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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VRRR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00961

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245314**
2.STATE VENDOR OR MEDICAID NO.
(L2) **841820900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WINTHROP**
(L4) **506 HIGH STREET**
(L5) **WINTHROP, MN** (L6) **55396**

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 **10/02/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37			
(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 Serie, Supervisor 10/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/13/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1986
(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
09/18/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5314

Electronically Delivered October 13, 2014

Ms. Teresa Hildebrandt, Administrator
Good Samaritan Society - Winthrop
506 High Street
Winthrop, Minnesota 55396

Dear Ms. Hildebrandt:

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 September 23, 2014 the above facility is certified for:

37 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 37 skilled nursing facility beds.

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

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

Sincerely,

Anne Kleppe

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: October 13, 2014

Ms. Teresa Hildebrandt, Administrator
Good Samaritan Society - Winthrop
506 High Street
Winthrop, Minnesota 55396

RE: Project Number S5314023

Dear Ms. Hildebrandt:

On August 27, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 14, 2014. 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 October 2, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 1, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 14, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 23, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 14, 2014, effective September 23, 2014 and therefore remedies outlined in our letter to you dated August 27, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245314	A. Building B. Wing	10/2/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

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 **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **09/23/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **09/23/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **09/23/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/23/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/23/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/23/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/23/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/AK	10/13/2014	03048	10/02/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/14/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245314	A. Building B. Wing 01 - MAIN BUILDING 01	10/1/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

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 K0051	Correction Completed 09/23/2014	ID Prefix ___ Reg. # ___ LSC ___	Correction Completed	ID Prefix ___ Reg. # ___ LSC ___	Correction Completed
ID Prefix ___ Reg. # ___ LSC ___	Correction Completed	ID Prefix ___ Reg. # ___ LSC ___	Correction Completed	ID Prefix ___ Reg. # ___ LSC ___	Correction Completed
ID Prefix ___ Reg. # ___ LSC ___	Correction Completed	ID Prefix ___ Reg. # ___ LSC ___	Correction Completed	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	PS/AK	10/13/2014	22373	10/01/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/20/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VRRR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00961

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245314**

2.STATE VENDOR OR MEDICAID NO.
(L2) **841820900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WINTHROP**
(L4) **506 HIGH STREET**
(L5) **WINTHROP, MN** (L6) **55396**

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 **08/14/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37			
(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 :
Wendy Buckholz, HFE NE II 09/08/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1986
(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
Posted 09/18/2014 Co.

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: August 27, 2014

Ms. Teresa Hildebrandt, Administrator
Good Samaritan Society - Winthrop
506 High Street
Winthrop, Minnesota 55396

RE: Project Number S5314023

Dear Ms. Hildebrandt:

On August 14, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

Informal Dispute Resolution - your right to request an informal reconsideration to dispute

the attached deficiencies.

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 East Lyon Street
Marshall, MN 56258-2529
Email: kathryn.serie@state.mn.us
Office: (507) 476-4233
Fax: (507) 537-7194

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 September 23, 2014, 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 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 November 14, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 14, 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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		9/23/14

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

Electronically Signed | 09/04/2014

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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	245314	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the physician when significant health changes occurred for 1 of 1 resident (R16) in the sample who had uncontrolled blood pressure. Findings include: R16 was admitted to the facility on 8/28/12, and the physician orders dated 7/22/14, identified diagnoses which included: coronary artery disease, congestive heart failure (CHF), history of myocardial infarction, hypertension, anoxic brain damage and chronic stage 3 renal disease. R16's physician orders dated 7/22/14, identified the following medications: Amlodipine, 5 milligrams (mg) every day (qd) for hypertension; Aspirin, 81 mg qd for hypertension; Lasix, 40 mg qd for hypertension; Lopressor,100 mg twice daily for hypertension; and Potassium Chloride, extended release, 20 millequivalents qd for hypertension. The medical record identified that R16 had been hospitalized on 5/2/14 with chest pain,	F 157	Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility□s allegation of compliance in accordance with section 7305 of the State Operations Manual. F-157 The physician was notified of abnormal blood pressure readings on 8/27/14. Physician order to check blood pressure	

