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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VOBD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00085

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/12/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HFE NE II 05/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/01/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/05/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245558

July 1, 2015

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

Dear Ms. Wepplo:

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

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

Effective April 30, 2015 the above facility is certified for:

78 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 19, 2015

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

RE: Project Number S5558023

Dear Ms. Wepplo:

On April 10, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 26, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 12, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 4, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 26, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 30, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 26, 2015, effective April 30, 2015 and therefore remedies outlined in our letter to you dated April 10, 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring

Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245558	A. Building B. Wing	5/12/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **04/23/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/30/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **04/30/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/30/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/kfd	05/19/2015	31223	5/12/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/26/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245558	A. Building B. Wing 01 - MAIN BUILDING 01	5/4/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0011	Correction Completed 04/03/2015	ID Prefix Reg. # NFPA 101 LSC K0072	Correction Completed 03/27/2015	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 03/27/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/kfd	05/19/2015	31223	05/04/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:
3/26/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VOBD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00085

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/26/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Becky Wong, HFE NE II 04/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/01/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 10, 2015

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

RE: Project Number S5558023

Dear Ms. Wepplo:

On March 26, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 5, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 5, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 26, 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 Services that your provider agreement be terminated by September 26, 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

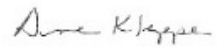
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Please contact me if you have any questions about this electronic notice.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		4/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	03/26/2015

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

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F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility failed to ensure Medicare appeal rights for Advanced Beneficiary Notice of Non-coverage (SNFABN) was given to 1 of 4 residents (R47) reviewed for liability notices. Findings include: R47 was admitted to the facility on 9/6/13, per the Admission Record. R47 had received notice Medicare denial on 2/11/15, however, R47 did not receive the proper liability and appeal rights for when she stayed in the facility. PT - Therapist Progress & Discharge Summary dated 2/5/15, indicated R47's start of care was 1/7/15, and end of care was 2/5/15. R47 was discharged to restorative program on 2/5/15 and	F 156	It is the current policy and procedure of GSS-Windom to follow all rules and regulations as outlined by CMS. R47 passed away during her Medicare A skilled stay on February 18, 2015. All current clients receiving Medicare A services have the potential to be affected by the deficient practice and will be reviewed for receipt of a denial if a therapy service ended while continuing to remain on Medicare A services, by April 21 and will be issued liability notices as directed by CMS Bulletin S&C-09-20. Business office staff was educated regarding the CMS Bulletin S&C-09-20, which covers Medicare Appeal Rights, by	

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F 156	Continued From page 3 notice should have been provided. PT - Therapist Progress & Discharge Summary dated 2/11/15, indicated R47's start of care was 1/7/15, and end of care was 2/11/15. OT - Therapist Progress & Discharge Summary dated 2/11/15, indicated R47's start of care was 1/8/15, and end of care was 2/11/15. On 3/24/15, at 3:00 p.m. the director of account services stated at the time therapy was ending, anything a resident incurred costs for required an Advanced Beneficiary Notice (ABN). After a resident had finished all skilled nursing they would get CMS10123, that was the end of all services then they would go into private pay. On 3/25/15, at 12:30 p.m. director of nursing (DON) stated R47 did not use 100 days and therapy was stopped for lack of progress. Physical therapy was dropped first, speech was dropped second, and occupational therapy continued. DON further stated R47 was not given notice of non-coverage, no notice was given of SNFABN. On 3/26/15, at 10:09 a.m. DON stated they did not have additional information. Only one notice was given. The facility stated they only gave one notice at the end of all skilled services. Good Samaritan Society Policy & Procedure Medicare Part B Billable Services dated 7/13, revised 2/14, indicated Procedure "Notifiers include physicians, providers, practitioners and suppliers paid under Part B. Providers must complete the ABN as described in the CMS instructions for CMS-R-131, and deliver the	F 156	the Payment Systems Director at the Good Samaritan Society National Campus on April 16, 2015. At the weekly Medicare meetings, the Medicare Team will audit all residents on Medicare A services to assure all beneficiary appeal rights have been given as outlined in CMS Bulletin S&C-09-20. This audit will occur weekly for 3 months and results will be reported to the QAPI committee with appropriate follow-up initiated.	

