of interest to R43's care plan lactindividualized and be of interest to R43's care plan lactindividualized and con 1/26/15, at 5:00 television in the day Channel on, not act On 1/27/15, at 9:30 television or radio of On 1/27/15, at 11:30 in front of the televisinot actively engage On 1/28/15, at 1:23 | and locomotion on the allucinations but none and. The MDS further it little energy about home as a failure or had levery day, had though off dead or of hurting every day. It field R43 felt the followere very important was a pets ups of people resh air when the we hous services or practices and magarity with the following times: It is following times: In p.m. sitting in front or or group activities the following times: In p.m. sitting in front or or or or with the Weather in the control of a.m. sitting in the control of a.m. sitting in the control of a.m. sitting in the control of the weather in | e that indicated half or bad about et her ghts that higherself dowing to her: zines to eather stice hat would of the ther hom, no day room Channel, bom | 21435 | | | | |

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| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|---------------|---|--|----------------|---|-------------------|------------------|
| | | 00322 | B. WING | | 01/2 | 9/2015 |
| NAME OF | PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | 1 0.72 | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | NAN DRIVE | I C MN EGG40 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | IDNAL FAL | LS, MN 56649 PROVIDER'S PLAN OF CORRECTI | ON | (X5) |
| PREFIX TAG | (EACH DEFICIENCY | YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | COMPLETE DATE |
| 21435 | Continued From pa | ge 32 | 21435 | | | |
| | attended / participa | mentation indicated R43 had ted in 10 activities in 11/14, 13 and 10 activities in 1/15. | | | | |
| | R50 was not provid assessed need. | ed activities according to | | | | |
| | R50's Admission Record dated 12/12/14, identified diagnoses of chronic obstructive airway disease, hypertension and anxiety. | | | | | |
| | R50 was cognitively | DS dated 12/25/14, indicated y intact and required minimal staff with transfers, ambulation the unit. | | | | |
| | | dicated R50 had felt the important or somewhat | | | | |
| | do favorite activitielisten to musickeep up with the rgo outside to get fwas good | | | | | |
| | and stated activities she would like, included weekends. R50 states provided much in the had more activities. | p.m. R50 was interviewed were not offered as often as uding on evenings and ted the facility had not ne way of activities and if they she would go. R50 further usually consisted of bingo | | | | |
| | | ked individualized and group I be of interest to R50. | | | | |

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Minnesota Department of Health

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY |
|---------------|--|--|----------------|---|-------------------|------------------|
| | | 00322 | B. WING | | 01/2 | 9/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | NAN DRIVE | I C MN 56640 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | IDNAL FAL | LS, MN 56649 PROVIDER'S PLAN OF CORRECTION | ON. | (X5) |
| PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | COMPLETE DATE |
| 21435 | Continued From pa | ge 33 | 21435 | | | |
| | director (HL)-A was facility gathered residently gathered residently accommodate the resident was unable individualized prefebring them to an activities and many were specidentify spontaneous from 1/26/15, through the nursing assistating individual resident cactivities the reside either assist them the actual time to in residents, HL-A stations activities actual time to in residents. | resident's preferences. If a e to state what their rences were, the facility may stivity that may stimulate them smaller group activities. HL-A not all activities were organized ontaneous. HL-A was unable to as activities that had occurred gh 1/28/15. HL-A also stated into were to utilize the the care plans to identify what into were interested in, and to the activity or initiate an ed if the nursing assistants had initiate activities with the ted probably not. HL-A verified ty care plan and a lack of | | | | |
| | was interviewed an activities was limite and from an organi not have time to do residents as their wassistants for 18 re was unaware if resiwere on the care pl | a.m. nursing assistant (NA)-I d stated his involvement in d to transporting residents to zed activity. NA-I stated he did spontaneous activities with vere only two nursing sidents. NA-I further stated he dent individual preferences an because he doesn't have care plans. | | | | |
| | time to look at the care plans. The facility policy and procedure on Activity Program revised 1/15, directed the facility to provide for an ongoing activities program designed to meet, in accordance with the comprehensive assessment, the interests and the | | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|---|-------------------------|--|----------|--------------------------|
| | | 00322 | | B. WING | | 01/2 | 29/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| GOODS | AMARITAN SOCIETY | - INTERNATIONA | - | NAN DRIVE TIONAL FAL | LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE: 'MUST BE PRECEDED BY SC IDENTIFYING INFORM <i>A</i> | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | IOULD BE | (X5) COMPLETE DATE |
| 21435 | Continued From page 34 | | | 21435 | | | |
| | physical, mental and psychosocial well-being of each resident. | | | | | | |
| | R26 did not receive program. | an individualized 1: | I activity | | | | |
| | 11/3/14, indicated F impairment and was disease and osteoa indicated R26 was in | imum Data Set (MDS 326 had severe cogn s diagnosed with Alz orthrosis. The MDS a non-ambulatory and oon one person for lo | itive heimer's also was | | | | |
| | R26's Activities Care Area Assessment (CAA) dated 2/21/14, indicated R26 had reduced activity participation due to physical disability, unstable acute/chronic health problems, cognitive deficits and chronic health conditions such as incontinence or pain. The CAA indicated activities would be addressed on the care plan. | | | | | | |
| | dependent on staff cognitive stimulation care plan directed s bedside/in-room vis and stimulation and include woodworkin spouse, lawn work of The care plan also | its to promote social identified topics of ing, R26's grandchildror keeping busy in the directed staff to turn ape in room when R2 | es, on. The ization nterest to en and ie garage. on TV, | | | | |
| | seated in the wheel | 2 p.m. R26 was obsection R26 was observed feeding | om table. | | | | |