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F 157	Continued From page 2 hypertension and CHF. During review of R16's medical record, it was noted in the vital statistic tracking section of the medical record that R16's blood pressure (B/P) was variable and irregular. In the past 30 days (7/13/14 thru 8/13/14), R16's B/P recordings ranged between 74/45 to 141/115. The following B/P readings were noted: (1) On 5/16/14, at 10:06 a.m. - BP was 74/45; rechecked one minute later and was recorded as 155/102 at 10:07 a.m. Documentation was lacking to indicate any follow-up notes related to the concern had been addressed;. (2) On 6/6/14 -B/P was 150/101; no documentation of any follow-up;. (3) On 6/20/14, at 5:46 p.m.- B/P was 141/115 and no documentation of follow-up in the medical record; (4) On 6/27/14, at 10:11 a.m. - B/P was 159/91 and again no follow-up notes; and (5) On 7/19/14, 12:20 a.m.- B/P was 83/47 with no follow-up assessment. During interview with registered nurse (RN)-A on 8/14/14, at 9:30 a.m. it was verified there were no follow-up nurses' notes nor had the physician been notified of the fluctuating B/P recordings. RN-A stated R16 had been to the hospital emergency room on 5/2/14 for elevated B/P and medication changes had been ordered by R16's physician. In addition, RN-A verified R16's B/P had not been controlled. RN-A stated that blood pressure reading were taken by trained medication assistants (TMA's) and they should had reported the fluctuating/irregular B/P readings to the RN's when elevated and/or low. RN-A indicated that if the TMA had notified her of the B/P's readings, follow-up with the physician	F 157	and pulse three times a day and follow up on 9/8/14. Physicians will be notified of residents having significant health changes including abnormal blood pressure readings. All current residents were reviewed to ensure that all current health changes have been communicated to the physician. Nursing staff educated on 8/28/14 to report significant health changes, including abnormal blood pressure readings, to the charge nurse. The charge nurse will notify the physician of significant health changes including abnormal blood pressure readings. Random audits of blood pressure readings will be completed by designated staff weekly X4 and then monthly x 2 to ensure that significant heatlh changes including abnormal blood pressure readings are reported to the physician. Results will be forwarded to the Quality Committee for further recommendations. Completion date 9/23/14	

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F 157	Continued From page 3 would have been done. RN-A stated a diastolic B/P under 50 or over 90 should have been reported to the RN by the TMA staff. During interview with RN-B on 8/14/14, at 10:15 a.m. she stated, after reviewing the documented recordings for R16's B/P, the B/P's were uncontrolled and should have been addressed with the physician. RN-B stated staff should have been monitored the B/P's more closely since they were out of range. The physician was not notified when BP readings fluctuated and R16 had a diagnosis of hypertension. The facility had a policy for Notification of Change in Resident Status dated 2/2005. The policy identified the facility should consult the physician and resident legal representative in the following cases: 1. Resident accident which results in injury with potential for requiring physician intervention. 2. Significant change in residents physical, mental or psychological status. 3. Need to alter treatment significantly. 4. Decision to transfer or discharge the resident from the center.	F 157		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278		9/23/14

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F 278	Continued From page 4 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the minimum data set (MDS) related to a left leg ulcer for 1 of 2 residents (R46) reviewed for pressure ulcers. Findings include: R46 was admitted to the facility on 5/5/14. The admission comprehensive assessment dated 5/12/14, revealed diagnoses including: peripheral vascular disease (PVD) and diabetes mellitus (DM). The assessment further revealed the presence of one stage 3 pressure ulcer. The quarterly assessment dated 8/1/14, also had documented the presence of one stage 3 pressure ulcer. The plan of care initiated 5/8/14,included a focus of: the arterial/ischemic	F 278	F-278 Each MDS for resident 46 was reviewed and MDS modification was done with the correct coding for left leg ulcer on 8/25/14. The MDS of all current residents with wounds were reviewed and MDS modification was done, if indicated, to ensure appropriate coding. Random audits will be completed by the DNS/designee to ensure accurate coding of wounds on the MDS. Results will be forwarded to the Quality Committee for further review and recommendations.	