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F 156	Continued From page 4 notice to affected beneficiaries or his/her responsible party before providing the items or services that are subject of the notice" and "An ABN is given to beneficiaries in Original Fee-for-Service Medicare to convey that Medicare Part B is not likely to provide coverage in a specific case."	F 156		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329		4/30/15

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F 329	Continued From page 5 Based on observation, interview and document review, the facility failed to ensure 1 of 5 residents (R14) was not prescribed duplicative medications and the facility did not ensure resident was free from unnecessary medication for 1 of 5 residents (R34). In addition, the facility failed to ensure on-going lab work was completed to compare to baseline to ensure R13 received care and appropriate treatment for diabetes for 1 of 5 residents reviewed for unnecessary medications. Findings include: R14 was observed on 3/25/15, at 7:30 a.m. at breakfast fully dressed chatting -with peers, at 8:51 a.m. R14 was leaving breakfast and stated she "did not feel well", her "stomach was upset and it had been a bad pain night." The facility intake recorded, "did not eat more than 50% of toast with strawberry jelly & drank of pot of tea" (approximately 300 milliliters). R14 was admitted to the facility 1/11/08, per the Admission Record, with severe rheumatoid arthritis and esophageal reflux. The quarterly Minimum Data Set (MDS) dated 3/13/15, indicated R14 was cognitively intact, required extensive assist of two staff and an EZ stand for transfers, toileting dressing and bed mobility. During the 14 day review period R14 had little energy 12 to 14 days and a poor appetite seven to 11 days. The Care Area Assessment dated 7/11/14, indicated chronic pain due to rheumatoid arthritis, chronic to moderate knee pain and right upper arm/shoulder pain daily. On the current pain regimen the pain was rated as almost moderate and continual, which caused difficulty sleeping and limited day to day activities.	F 329	It is the current policy and procedure of GSS-Windom to provide adequate monitoring and documentation of medications and appropriate follow-up for labs. On April 23, 2015, R14□s physician will be informed and educated, during his visit, of the deficient practice regarding medications and will be asked to clarify his rational for prescribing duplicate medications, which affect the stomach. To identify other residents having the potential to be affected by the same deficient practice, an audit will be completed to identify other residents who receive the same combination of the medications, Axid and Nexium. Their doctors will be informed and educated with clarification of rational being requested by April 24, 2015. Licensed nurses will be educated regarding duplicate medications by April 30, 2015. A policy regarding duplicate medications will be developed by the consulting pharmacist by April 30, 2015. An audit of new orders for duplicate stomach medications will occur weekly for 12 weeks. Results will be reported to the QAPI committee with appropriate follow-up initiated. R34 was seen by her physician on April 7, 2015, and evaluated for appropriateness of medication and occurrence of side effects. Her care plan was reviewed on	

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F 329	Continued From page 6 The care plan dated 3/18/15, indicated R14 required extensive assistance of two staff related to rheumatoid arthritis pain, had mild depression as evidenced as feeling tired and had a poor appetite. R14 received medications that put her at risk of gastrointestinal bleeding (GI) and esophageal erosions and stomach upset, which included Coumadin (a blood thinner) for pulmonary embolism, Enbrel (an immunosuppressive drug) for rheumatoid arthritis, Plaquenil (a medications used for Malaria) for rheumatoid arthritis, Methotrexate (an immunosuppressive drug) for rheumatoid arthritis, Hydrocodone (a narcotic) for pain. In addition, R14 received Milk of Magnesia for nausea and vomiting and Zofran for nausea and vomiting. On 3/24/15, at 2:00 p.m. registered nurse (RN)-C stated R14 has a lot of pain because of arthritis, but they work really hard here to make sure people are on a pain control regimen that works for them. R14 has some weight loss because she was frequently nauseated. On 1/22/15, a consultant pharmacist (CP) Monthly Drug Review Report (MDDR) recommendation was written to address "Drug Duplication: Nexium 40 mg and Axid 150 mg HS. The Nexium order should suffice for GI bleed prevention. Can the Axid be discontinued", a hand written note from the CP stated Nexium is ordered for esophageal reflux, Axid is ordered for esophageal reflux). The physician response had written on the MDDR was "So who's determined these are "unnecessary"? Please advise. Nexium = PPI, Axid - H2 Blocker -duplicate??" "Speaks of easily upset stomach." "Will stay the course."	F 329	March 26, 2015 with appropriate changes. To identify other residents having the potential to be affected by the same deficient practice, an audit was completed to find other residents taking multiple psychoactive medications. Care plans, MDS/CAAs, mood and behavior documentation, and side effect documentation will be reviewed by April 30, 2015 with appropriate follow-up as indicated for those identified. Psychopharmacological Medications Sedative/Hypnotic procedure will be updated to include how and when the documentation will occur by April 30, 2015. Staff will be educated by the Good Samaritan Society National Campus regarding documentation and monitoring by April 30, 2015. Licensed nurses, social workers, and nursing assistants will be educated, with a goal of improving our multi-faceted behavior documentation process including the monitoring of side effects and the writing of CAAs for psychoactive medications by April 30, 2015. An audit of residents taking multiple psychoactive medications will occur weekly for 3 months during their MDS cycle for following the new documentation/monitoring procedure. Results will be reported to the QAPI committee with appropriate follow-up initiated. R13 had her HgbA1C checked on March	