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|--------------------------|--|-------------------|--------------------------|
| | | | A. BOILDING. | | | |
| | | 00322 | B. WING | | 01/2 | 9/2015 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, S | STATE, ZIP CODE | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | ENAN DRIVE TIONAL FAL | LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21435 | Continued From pa | age 35 | 21435 | | | |
| | On 1/27/15, at 10:1 (FM)-B stated staff | 5 a.m. R26's family member did not encourage or bring FM-B stated they "never did | | | | |
| | laying in bed. A ke place in the fellows | 1 p.m. R26 was observed no activity was currently taking hip hall. R26's room was vision or book on tape in use. | | | | |
| | On 01/28/15, at 7:19 a.m. R26 was observed in bed with the TV on. R26 remained the same until 8:09 a.m. at which time R26 was positioned on his left side and the TV remained on. R26 remained the same until 8:21 a.m. At 8:47 a.m. R26 was observed dressed and seated in the wheelchair in the dining room being fed breakfast. At 8:59 a.m. R26 had completed his meal and was observed to remain seated at the dining room table until 9:23 a.m. At 9:56 a.m. R26 was observed in bed with the TV on. | | | | | |
| | facility did not do at FM-B stated she we group activities suc | o p.m. FM-B again stated the nything with R26 for activities. ould, at times, bring R26 to the as bingo but stated she had visiting 1:1 or assisting R26 y kind. | | | | |
| | they were not awar | p.m. NA-D and NA-E stated re of any activities done for they would put his TV on but d. | | | | |
| | would take him to be stated R26 required could not tolerate s | 2 p.m. NA-F stated R26's wife bingo at times. NA-F also d repositioning frequently and sitting up for long periods so he d any group activities. | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | , , | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--|---------------------|--|---------------------------------|--------------------------|
| | | 00322 | | B. WING | | 01/ | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONA | 2201 KEE | NAN DRIVE | STATE, ZIP CODE LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| 21435 | On 1/29/2015, at 10 bed with the TV qui player was observe calendar indicated a scheduled for 10:00 On 1/29/2015, at 10 have a player that rwould occasionally do this once a week activity they usually TV on. On 1/29/2015, at 10 was supposed to ha assistants or homer also taken to group at times so he could Documentation Surmonths of Novembor January 2015 was revealed the following the supposed to the supposed to have a supposed to have also taken to group at times so he could be compared to the supposed to have a suppos | 0:06 a.m. R26 was o etly on. No radio or t d in the room. The a church service was 0 a.m. 0:08 a.m. NA-H state ead stories to him th use. NA-H stated the or so. NA-H stated did for R26 was to leave 1:1 visits with the makers. HL-B state activities in the fellod listen in. R26's vey Report for activitier 2014, December 2 reviewed with HL-B at the entire the state of the state activities in the fellod listen in. R26's vey Report for activitier 2014, December 2 reviewed with HL-B at the state activities in the fellow of the state activities with the state activities in the fellow of the state activities activities in the fellow of the state activities in the fellow of the state activities activ | ape activity sed R26 did at they bey might I the only eave the d R26 e nursing d R26 was wship hall ties for the 2014 and and | 21435 | | | |
| | events (documenta event) -December 2014 - d events. | tion lacked name of documentation of 0 actions | activity | | | | |
| | attendance sheets of homemakers for accomber 2014, ar revealed R26 attended 12/25/14, a group a on 12/31/14, 1/6/15 | e were additional accompleted by the stivities for the month and January 2015. The ded present opening activity on 12/26/14, and 1/7/15. HL-B verset in the stivities and no 1:1 | ns of nese on and bingo erified | | | | |