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F 278	Continued From page 5 ulcer of the left leg r/t (related to) PVD and DM E/B (evidenced by) toe amputation and ulcer. When interviewed on 8/13/14, at 3:42 p.m. the registered nurse (RN)-A (who is also the MDS coordinator) stated she had not received clarification as to whether R46's leg ulcer was a pressure or venous ulcer. RN-A confirmed R46 had diagnoses of diabetes and peripheral vascular disease but since the documentation from the physician was so vague she decided to code his left leg ulcer as pressure. RN-A stated clarification had been requested from the podiatrist but none had been communicated; and RN-A was unable to provide evidence of the request. RN-A further stated the rationale to code R46's left leg ulcer as pressure instead of a venous ulcer was because additional interventions would be provided. When interviewed on 8/14/14, at 8:44 a.m. R46 stated the ulcer on the left lower leg and the amputation of the second toe on the left foot were due to diabetes and poor circulation. Further review of R46's record revealed a physician progress note from the Vascular Specialists of Minnesota dated 5/28/14, the diagnosis included: venous stasis ulcer. The progress note further identified the ulcer to be located on the "left lateral mid-tibial area". When interviewed on 8/14/14, at 2:00 p.m. RN-A confirmed that R46's diagnosis of a venous stasis ulcer of the left leg was located in the medical record on 5/28/14 and the 8/1/14 assessment was inaccurate and coded incorrectly.	F 278		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		9/23/14

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F 279 SS=D	Continued From page 6 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop a comprehensive care plan which included the use of a partial denture for 1 of 3 residents (R52) reviewed for dental concerns. Findings include: On 8/12/14, at 7:00 p.m. R52 was observed in the dining room eating supper and had no lower teeth visible. During a subsequent interview with R52 and his wife, R52 indicated he wore a lower partial denture which helped with eating. This	F 279	F-279 Resident 52 care plan was updated on 8/14/14 to include the use of a partial denture. Other residents with dentures will be identified and care plans reviewed and updated to include the use of dentures. Dentures are to be in place during meal times. All residents requiring dentures will have	

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F 279	Continued From page 7 was confirmed by his wife. During observation on 8/14/14, at 7:40 a.m. R52 attempted to eat a regular diet which consisted of 2 slices of toast, 1 fried egg, and a ham patty in the form of a sandwich without his partial denture. R52 then pointed to his lower gum, rubbed with his finger and stated the word "teeth", requesting his partial denture. The care plan identified the following diagnoses: pneumonitis due to inhalation of food or vomitus; chronic airway obstruction; stricture and stenosis of esophagus; dysphagia; gastrostomy; and nutritional deficiency. The care plan further identified that R52 had his own teeth, but did not identify the use of a partial denture plate. No interventions had been identified related to the partial denture plate. Interview with the director of nursing (DON) on 8/14/14, 9:00 a.m. verified the care plan had not identified the use of a lower partial denture plate.	F 279	dentures indicated on care plan. The MDS nurse and other nursing staff were educated on 8/28/14 on how to review and update resident care plans. Random audits of resident care plans will be completed weekly X 4 and monthly X2 by the DNS/designeee to ensure that dentures are care planned and in place during mealtime. Audit results will be forwarded to the Quality committee for further review/recommendations.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the plan of care was followed for 1 of 1 resident (R52) reviewed who required a mechanically altered diet and who received a regular texture diet.	F 282	F282 Resident 52 was given the correct diet immediately upon discovery of receving an incorrect diet and continues to receive a mechancial altered diet.	9/23/14