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F 329	Continued From page 7 The medical record lacked evidence to clarify the rationale for the duplicate medication, to determine the risks versus benefits of the duplicate therapy, and the approach to monitoring for benefits and adverse consequences. On 3/26/15, at 1:30 p.m. the director of nursing services (DNS) stated the CP had written the recommendation once and had not repeated it. When asked when does the DNS become involved, the DNS indicated "This was the medical director of the facility." The DNS further commented it was reiterated to the medical director that "CMS requires and MDH requires." A review of the medication package inserts (The National Institute of Health, U.S. National Library of Medicine, dailymed.nlm.nih.gov.) for Axid (9/1/10) and Nexium (7/15/14) indicated: H2 (histamine) blocker was a shorter acting medication and would only last 12 hours for the relief of occasional or intermittent heartburn by blocking the histamine release that causes acid secretion. The PPI (proton-pump inhibitor) was a longer acting medication that was indicated for people with esophageal erosions that needed long term control of acid production to reduce the inflammation in the esophagus for people at chronic high risk from erosions and esophageal inflammation. The facility policy for duplicative medications was requested and none was provided. R34 was observed lying in bed with her eyes closed on 3/25/15, at 7:13 a.m. -At 7:25 a.m. R34's door to room was observed slightly open R34 still lying in bed asleep.	F 329	27, 2015 and no changes were indicated. To identify other residents having the potential to be affected by the same deficient practice, an audit will occur of HgbA1C orders with corresponding results, with appropriate follow-up as indicated. Our new procedure includes a daily review of new lab orders to ensure they are properly scheduled. The nurses will be educated by April 30 regarding this new procedure. An audit of HgbA1C orders with corresponding lab results to ensure all are done in the proper time frame will occur weekly for 12 weeks. Results will be reported to the QAPI committee with appropriate follow-up initiated.	

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F 329	Continued From page 8 -At 7:40 a.m. upon entering room nursing assistant (NA)-A was observed standing next to R34 who was seated on the edge of bed. NA-A was observed providing R34 with cares and cued R34 as she assisted R34 to get her clothing on. During the observation R34 was noted to be sleepy and dozing on and off. When asked how she had slept R34 stated "well." -At 7:49 a.m. both NA's were observed cue R34 to stand with lift provided pericare, adjusted clothing and sat R34 on the wheelchair (w/c). R34 was appeared sleepy, calm, pleasant and followed commands during the entire time cares were being provided. -At 7:58 a.m. NA-B was observed wheeling R34 to the television lounge area and stationed her w/c in front of the television. -At 8:25 a.m. R34 was observed still seated on her w/c in the television lounge with her eyes closed, asleep, and not easily aroused with noise. -At 8:40 a.m. R34 woke up abruptly observed smiling looked around appeared confused indicated a friend had visited the previous night then briefly went back to sleep. -At 9:10 a.m. R34 still sleeping in front of the TV. On 3/25/15, at 11:35 a.m. R34 was observed seated on a recliner in front of the nursing station then two NA's came and transferred R34 from the recliner to the w/c and took R34 to the bathroom then took her to the dining room for lunch. - At 2:55 p.m. R34 was observed seated in the recliner a sleep again. R34 was able to be woken up with loud noise from the emergency weather system and the medication room door slamming. R34 then would go right back to sleep. On 3/26/15, at 7:40 a.m. R34 was observed seated on her w/c by the nursing station eyes	F 329		

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closed head bend over and asleep.
- At 11:20 a.m. R34 was observed seated on her w/c by the nursing station eyes closed head bend over and asleep.