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| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|--|---------------------|---|-------------------|--------------------------|
| | | 00322 | B. WING | | 01/29/2015 | |
| | PROVIDER OR SUPPLIER | - INTERNATIONA 2201 KEE | NAN DRIVE | STATE, ZIP CODE | | |
| (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 CROSS-REFERENCED TO THE APPROVIDERICIENCY) | D BE | (X5) COMPLETE DATE |
| 21435 | documented for R2 have had 1:1 visits. expected staff to pr directed by the care | 6 and confirmed R26 should HL-B stated she would have ovide 1:1 activities for R26 as | 21435 | | | |
| | admissions and ho that she worked in ensure activities we there was no docur 1:1 visits as directe | usehold life (AHL) indicated coordination with HL-B to ere provided. AHL verified mentation R26 had received d on the care plan and uld have received 1:1 visits as | | | | |
| | R19 was not provid assessed need. | ed activities according to | | | | |
| | was diagnosed with The MDS also indic cognitive impairmed and encouragement indicated R19's dai were identified as Finvolvement in care | dated 1/13/15, indicated R19 in dementia and depression. Cated R19 had severe introduced and required staff reminders into attend activities. The MDS by and activity preferences R19 enjoyed family ediscussions, doing things with and participating in favorite | | | | |
| | R19's activity goals | A dated 1/13/15, indicated were being met and this care ed as R19 had been included ctivities. | | | | |
| | 1/20/15, indicated hincluded discussion newspapers, huntir | est Data Collection Tool dated nis current leisure interests n/reminisce, magazines, ng/fishing, camping, listening to c. he played the harmonica. | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | , , | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------------|---|--------------------------------|--------------------------|
| | | 00322 | B. WING | | 01/ | 29/2015 |
| | PROVIDER OR SUPPLIER | - INTERNATIONA 2201 KE | DDRESS, CITY, SENAN DRIVE | TATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| 21435 | 1:1 socializing, milit children. R19's current care interventions which interests and needs On 1/27/15, at 3:30 laying in his bed. R activity being held in the control of the control o | plan lacked a focus area and identified R19's activity. p.m. R19 was observed 19 did not attend the Kenon the fellowship hall. p.m. the activity calendar a social hour with a card At this time, R19 was observed and did not participate in this on Survey Report for activities ing: 9 participated in one activity on lacked name of the activity R19 participated in one activity on lacked name of the activity R19 participated in two activity he holiday potluck on 1/19/14 P participated in 9 activity ingo, small group, ball toss, | d d y y | | | |

Minnesota Department of Health

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|---|---------------------|---|-------------|--------------------------|
| | | 00322 | | B. WING | | 01/ | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONA | 2201 KEE | NAN DRIVE | STATE, ZIP CODE LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETE DATE |
| 21435 | around and make s to attend the activity stated the nursing a responsible for cook however they did as residents to the activity calendar the however nobody knexample, on 1/4/15 "couch potato" listed there was no time of what this activity me on 1/28/15, at 1:50 no documentation of participated in befollooks pretty pathetic on 1/29/15, at 1:25 director of admission were interviewed. The HL-B con R19's activity goals thought he had met admitted she had not documentation with had actually attended activity area of focu confirmed R19 had and that some of the more appropriate for listening to music, so box in his room and harmonica. HL-B cleisure interest eval on 1/20/15, the interest eval o | ure the residents who got to the activity. Sassistants were not redinating the activities esist in transporting the invities. O a.m. NA-E stated of ey will have somethin ows what it means. It is the activity calendard as a scheduled activities and nobot eans. p.m. HL-B confirmed a confirmed that activities R19 re 11/30/14. HL-B states." p.m. the HL-B and the same half on each resident firmed she had just ron his care plan becarbins goals; however the same activity. | s; ne in the g listed, For had ivity, dy knows d she had had ated "it ine e (AHL) ctivities has care esolved ause she he HL-B vities R19 ng R19's HL-B pairment uld be visits, e tinker play his o R19's reviewed ied did | 21435 | | | |