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F 282	Continued From page 8 Findings Include: R52's care plan identified the following diagnoses: pneumonitis due to inhalation of food or vomitus; chronic airway obstruction; stricture and stenosis of esophagus; dysphasia; and nutritional deficiency. The care plan identified that R52 received a pureed texture diet with nectar thickened liquids. The care plan also directed staff to monitor resident closely & report signs/symptoms of chewing/swallowing difficulties, coughing, choking, etc. On 8/12/14, at 5:57 p.m. during the evening, R52 was noted to have a pureed texture diet with nectar thickened liquids served. During the meal observation, R52 coughed and grimaced as he attempted to swallow bites of food. During this observation it was noted he had no lower teeth with no partial denture plate. During an interview with R52 and his spouse, on 8/12/14, at 6:30 p.m. it was confirmed that R52 had a lower partial denture plate but he did not have the partial denture placed for use during the evening meal. On 8/13/14, at 11:44 a.m. R52 was observed seated in the dining room and attempted to chew soft bite size pieces of chicken, mashed potatoes and cooked tomatoes. It was noted that the speech therapist (ST) applied denture cream to R52's lower partial denture and assisted with placement in his mouth. ST then repeatedly reminded R52 to, "take a bite", "double swallow", and then "take a drink". It was observed on 8/14/14, at 7:40 a.m. that R52 attempted to consume the regular diet for breakfast which consisted of: 2 slices of toast, a fried egg and a ham patty in the form of a	F 282	All residents are receiving the correct diet. Nursing and dietary staff were educated on 8/28/14 on how to ensure that each resident receives the appropriate diet. Random audits of meal service to ensure that residents are receiving the appropriate diet will be completed by designated staff weekly X 4 and then monthly X 2. Results will be forwarded to the Quality committee for review and further recommendations.	

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F 282	Continued From page 9 sandwich. R52 was observed to break pieces from the sandwich and place them into his mouth. A pureed consistency diet was not served to R52. During an follow-up observation on 8/14/14, at 7:50 a.m. R52 had pureed texture foods in three bowls placed on the table. When R52 was questioned about the sandwich he had been served and had consumed a portion of, R52 responded, the "nurse took it". When interviewed on 8/14/14, at 8:00 a.m. the licensed practical nurse (LPN)-A and NA-A verified that R52 was at risk for choking and the care plan/physician orders required a pureed texture diet with nectar thickened liquids and NOT a regular textured diet. The director of nursing (DON) was interviewed on 8/14/14, at 9:00 a.m. and verified that R52 was at risk for choking and aspiration. When interviewed on 8/14/14, at 12:28 p.m. the ST confirmed that R52 required pureed texture food items with nectar thickened liquids as stated in the care plan. She verified that since R52 was at risk for choking, and trials of textured food was to be attempted only by speech therapy staff.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		9/23/14

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F 323	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow proper procedure when an unwitnessed fall was discovered by staff for 1 of 3 residents (R49) reviewed for accidents and failed to provide the physician ordered pureed diet for 1 of 1 resident (R52) reviewed in the sample who was at risk for choking. Findings include: On 8/12/14, at 5:08 p.m. when the surveyor walked in the hallway past R49's room, it was noted that a wheelchair (w/c) was tipped over onto it's back on the floor in the room. Upon entering, it was observed that R49 was located on his knees on the floor next to his bed with the upper half of his body resting on the bed; a strong bowel movement type odor was present in the room. Nursing assistant (NA)-C, who was nearby, provided assistance to R49 and questioned R49 whether had fallen and the resident denied he had fallen. When NA-C questioned whether bathroom assistance was required, R49 indicated he needed assistance to pull his pants farther up. NA-C assisted R49 up from the floor and with the use of his 2 wheeled walker assisted R49 into the bathroom. R49 was admitted on 6/18/14 and the admission minimum data set (MDS) dated 6/24/14, revealed R49's diagnosis included a history of falls, Documentation on the MDS assessment indicated R49 required extensive assistance with one person physical assist with transfer, walk in room/corridor and locomotion on/off the unit.	F 323	F-323 Resident 49 experienced an unwitnessed fall on 8/12/14. No injuries were noted. The MD was notified by fax on 8/18/14 and the family was notified by phone on 8/14/14. corrective action was performed on the nursing assistant working with that resident on 8/14/14 and education provided to that nursing assistant on the facility's fall policy and procedure, emphasizing the importance of reporting unwitnessed resident falls to the charge nurse. All staff educated on the facility's falls policy and procedure on 8/28/14 to ensure compliance. Resident 52 is receiving pureed diet. All resident with a pureed diet order will receive a pureed diet. Nursing and dietary staff were educated on 8/28/14 on the need for all residents to receive the proper diet. Incident reports will be reviewed on a regular basis by the Administrator, DNS, and SW. Incident reports reviewed monthly at the Falls and Safety Committee meetings. Audits of incident reports will be completed the DNS/desingnee to ensure that staff are reporting unwitnessed falls and following the facility falls policy and procedure. Audits will be done weekly X 4	