R34's diagnoses included dementia with behavioral disturbance, generalized pain, depressive disorder, anxiety disorder and Myasthenia gravis obtained from quarterly Minimum Data Set (MDS) dated 12/19/14.

R34's psychotropic drug use Care Area Assessment (CAA) dated 12/29/14, indicated R34 had a diagnosis of dementia with behavioral disturbances, was resistive with cares, attempted to exit building looking for deceased spouse and parents. CAA indicated R34 was on Zoloft (an antidepressant), Seroquel (an anti-psychotic medication) and Ativan (an anti-anxiety medication) as needed. R34's CAA's did not indicated behavior and side effects was to be completed/monitored.

R34's care plan dated 3/23/15, indicated R34 was on antipsychotic medication therapy related to dementia with behavioral disturbance. The care plan directed to monitor for behavioral symptoms that presented a danger to R34 or others. In addition care plan dated 7/30/14, indicated R34 was using psychopharmacological medications related to dementia as evidenced by potential for physical abuse or verbal sarcasm with cares, weepiness when delusional about finding her home, searching for husband, parents or children. The care plan directed "monitor/record/report to health care provider as needed [prn] side effects and adverse reactions..."

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F 329	Continued From page 10 R34's physician order summary report dated 3/25/15, revealed the following medications: -Seroquel 25 milligram (mg) by mouth (PO) one time a day for exit seeking behaviors related to dementia with behavioral disturbance. -Zoloft 100 mg 1 tablet PO in the morning for generalized anxiety -Ativan 1 mg every six hours as needed for generalized anxiety disorder. On 3/26/15, at 7:40 a.m. when asked how the staff documented R34's behaviors registered nurse (RN)-A stated "nursing assistants can document on the mood and behavior and the nurse can chart in the progress notes as it happens and the team discusses the medication effectiveness and if medication is doing what it is supposed to be doing every three months usually with their MDS's and this can be done early if there is any problems that have been identified." When asked about side effect monitoring for both antipsychotics, anti-anxiety, and antidepressant, RN-A indicated that was documented by exception as they were identified. RN-A verified R34 did not have side effect monitoring. When surveyor indicated R34 had been noted to be sleepy since 3/25/15, RN-A stated R34 would be at times be up and going for a few days then would have days that she was down and did not think R34 was sedated. The medical record lacked evidence of the side effect monitoring of the psychotropic medication as the facility indicated they documented by exception for the monitoring of side effects, mood symptoms and target behaviors as R34 was noted to sleepy during the observations. On 3/26/15, at 8:50 a.m. director of health information management approached surveyor	F 329		

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and indicated she had run reports for behavior and mood monitoring and had not found any records for R34.

On 3/26/15, at 10:38 a.m. RN-B stated behaviors and side effects were both documented for residents who were on long standing psychoactive medication as it happened, unlike those residents who were on Medicare charting was completed every shift. RN-B further stated R34 behaviors were documented as they happened. When asked about side effect monitoring RN-B stated "this is something we always watch for and charted as it happened."

On 3/26/15, at 11:41 a.m. when asked how behaviors were tracked and trended for residents with behaviors and were on antipsychotics, RN-A indicated at the time of the meetings documentation was reviewed and the number of times documented was counted and the team would review to see if the medication was effective. RN-A showed surveyor a progress noted dated 2/19/15, but in the note only R34's increased behavior had been discussed related to a trial dose reduction no side effects were noted.