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| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | , , | LE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 00322 | B. WING | B. WING0 | | | |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONA 2201 KE | ENAN DRIVE | STATE, ZIP CODE | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE | |
| 21435 | offered or participated the facility would program designed to physical, mental an each resident. In a focus on the cognit community, social a individual resident. The Non-Traditional dated 6/12, indicated would be reflected and self-directed accivity director would response of the activity. | | | | | | |
| | The Director of Nur develop, review, an procedures to ensu inidivdualized activi needs. The Director of Nur educate all appropr procedures. The Director of Nur develop monitoring compliance. | THOD OF CORRECTION: sing or designee could d/or revise policies and re resident's have an ty program that meets their sing or designee could iate staff on the policies and sing or designee could systems to ensure ongoing | е | | | | |

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| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | 3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--|-------------------------|--|-----------------------------|--------------------------|
| | | 00322 | | B. WING | | 01/2 | 29/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | | NAN DRIVE ΓΙΟΝΑL FAL | LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT | ULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21445 | Continued From pa | ge 41 | | 21445 | | | |
| 21445 | MN Rule 4658.0900 Recreation Progran | Subp. 3 Activity and n; Director | | 21445 | | | 3/4/15 |
| | The activity and rec be a person who is | nd recreation program creation program direct trained or experience nd recreation staff and sing home. | tor must d to | | | | |
| | by: Based on interview facility failed to ensi directed by a qualifi was responsible for implementation, suj evaluation of the ac | and document review ure the activity professional directing the development and ongoing tivities program, as reial to effect all residernits. | y, the m was al who oment, g equired. | | corrected | | |
| | Findings include: | | | | | | |
| | policy and procedur activity program wo professional who ha a social or recreation five years, one of w | cations of Activity Directed dated 6/12, indicated uld be directed by a condition of the case of experience of the case of experience of exper | ed the jualified ience in e last a patient | | | | |
| | admissions and hot she had worked full years, but has not we department for any verified she did not required per facility director. | a.m. the director of usehold life (AHL)-C time at the facility for worked full time in the of those three years. have the qualification policy to be an activit | three activity DAHL-C s ies | | | | |
| | On 1/27/15, at 9:43 | a.m. the AHL-C state | ed she | | | | |

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| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | | SURVEY PLETED | |
|--------------------------|--|---|--|---------------------|--|------------------|--------------------------|
| | | 00322 | | B. WING | ····· | 01/2 | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONA | 2201 KEE | NAN DRIVE | STATE, ZIP CODE LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | IOULD BE | (X5) COMPLETE DATE |
| 21445 | spent approximatel activities and was a admissions, referra services, volunteers management. On 1/27/15, at 9:13 AHL-C had not wor department as has administrator also vice 30% of her time to services. SUGGESTED MET The administrator of activity director has | y 25-30% of her time ulso responsible for ls, discharge plannin s and health informat a.m. the administrat ked full time in the ad had multiple roles. T verified AHL-C was al | g, social ion or verified ctivity he lotted TION: sure the ions. | 21445 | | | |
| 21535 | Subpart 1. General must be free from unnecessary drug is A. in excessive therapy; B. for excessive C. without adec D. in the prese which indicate the odiscontinued. In addition to the dipart 4658.1310, the with provisions in the Code of Federal Research | al. A resident's drug lunnecessary drugs. It is any drug when use dose, including dupl | regimen An d: icate drug ts use; or equences ed or equired in comply ines for ection | 21535 | | | 3/4/15 |