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F 323	Continued From page 11 Review of R49's care plan initiated 6/19/14, indicated: "The resident is at risk for fall R/T (related to) poor gait E/B (evidenced by) hx (history) of fall, need for SBA (stand by assist)." Review of incident reports revealed R49 had experienced three (3) falls since admission on 6/18/14: 6/23/14, 7/18/14 and 7/30/14. Documentation was lacking which indicated the observed incident on 8/12/14 had been noted and a follow-up nursing assessment had been completed for R49. The incident reports also lacked any documentation related to the incident on 8/12/14. When interviewed on 8/14/14, at 9:54 a.m. R49 confirmed he had fallen on 8/12/14 and stated that he is supposed to notify staff when transferred or ambulated. R49 further stated he was admitted to the facility because, "I fall a lot", and confirmed that prior to coming to the facility he had frequently fallen when at home. When interviewed on 8/14/14, at 10:26 a.m. registered nurse (RN)-A confirmed that upon discovery of a witnessed and/or unwitnessed resident fall, NA's are expected to notify the nurse immediately and prior to moving the resident. RN-A explained that facility procedure included a nursing assessment with vital signs monitored and treatment when needed. After the completion of the nursing assessment, the resident is then transferred with a total lift when no major injuries are identified, an incident report is completed, and the physician, administrator, and family are notified; an investigation is then conducted. RN-A confirmed that NA-C did not follow proper procedure upon discovery R49 and verified documentation was lacking in the progress notes which described the observed	F 323	and then monthly X3 and reported to QA committee for futher followup.	

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incident, nor had an incident report been documented.

When interviewed on 8/14/14, at 11:05 a.m. the director of nursing (DON) confirmed the observation noted on 8/12/14 related to the discovery of R49 located on the floor by the bed on his knees would meet the criteria of an unwitnessed fall and NA-C should have informed the charge nurse of the incident so further assessments could be conducted.

When interviewed on 8/14/14, at 11:35 a.m. the administrator confirmed that NA-C should have notified the charge nurse of R49's fall on 8/12/14.

When interviewed by phone on 8/14/14, at 11:55 a.m. NA-C confirmed that on 8/12/14, after finding R49 kneeling on the floor in his room, she should have notified the charge nurse stating she, "Just forgot".

The procedure titled, "Fallen or Injured Resident" revised 6/14 was reviewed and included:
1. DO NOT MOVE THE RESIDENT.
2. Remain calm and reassure and comfort the resident.
3. Summon charge nurse or other help by:
   a. Turning on call light if in room
   b. Asking passerby to get someone
   c. Utilizing all available communication devices
8. A licensed nurse must observe the resident and perform a full body exam to determine if there may be a suspected fracture and direct whether to move the resident. Use a lift if transferring the resident. Do not attempt to move the resident if spinal or hip fracture is suspected.
R52's care plan identified the following diagnoses: pneumonitis due to inhalation of food

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or vomitus; chronic airway obstruction; stricture and stenosis of esophagus; dysphasia; and nutritional deficiency. The care plan identified that R52 had his own teeth, and required set up of supplies and staff assistance with oral cares. The care plan also identified that R52 received a pureed texture diet with nectar thickened liquids. The care plan also directed staff to monitor resident closely & report signs/symptoms of chewing/swallowing difficulties, coughing, choking, etc.