On 3/26/15, at 12:18 p.m. the director of nursing services stated "I suppose corporate has not given direction to monitor behaviors and side effects daily or weekly. Nurses were educated in the meeting in January about safe medication management and medication side effects. There is a fault in Point Click Care [PCC] and in our old system the side effects were right in front of you." The DNS acknowledged there was nothing in the system for adequate monitoring for both behaviors and side effects.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 12 Psychopharmacological Medications Sedative/Hypnotic procedure revised 6/14/15, directed "9. Throughout the administration of the psychopharmacological medications and sedative/hypnotic drugs, the following must be completed: a. Mood and behavior documentation must continue in order to indicate the effect the medication has on the behavior. b. Monitor for side effects of the medication. If a side effect occurs or worsening of known side effect is noted..." The procedure did not indicate who was responsible for ensuring behavior and side effect monitoring was in place for residents who received psychoactive medications. R13 had been receiving Novolog 70/30 insulin 32 units daily subcutaneously to treat the medical diagnosis of diabetes mellitus type II. During review of the laboratory (lab) results for the Hemoglobin A1C (used to monitor blood sugar) dated 9/2/14, the level was 6.8 which was high (out of the reference range of 4.8-6.0). The Physician Orders (dated 8/27/14)specified the A1C to be checked every three months. Review of the medical record indicated a repeat A1C was not drawn since 9/2/14. During an interview on 3/26/15, at 1:44 p.m. the DNS verified the A1C had not been completed since 9/2/14. The DON also verified that R13 had not been scheduled for a lab draw since the 9/2/14, lab test. R13's A1C had not been drawn to collect ongoing data to compare to baseline to ensure R13 received care and appropriate treatment for diabetes.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		4/30/15

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	245558	A. BUILDING _____ B. WING _____	03/26/2015

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F 428	Continued From page 13 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the consultant pharmacist identified and reported irregularities in medication regimen for 2 of 5 residents (R34, R13). Findings include: R34 was observed lying in bed with her eyes closed on 3/25/15, at 7:13 a.m. -At 7:25 a.m. R34's door to room was observed slightly open R34 still lying in bed asleep. -At 7:40 a.m. upon entering room nursing assistant (NA)-A was observed standing next to R34 who was seated on the edge of bed. NA-A was observed providing R34 with cares and cued R34 as she assisted R34 to get her clothing on. During observation R34 was noted to be sleepy and dozing on and off. When asked how she had slept R34 stated "well." -At 7:49 a.m. both NA's were observed cue R34 to stand with lift provided pericare, adjusted clothing and sat R34 on the wheelchair (w/c). R34 was appeared sleepy, calm, pleasant and	F 428	It is the current policy and procedure of GSS-Windom for the resident medication regime to be reviewed monthly by the consulting pharmacist with appropriate recommendations given. The consulting pharmacist was informed of the deficient practice regarding resident R34 and R13. A new pharmacy drug review report will be completed for these residents by April 23, 2015, focusing on efficacy and monitoring of side effects. Care plan updates will be made as indicated based on the recommendations. Residents at risk are all those currently taking Seroquel or Insulin. The consulting pharmacist will review these residents for appropriate efficacy and monitoring of side effects. Care plans will be updated as recommended. All future residents taking Seroquel or Insulin will be monitored for efficacy and	

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F 428	Continued From page 14 followed commands during the entire time cares were being provided. -At 7:58 a.m. NA-B was observed wheeling R34 to the television lounge area and stationed her w/c in front of the television. -At 8:25 a.m. R34 was observed still seated on her w/c in the television lounge with her eyes closed, asleep, and not easily aroused with noise. -At 8:40 a.m. R34 woke up abruptly observed smiling looked around appeared confused indicated a friend had visited the previous night then briefly went back to sleep. -At 9:10 a.m. R34 still sleeping in front of the TV. On 3/25/15, at 11:35 a.m. R34 was observed seated on a recliner in front of the nursing station then two NA's came and transferred R34 from the recliner to the w/c and took R34 to the bathroom then took her to the dining room for lunch. On 3/25/15, at 2:55 p.m. R34 was observed seated in the recliner a sleep again. R34 was able to be woken up with loud noise from the emergency weather system and the medication room door slamming. R34 then would go right back to sleep. On 3/26/15, at 7:40 a.m. R34 was observed seated on her w/c by the nursing station eyes closed head bend over and asleep. On 3/26/15, at 11:20 a.m. R34 was observed seated on her w/c by the nursing station eyes closed head bend over and asleep. R34's diagnoses included dementia with behavioral disturbance, generalized pain, depressive disorder, anxiety disorder and Myasthenia gravis obtained from quarterly	F 428	side effects. The monthly drug review reports will be audited for those residents taking Seroquel or Insulin to ensure the consulting pharmacist has completed a monthly assessment for 6 months by the QAPI Coordinator or designee. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated.	