Minnesota Department of Health STATE FORM

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING: | | | |
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| | | | | | | |
| | | 00322 | B. WING | | 01/2 | 9/2015 |
| NAME OF | PROVIDER OR SUPPLIER | | | TY, STATE, ZIP CODE | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | KEENAN DR RNATIONAL | IVE FALLS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN | ACTION SHOULD BE FO THE APPROPRIATE | (X5) COMPLETE DATE |
| 21535 | Continued From pa | age 43 | 21535 | | | |
| | Long-Term Care Fa Department of Hea Health Care Finand This standard is ind available through the | I, Guidance to Surveyors for acilities, published by the alth and Human Services, bring Administration, April 19 corporated by reference. It he Minitex interlibrary loan ate Law Library. It is not change. | 92. | | | |
| | This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure antipsychotic medications were monitored, managed and justification of use was identified for 2 of 5 residents (R6, R43) reviewed for unnecessary medications. | | ons | corrected | | |
| | Findings include: | | | | | |
| | R6 did not have a gradual dose reduction attempted nor justification / adequate indications for use identified for the continued use of Seroquel (an antipsychotic medication). | | | | | |
| | diagnoses that inclinsomnia, anxiety a orders dated 12/15 milligrams (mg) po 75 mg po at bedtim | eview Report indicated uded senile dementia, and paranoia. The physiciar /14, directed Seroquel 25 (by mouth) three times a doe, and 25 mg as needed uurs between midnight and 4 | ay, p to | | | |
| | 10/24/14, indicated had mood problem asleep or staying a and feeling tired or | mum Data Set (MDS) dated I R6 was cognitively intact a s that included trouble falling sleep, or sleeping too much having little energy nearly S further identified R6 had | ınd ig า | | | |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| AND DUAN OF CODDECTION IDENTIFICATION NUMBER. | | | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|-----------------------------|--|-------------------------------|--------------------------|--|
| | | 00322 | B. WING | | 01/: | 01/29/2015 | |
| NAME OF | PROVIDER OR SUPPLIER | • | ADDRESS, CITY, | STATE, ZIP CODE | 1 01/2 | 20/2010 | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | EENAN DRIVE NATIONAL FAL | .LS, MN 56649 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETE DATE | |
| 21535 | Continued From pa | age 44 | 21535 | | | | |
| | hallucinations or de | elusions. | | | | | |
| | paranoia, staff inter | not address behaviors of rventions for paranoid eroquel nor potential side quel. | | | | | |
| | was interviewed an addressed on the cowere no behaviors. reduction had been | S a.m. registered nurse (RN)- ad stated if behaviors were no care plan, it was because the RN-A stated a gradual dose a attempted on 8/13, but was a reduction had not been at time. | re | | | | |
| | justification/adequa | ored for side effects, or ate indication for use for sychotic medication) . | | | | | |
| | R43's Medication Review Report identified diagnoses that included unspecified psychosis. The physician's orders dated 1/20/15, identified an order for risperdal 0.125 mg po twice a day for diagnosis of psychosis, and may increase back to 0.125 mg in the a.m. and 0.25 mg in the p.m. if hallucinations return. | | | | | | |
| | had severely impair hallucinations, but in present. The MDS or had little energy felt bad about herse had let her family di thoughts that she will hurting herself in so MDS documented | dated 12/5/14, indicated R43 red cognition, had behaviors none that were recently further identified R43 felt tire about half or more of the day elf or that she was a failure of lown nearly every day, and havould be better off dead or of ome way nearly every day. The R43 had behaviors of sions, however it indicated not own. | or d vs, r ad | | | | |

| STATEMEN | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 00322 | B. WING | | 01/2 | 9/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | NAN DRIVE | LO MN 50040 | | |
| (VA) ID | SHIMMA DV STA | TEMENT OF DEFICIENCIES | | LS, MN 56649 PROVIDER'S PLAN OF CORRECTION | - NI | (VE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21535 | Continued From pa | ge 45 | 21535 | | | |
| | hallucinations/beha hallucinations / delurisperdal or potential On 1/29/15, at 9:25 and stated R43's cabehaviors because behaviors at this time monitoring had not On 1/29/15, at 1:09 (DON) was intervieexpect staff to follow dose reduction of periodic monitoring of side expects and the state of the state | p.m. the director of nursing wed and stated she would w the policy regarding gradual sychotropic medications, effects, and monitoring for te indication for use of | | | | |
| | Sedative/Hypnotics and behavior docur order to indicate the behavior, side effect monitored, and grad attempted. SUGGESTED MET | cal Medications and dated 6/14, directed mood mentation must continue in e medication has on the cts of the medication must be dual dose reductions must be | | | | |
| | SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident's medications are free from unnecessary medications. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. | | | | | |