On 8/12/14, at 5:57 p.m. during the evening, R52 was noted to have a pureed texture diet with nectar thickened liquids served. During the meal observation, R52 coughed and grimaced as he attempted to swallow bites of food. During this observation it was noted he had no lower teeth with no partial denture plate. During an interview with R52 and his spouse, on 8/12/14, at 6:30 p.m. it was confirmed that R52 had a lower partial denture plate but he did not have the partial denture placed during the evening meal.

On 8/13/14, at 11:44 a.m. R52 was observed seated in the dining room and attempted to chew soft bite size pieces of chicken, mashed potatoes and cooked tomatoes. It was noted that the speech therapist (ST) applied denture cream to R52's lower partial denture and assisted with placement in his mouth. ST then repeatedly reminded R52 to, "take a bite", "double swallow", and then "take a drink". R52 was noted to cough intermittently when he consumed bites of food.

It was observed on 8/14/14, at 7:40 a.m. that R52 attempted to consume the regular diet for breakfast which consisted of: 2 slices of toast, a fried egg and a ham patty in the form of a sandwich. R52 was observed to break pieces of the sandwich and place them into his mouth. A pureed consistency diet was not served to R52.

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F 323	Continued From page 14 When approached, R52 pointed to his mouth and indicated there was no lower teeth/partial denture and stated "teeth". When questioned whether he desired the partial denture plate, he nodded his head 'yes'. Nursing assistance (NA)-A was subsequently notified of R52's request for his partial denture and NA-A agreed she would retrieve them from the room and left the dining area. During an follow-up observation on 8/14/14, at 7:50 a.m.. R52 had pureed texture foods in three bowls placed on the table for breakfast. When R52 was questioned about the sandwich he had been eating, R52 responded, the "nurse took it". On 8/14/14, at 7:53 a.m. an interview was conducted with cook-A, who dished up the breakfast meal from the steam table. Cook-A stated that after the breakfast had been served, she realized that a bowl of pureed toast remained on the steam table. Cook-A further indicated that when she walked around dining room, she noted that R52 had a regular diet as he was eating a sandwich with egg and ham, so replaced a pureed textured diet. When interviewed on 8/14/14, at 8:30 a.m. the dietary manager (DM) verified that R52 had been served a regular texture breakfast that morning instead of the physician ordered pureed texture diet. DM also indicated that R52's tablemate was routinely fed by staff who also monitored R52 while at the table. The DM confirmed that R52's tablemate was not at the table during the time R52 consumed the regular diet. When interviewed on 8/14/14, at 8:00 a.m. licensed practical nurse (LPN)-A and NA-A verified that R52 was at risk for choking and R52 was to be served a pureed texture diet with nectar thickened liquids and NOT a regular textured diet.	F 323		

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F 323	Continued From page 15 When interviewed on 8/14/14, at 9:00 a.m. the director of nursing (DON) verified that R52 was at risk for choking and aspiration and was to receive a pureed texture diet with nectar thickened liquids. On 8/14/14, at 12:28 p.m. ST was interviewed and verified that R52 had a gastric tube inserted while in the hospital prior to admission as he required additional nutritional intake and was not considered safe to ingest food or fluids orally during that time. However, prior to discharge from the hospital the dietary order was changed to pureed texture with nectar thickened liquids. ST then verified that R52 was at risk for choking and that trials of textured food would be attempted only by therapy staff. .	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. 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	F 329		9/23/14

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F 329	Continued From page 16 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to monitor the continued need for a seasonal allergy medication and the effectiveness of antihypertensive medications for 2 of 5 residents (R15 & R16) in the sample reviewed for unnecessary medications. Findings include: Review of R15's physician's orders dated 4/29/14, included the use of Zyrtec 5 milligram (mg) by mouth (PO) every day (QD) for chronic rhinitis (runny nose). The pharmacist's recommendation to discontinue the medication was made during the monthly visit on 4/18/14 and documented on the consulting pharmacy note. This document was then forwarded to the director of nursing who followed up with the primary physician. The physician's response included the order to continue with Zyrtec through the Spring season and then re-evaluate in July 2014. A review of R15's medication administration record (MAR) for July 2014 and August 2014 was completed and documentation indicated that R15 continued to receive daily Zyrtec 5 mg until 8/14/14. No additional physician orders or follow up documentation was found to indicate the issue had been addressed with the physician as	F 329	F-329 Resident 15's use of Zyrtec was evaluated on 8/19/14 by the practitioner and the medication was D/C'd. Resident 16's blood pressure readings were reviewed by the MD on 8/27/14 and the MD ordered to monitor blood pressure and pulse three times/day and follow up on 9/8/14. All residents currently receiving a seasonal allergy medication were reviewed for appropriateness. All residents currently on antihypertensive medications were reviewed and any fluctuation in blood pressure readings were communicated to the MD if needed. Nursing staff were educated on 8/28/14 on the need to identify abnormal blood pressure readings and for the charge nurse to notify the MD of abnormal blood pressure readings. Education also provided to nursing staff on 8/28/14 on the need to monitor the effectiveness of and continued need for seasonal allergy as to reduce the use of unnecessary medications.	