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F 428	Continued From page 15 Minimum Data Set (MDS) dated 12/19/14. R34's psychotropic drug use Care Area Assessment (CAA) dated 12/29/14, indicated R34 had a diagnosis of dementia with behavioral disturbances, was resistive with cares, attempted to exit building looking for deceased spouse and parents. CAA indicated R34 was on Zoloft (an antidepressant), Seroquel (an anti-psychotic medication) and Ativan (an anti-anxiety medication) as needed. R34's CAA's did not indicated behavior and side effects was to be completed/monitored. R34's care plan dated 3/23/15, indicated R34 was on antipsychotic medication therapy related to dementia with behavioral disturbance. The care plan directed to monitor for behavioral symptoms that presented a danger to R34 or others. In addition care plan dated 7/30/14, indicated R34 was using psychopharmacological medications related to dementia as evidenced by potential for physical abuse or verbal sarcasm with cares, weepiness when delusional about finding her home, searching for husband, parents or children. The care plan directed "monitor/record/report to health care provider as needed [prn] side effects and adverse reactions..." R34's physician order summary report dated 3/25/15, revealed the following medications: -Seroquel 25 milligram (mg) by mouth (PO) one time a day for exit seeking behaviors related to dementia with behavioral disturbance. -Zoloft 100 mg 1 tablet PO in the morning for generalized anxiety -Ativan 1 mg every six hours as needed for generalized anxiety disorder.	F 428		

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F 428	Continued From page 16 On 3/26/15, at 7:40 a.m. when asked how the staff documented R34's behaviors registered nurse (RN)-A stated "nursing assistants can document on the mood and behavior and the nurse can chart in the progress notes as it happens and the team discusses the medication effectiveness and if medication is doing what it is supposed to be doing every three months usually with their MDS's and this can be done early if there is any problems that have been identified." When asked about side effect monitoring for both antipsychotics, anti-anxiety, and antidepressant, RN-A indicated that was documented by exception as they were identified. RN-A verified R34 did not have side effect monitoring. When surveyor indicated R34 had been noted to be sleepy since 3/25/15, RN-A stated R34 would be at times be up and going for a few days then would have days that she was down and did not think R34 was sedated. The medical reocrd lacked evidence of the efficacy of the psychtropic medication as the facility indicated they documented by exeception for the monitoring of side effects, mood symptoms and target behaviors. On 3/26/15, at 8:50 a.m. director of health information management approached surveyor and indicated she had run reports for behavior and mood monitoring and had not found any records for R34. On 3/26/15, at 10:38 a.m. RN-B stated behaviors and side effects were both documented for residents who were on long standing psychoactive medication as it happened, unlike those residents who were on Medicare charting was completed every shift. RN-B further stated	F 428		

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F 428	Continued From page 17	F 428		

R34 behaviors were documented as they happened. When asked about side effect monitoring RN-B stated "this is something we always watch for and charted as it happened."

On 3/26/15, at 11:41 a.m. when asked how behaviors were tracked and trended for residents with behaviors and were on antipsychotics RN-A indicated at the time of the meetings documentation was reviewed and the number of times documented was counted and the team would review to see if the medication was effective. RN-A showed surveyor a progress noted dated 2/19/15, but in the note only R34's increased behavior had been discussed related to a trial dose reduction no side effects.

On 3/26/15, at 12:18 p.m. the director of nursing services stated I suppose corporate has not given direction to monitor behaviors and side effects daily or weekly. Nurses were educated in the meeting in January about safe medication management and medication side effects. There is a fault in Point Click Care [PCC] and in our old system the side effects were right in front of you." The DNS acknowledged there was nothing in the system for adequate monitoring for both behaviors and side effects.

During further document review it was revealed the consultant pharmacist (CP) monthly medication regimen review was last completed on 2/25/15, and 3/17/15, no irregularities had been identified.

On 3/26/15, at 3:15 p.m. when asked about behavior monitoring CP indicated they do weekly behavior meetings with the staff and Social Worker (SW). There is a sheet to review upon

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admission telling them about side effects. He didn't know when they switched to (PCC). CP further stated "It depends on how you enter the drug, you have to enter it twice to get the side effect monitoring to come in. I don't know how the other facilities do it."