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| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMI | | | SURVEY |
|--------------------------|--|--|---|---|------|--------------------------|
| | | 00322 | B. WING | | 01/2 | 9/2015 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | NAN DRIVE | LS, MN 56649 | | |
| (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 APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21535 | Continued From pa | ge 46 | 21535 | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |
| 21805 | MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights | | 21805 | | | 3/4/15 |
| | residents have the courtesy and respe | us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a | | | | |
| | This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to honor the right to be treated in a dignified manner regarding toileting concerns for 1 of 1 resident (R3) who was reviewed for dignity. | | | corrected | | |
| | Findings include: | | | | | |
| | uncomfortable becaher pants. R3 state her need to urinate staff tell her to just of they would clean he unable to stand the with a mechanical lin the wheelchair, sbed in order to clea sometimes her clot like. R3 added, "but One day I will get o sometimes she cou | p.m. R3 stated she was aluse she had just urinated in d when she informed staff of or have a bowel movement, go in the incontinent brief and er up. R3 stated she was refore staff transferred her ift and when she was seated taff had to transfer her into n her up. R3 stated hes got wet which she did not a what can I do? I can't stand. In the toilet." R3 stated held feel the urge to urinate or ment but when she told staff | | | | |

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Minnesota Department of Health

| - | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 00322 | | B. WING | | 01/ | 29/2015 |
| | PROVIDER OR SUPPLIER AMARITAN SOCIETY | - INTERNATIONA | 2201 KEE | NAN DRIVE | STATE, ZIP CODE LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| 21805 | they would say, "go you up." R3's Diagnosis Rep R3's diagnoses inclinhalation of food of type 2 diabetes, paid R3's quarterly Minimal 1/7/15, indicated R3 impairment and recone staff for person bed mobility, transformed mobility incontinent of urine bowel. The MDS indicated R3 was of toileting program to which could include voiding or bladder to indicated R3 was of toileting program to incontinence. R3's bladder inconting the memory mobility, minimal uritoileting. R3's Activity plan revised 1/5/15 staff assistance to to the care plan indicconsisted of having checked and changed in addition, the care benefits of refusals toilet substitutes have on 1/28/15, at 8:00 stated R3 did not us | ahead and go and valued and and go and valued preumonia during vomit, depression, in and osteoarthrosis and mand extensive assistant hygiene and two seers, dressing and toil exted R3 was frequer and always incontined and an unidentified bow manage R3's boweld in an unidentified bow manage R3's boweld in an unidentified bow manage R3's boweld in an unidentified and refusates of Daily Living (A, indicated R3 require atted R3's toileting so the incontinent product and indicated the refusated | dicated e to the anxiety, s.) dated nitive stance of staff for let use. Intly ent of urinary etinence prompted of ther wel sed on related to sed als of ADL) care ed total anical lift. The dule luct ur hours. It is and an and ant (NA)-A the bed | 21805 | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--|-------------------------|--|-----------------------------------|--------------------------|
| | | 00322 | | B. WING | | 01/2 | 29/2015 |
| NAME OF | PROVIDER OR SUPPLIER | • | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| GOOD S | AMARITAN SOCIETY | - INTERNATIONA | | NAN DRIVE TIONAL FAL | LS, MN 56649 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| 21805 | hours and she was also stated R3 did voided a large amowet. On 1/28/15, at 1:45 told her to go in her seldom used the bergod to sit in wet personetimes tell where a bowel movement tell her to go ahead would clean her up about it. I look at the so bad and I've new On 1/28/15, at 2:20 could at times tell shave a bowel moves she had never put I transferred. NA-A span and she did we asked R3 if she was verified staff would down her pants and with the mechanical probably not make accident. NA-A state could use to put R3 on the unable to walk and lift to transfer. NA-O | offered the bed panavery well with the bed punt and was also used punt and was also used penats. R3 also stated panats. R3 also stated pour pants is no good ants." R3 stated she en she has to urinate but when she tells so and go in her pants. R3 stated "I don't feat toilet and I want tower sat on it." I p.m. NA-A confirment to penate to be penated by the pant of the penated we put R3 on the stated we put R3 on the stated we put R3 on the stated we put R3 on the penated to use the toilet have to lay R3 downed then move her to the penated by the penated R3 it to the toilet before the penated the penated the penated the penated pena | d pan, ually quite d staff ed she hated it. d. It's no can and have taff, they and they el good o sit on it ed R3 urinate or A stated o how she he bed has never . NA-A l, pull he toilet would having an ing they he had was echanical nge her." | | | | |