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F 329	Continued From page 17 ordered on the original pharmacy document. When interviewed on 8/14/14, at 11:00 a.m. registered nurse (RN)-D verified the order for a medication assessment was to be completed in July 2014 and had been missed so a follow up assessment had not been completed. In addition RN-D verified that R15 had continued to receive daily Zyrtec 5 mg orally until 8/14/14 without adequate indications for continued use. R16 was admitted to the facility on 8/28/12, and the physician orders dated 7/22/14, identified diagnoses which included: coronary artery disease, congestive heart failure (CHF), history of myocardial infarction, hypertension (elevated blood pressure), anoxic brain damage and chronic stage 3 renal disease. R16's physician orders dated 7/22/14, identified the following medications: Amlodipine, 5 milligrams (mg) every day (qd) for hypertension; Aspirin, 81 mg qd for hypertension; Lasix, 40 mg qd for hypertension; Lopressor,100 mg twice daily for hypertension; and Potassium Chloride, extended release, 20 millequivalents qd for hypertension. The medical record identified that R16 had been hospitalized on 5/2/14 with chest pain, hypertension and CHF. During review of R16's medical record, it was noted in the vital statistic tracking section of the medical record that R16's blood pressure (B/P) was variable and irregular. In the past 30 days (7/13/14 thru 8/13/14), R16's B/P recordings ranged between 74/45 to 141/115. The following B/P readings were noted: (1) On 5/16/14, at 10:06 a.m. - BP was 74/45;	F 329	Random audits will be completed monthly X 3 months by DNS/designee to ensure that the MD is being notified of abnormal blood pressures and to monitor for unnecessary medications.	

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F 329	Continued From page 18 rechecked one minute later and was recorded as 155/102 at 10:07 a.m. Documentation was lacking to indicate any follow-up notes related to the concern had been addressed;. (2) On 6/6/14 -B/P was 150/101; no documentation of any follow-up;. (3) On 6/20/14, at 5:46 p.m.- B/P was 141/115 and no documentation of follow-up in the medical record; (4) On 6/27/14, at 10:11 a.m. - B/P was 159/91 and again no follow-up notes; and (5) On 7/19/14, 12:20 a.m.- B/P was 83/47 with no follow-up assessment. During interview with registered nurse (RN)-A on 8/14/14, at 9:30 a.m. it was verified that there were no follow-up nurses' notes nor had the physician been notified of the fluctuating B/P recordings. RN-A stated R16 had been to the hospital emergency room on 5/2/14 for elevated B/P and medication changes had been ordered by R16's physician. In addition, RN-A verified R16's B/P had not been controlled. RN-A stated that blood pressure reading were taken by trained medication assistants (TMA's) and they should had reported the fluctuating/irregular B/P readings to the RN's when elevated and/or low. RN-A indicated that if the TMA had notified her of the B/P's readings, follow-up with the physician would have been done. RN-A stated a diastolic B/P under 50 or over 90 should have been reported to the RN by the TMA staff. During interview with RN-B on 8/14/14, at 10:15 a.m. she stated, after reviewing the documented recordings for R16's B/P, the B/P's were uncontrolled and should have been addressed with the physician. RN-B stated staff should have monitored the B/P's more closely since they were	F 329		