Psychopharmacological Medications
Sedative/Hypnotic procedure revised 6/14/15, directed "9. Throughout the administration of the psychopharmacological medications and sedative/hypnotic drugs, the following must be completed:
a. Mood and behavior documentation must continue in order to indicate the effect the medication has on the behavior.
b. Monitor for side effects of the medication. If a side effect occurs or worsening of known side effect is noted..." The procedure did not indicate who was responsible for ensuring behavior and side effect monitoring was in place for residents who received psychoactive medications.
R13 had been receiving Novolog 70/30 insulin 32 units daily subcutaneously to treat the medical diagnosis of diabetes mellitus type II. During review of the laboratory (lab) results for the Hemoglobin A1C (A1C, used to monitor blood sugar) dated 9/2/14 the level was 6.8 which was high (out of the reference range of 4.8-6.0). The physician orders (dated 8/27/14)specified the A1C to be checked every 3 months. Review of the medical record indicated that a repeat A1C was not drawn since 9/2/14. The facilty pharmacist consultant revied the medication regimen monthly and did not note any irregularities or made recommendations regarding the A1C level not being drawn.

During an interview on 3/26/15, at 2:20 p.m. the

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F 428	Continued From page 19 pharmacist consultant verified the A1C should have been checked per physcian orders stating, "I have the orders here. I should have caught it."	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		4/30/15

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F 441	Continued From page 20 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were used during cares for 1 of 2 residents (R34) who received personal cares. Findings include: On 3/25/15, at 7:40 a.m. to 7:45 a.m. upon entering room nursing assistant (NA)-A was observed standing at the edge of bed and R34 was seated on the edge of bed. NA-A was observed wash R34's upper torso applied shirt and sweater. NA-A then assisted R34 to lie back down. NA-A indicated she was going to get the lift and another staff to assist her to get R34 up. NA-A then covered R34, lowered the bed, and went to the bathroom. She then dumped the soiled water in the toilet. NA-B entered the room and then went out of the room and immediately came back with the lift and she left the room to get the commode. NA-A gathered all the linen used for cares with same gloves went outside the room disposed the linen came back room went to the never washed hands. -At 7:46 a.m. both NA's were observed hook R34 to the EZ-standing lift (mechanical lift used for transfers) cued R34 to stand with the lift and then pulled the lift over to the commode removed R34's incontinent pad and sat her on the commode and cued R34 to void. -At 7:49 a.m. NA-B cued R34 to stand as she controlled the lift. NA-A was observed to don a	F 441	It is the current policy and procedure of GSS-Windom for all nursing assistants to follow proper infection control procedures including soiled glove removal at the appropriate time. All residents under the care of NA-A during the shift of March 25, 2015 would have been at risk for the deficient practice. NA-A received education, during her March 25, 2015 shift, regarding proper soiled glove removal. All nursing assistants will be educated by April 30, 2015, regarding proper soiled glove removal. An audit will occur of nursing assistants, regarding proper soiled glove removal during toileting and peri-care, 5x/week for 2 weeks, and then 3x/week for 4 weeks, and then 2x/week for 6 weeks. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated.	

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F 441	Continued From page 21	F 441		

pair of gloves. She came in the bathroom with a wash basin with a small amount of water in it, a wash towel and another towel. She then provided R34 with pericare with a wash cloth observed a smear of brown matter upon first wipe, pat dried R34's bottom applied a clean incontinent pad from one side as NA-B was doing the other side. NA-A never removed her gloves and then pulled R34's pants up. NA-B wheeled the lift machine to wheelchair (w/c) then from each side both NA's unhooked the lift sheet. Both NAs still had the same soiled gloves on from when they had provided pericare.
-At 7:51 a.m. NA-B went over to the bathroom removed gloves washed her hands came back took the lift sheet off the back of R34 and adjusted her clothing and combed her hair.
-At 7:53 a.m. NA-A was observed touch the back w/c handles with same soiled gloves. Then NA-A went into the bathroom, dumped the soiled pericare water, and took out the soiled linen. NA-A went over to the bed side and touched the bed linen. She collected more soiled linen and trash and then still with the same gloves touched the back of the commode handle. NA-A then opened the door by touching the doorknob with the same soiled gloves she had used to provide pericare. NA-A went down the hallway to the soiled utility room open the door with same soiled gloves, disposed the trash, dumped the urine from the commode to the hopper, sprayed both the container and the surface of the commode, and then removed gloves at that time and washed her hands.