| | | 3 a.m. registered nu | | | | | |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| MAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INTERNATIONA PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUIL. TAG PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUIL. TAG PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUIL. TAG TAG TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUIL. TAG TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUIL. TAG TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUIL. TAG TAG SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUIL. TAG TAG SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEPICENCE TO THE TAG CROSS-REFERENCE TO THE APTROPHY AND COMPARY (EACH CAPPED AND COMPARY TAG SUMMARY STATEMENT ON THE TAG (EACH CAPPED AND COMPARY (EACH CAPPED AND COMPARY (EACH CAPPED AND COMPARY (EACH CAPPED AND COMPARY (EA | - | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|-----------|--|---|--|--|---|-------------|-------------------------------|--|
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - INTERNATIONA XUMMARY STATEMENT OF DEFICIENCIES 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | | | | | A. BOILDING. | | | | |
| COOD SAMARITAN SOCIETY - INTERNATIONA 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | | | 00322 | | B. WING | | 01/2 | 29/2015 | |
| Comparison Com | NAME OF F | PROVIDER OR SUPPLIER | STF | REET ADI | ORESS, CITY, S | STATE, ZIP CODE | | | |
| PRIEFIX TAG REQUILATORY OR LSC IDENTIFYING INFORMATION) 21805 Continued From page 49 toilet and the toileting program therefore R3 was to have her incontinent product checked and changed. RN-B stated R3 rarely used the bed pan. When asked if staff should be let let line incontinent product and they would be cleaned up afterward, RN-B stated staff should be putting R3 on the bedpan. RN-B verified the mechanical lift sling could be used to transfer a resident on the toilet. RN-B also stated the facility had a hygiene sling but no longer used it. On 1/29/15, at 2:00 p.m. the director of nursing (DON) stated she expected staff to follow the care plan as long as the resident's request was in line with the care plan directive. The DON was asked if it was appropriate to tell a resident who stated they needed to use the bathroom to go in their pants and then they would be cleaned up, the DON stated "No." The facility's Resident Dignity policy issued 2/13, indicated the purpose was to maintain the dignity of all residents. The policy was to promote care for residents in a manner and an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents' dignity is | GOOD S | AMARITAN SOCIETY | - INTERNATIONA | | | LS, MN 56649 | | | |
| toilet and the toileting program therefore R3 was to have her incontinent product checked and changed. RN-B stated R3 rarely used the bed pan. When asked if staff should tell R3 or any other resident to void / defecate in their incontinent product and they would be cleaned up afterward, RN-B stated staff should be putting R3 on the bedpan. RN-B verified the mechanical lift sling could be used to transfer a resident onto the toilet. RN-B also stated the facility had a hygiene sling but no longer used it. On 1/29/15, at 2:00 p.m. the director of nursing (DON) stated she expected staff to follow the care plan as long as the resident's request was in line with the care plan directive. The DON was asked if it was appropriate to tell a resident who stated they needed to use the bathroom to go in their pants and then they would be cleaned up, the DON stated "No." The facility's Resident Dignity policy issued 2/13, indicated the purpose was to maintain the dignity of all residents. The policy was to promote care for residents in a manner and an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident's dignity is | PRÉFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | N SHOULD BE | COMPLETE | |
| The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. | 21805 | toilet and the toileting to have her inconting thanged. RN-B stapan. When asked if other resident to voincontinent product afterward, RN-B stapent the bedpan. RN-B stapent toilet. RN-B also stapent to longer. On 1/29/15, at 2:00 (DON) stated she care plan as long a line with the care plane with the care plane with the care plane with the care plane with the DON stated "Not the DO | ng program therefore R3 nent product checked and ated R3 rarely used the bif staff should tell R3 or an id / defecate in their and they would be clean ated staff should be putting. B verified the mechanical to transfer a resident on ated the facility had a hygused it. p.m. the director of nurse expected staff to follow the sthe resident's request wan directive. The DON was copriate to tell a resident to use the bathroom to go in they would be cleaned by they would be cleaned by the policy was to promote of anner and an environment and an | d bed any med up ng R3 al lift ato the giene was in who go in up, 2/13, ignity care ent s or her | 21805 | | | | |

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| 00322 B. WING | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|--|---------|--|-------|--------------------------|
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE 7IP CODE | | | 00322 | B. WING | | 01/2 | 9/2015 |
| GOOD SAMARITAN SOCIETY - INTERNATIONA 2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649 | | | | | | | |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM | PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | LD BE | (X5) COMPLETE DATE |
| 21805 Continued From page 50 develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | - | develop monitoring compliance. TIME PERIOD FOR | systems to ensure ongoing | 21805 | | | |