On 3/25/15, at 7:57 a.m. NA-A was interviewed. NA-A was asked what the facility policy was for gloving and hand washing. NA-A stated she was supposed to have removed her gloves and

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F 441	Continued From page 22 washed her hands after pericare. She acknowledged she had not removed/ changed gloves through the entire observation after providing pericare. -At 7:59 a.m. NA-B stated the facility policy was staff was supposed to remove gloves after pericare before continuing with other cares and then don another pair to continue with cares. On 3/26/15, at 12:40 a.m. the director of nursing service stated all the nursing assistants had been given education on gloving and hand washing and during the in-service various scenarios had been reviewed and staff had been directed "to remove gloves in the room, wash hands and leave the germs in the room." DNS indicated she would have expected the staff to have followed through as in-serviced.	F 441		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on March 26, 2015. At the time of this survey, Good Samaritan Society Windom was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/20/2015

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

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Windom is a one-story building with partial basement, and was constructed at five different times. The original building was constructed in 1959, with building additions in 1962, 1972, 1994 and 2000. All buildings were determined to be of Type II(111) construction. The facility is fully sprinklered. The building has a fire alarm system with smoke detection in the corridors, including all spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a capacity of 78 beds and had a census of 74 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a	K 011		4/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/26/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 011	Continued From page 2 nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour rated construction at the building separation walls in accordance with 2000 - NFPA 101, sections 19.1.1.4.1 and 8.2.3.2. The deficient practice could affect all 74 residents. Findings include: On facility tour between 11:30 AM and 2:45 PM on 03/26/2015, observation revealed, that the 2 hour fire separation wall from the 100 Wing and the 200 Wing above the lay in ceiling had a penetration around conduit pipe. This deficient practice was confirmed by the Facility Maintenance Director (KD) at the time of discovery.	K 011	The penetration in the wall was repaired on April 3, 2015. All other walls were checked and found to be compliant. The Safety Coordinator and Maintenance Director will monitor the facility for future issues through the Safety Meeting audits and the QAPI committee.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072		3/27/15

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	245558	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/26/2015**

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K 072	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain an egress corridor free from impediments to full instant use in the case of fire or other emergency, in accordance with NFPA 101 (2000), Chapter 7, Sections 7.1.10.1 and 7.1.10.2.1, and, the 2007 edition of Minnesota State Fire Code (MSFC) Chapter 10, Section 1028. In an emergency evacuation situation, these impediments could interfere with the prompt and orderly evacuation of 20 of 74 residents, staff and visitors. FINDINGS INCLUDE: On 3/25/15 at 1:30 PM, observation revealed boxes of ceiling tiles and other maintenence repair items being stored in the 500-Wing egress corridor.near the exterior exit. On 3/25/15 at 2:00 PM, observation revealed broken chairs and other furniture items waiting to be disposed of being stored in Service Exit egress corridor. These storage arrangements are not in conformance with NFPA 101 (00) Chapter 7 and the 2007 edition of Minnesota State Fire Code (MSFC) Section 1028. This finding was confirmed with the Facility's Maintenence Director (KD) at the time of discovery.	K 072	The items in the means of egress were removed on March 27, 2015. All other means of egress were compliant. The Safety Coordinator and Maintenance Director will monitor the facility for future issues through the Safety Meeting audits and the QAPI committee.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in	K 144		3/27/15

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K 144	Continued From page 4 accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 74 residents. Findings include: On facility tour between 11:30 AM and 2:45 PM on 03/26/2015, documentation review of the monthly inspection logs of 2015/2014 for the diesel emergency generator revealed that the warm up time, time operating under full load and the cool down time was not being documented properly. This deficient practice was confirmed by the Facility Maintenance Director (KD) at the time of discovery	K 144	The emergency generator documentation was amended to include noting the warm-up time, full load for 30 minutes, and cool-down time on March 27, 2015. The Safety Coordinator and Maintenance Director will monitor the facility for future issues through the Safety Meeting audits and the QAPI committee.	