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F 329	Continued From page 19 out of range. The facility failed to adequately assess and monitor R16's response to her medication regimen related to the hypertension diagnosis. Communication with the physician was lacking when blood pressure readings fluctuated and R16 had a history of hospitalization for cardiac conditions.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the consultant pharmacist failed to report irregularities related to fluctuating blood pressure readings for 1 of 5 residents (R16) in the sample reviewed for unnecessary medications and who received daily antihypertensive medications. Findings include: R16 was admitted to the facility on 8/28/12, and the physician orders dated 7/22/14, identified diagnoses which included: coronary artery disease, congestive heart failure (CHF), history of	F 428	F-428 The consulting pharmacist completed a medication review on 8/18/14 for resident 16 and antihypertensive medications. Those recommendations were routed to the MD for further evaluation. The consulting pharmacist completed a medication review on 8/18/14 for resident 15. Those recommendations were routed to the MD for further evaluation on 8/19/14 and the Zyrtec was DC'd on 8/19/14.	9/23/14

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F 428	Continued From page 20 myocardial infarction, hypertension, anoxic brain damage and chronic stage 3 renal disease. R16's physician orders dated 7/22/14, identified the following medications: Amlodipine, 5 milligrams (mg) every day (qd) for hypertension (elevated blood pressure); Aspirin, 81 mg qd for hypertension; Lasix, 40 mg qd for hypertension; Lopressor,100 mg twice daily for hypertension; and Potassium Chloride (potassium supplement), extended release, 20 millequivalents qd for hypertension. The medical record identified that R16 had been hospitalized on 5/2/14 with chest pain, hypertension and CHF. During review of R16's medical record, it was noted in the vital statistic tracking section of the medical record that R16's blood pressure (B/P) was variable and irregular. In the past 30 days (7/13/14 thru 8/13/14), R16's B/P recordings ranged between 74/45 to 141/115. The following B/P readings were noted: (1) On 5/16/14, at 10:06 a.m. - BP was 74/45; rechecked one minute later and was recorded as 155/102 at 10:07 a.m. Documentation was lacking to indicate any follow-up notes related to the concern had been addressed;. (2) On 6/6/14 -B/P was 150/101; no documentation of any follow-up;. (3) On 6/20/14, at 5:46 p.m.- B/P was 141/115 and no documentation of follow-up in the medical record; (4) On 6/27/14, at 10:11 a.m. - B/P was 159/91 and again no follow-up notes; and (5) On 7/19/14, 12:20 a.m.- B/P was 83/47 with no follow-up assessment.	F 428	Pharmacy recommendations have been communicated to the DNS and MD to ensure that these recommendations are acted upon by the MD. The consulting pharmacist was educated on 8/18/14 to monitor the abnormal blood pressure readings and to monitor unnecessary medications. The consulting pharmacist will continue monthly medication record reviews and recommendations will be sent to the MD for further evaluation. Random audits will be completed monthly X 3 by the DNS/designee to ensure that abnormal blood pressure readings and appropriateness of medications are being addressed by the MD.	

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F 428	Continued From page 21 During interview with registered nurse (RN)-A on 8/14/14, at 9:30 a.m. it was verified that there were no follow-up nurses' notes nor had the physician been notified of the fluctuating B/P recordings. RN-A stated R16 had been to the hospital emergency room on 5/2/14 for elevated B/P and medication changes had been ordered by R16's physician. In addition, RN-A verified R16's B/P had not been controlled. RN-A stated that blood pressure reading were taken by trained medication assistants (TMA's) and they should had reported the fluctuating/irregular B/P readings to the RN's when elevated and/or low. RN-A indicated that if the TMA had notified her of the B/P's readings, follow-up with the physician would have been done. RN-A stated a diastolic B/P under 50 or over 90 should have been reported to the RN by the TMA staff. During review of the monthly pharmacy reviews, it was noted that no identified concerns were documented by the consulting pharmacist from 11/19/13 through 6/17/14. However, the pharmacy review dated 7/16/14, included two recommendations: (1) Zyrtec could increase risk for falls and cause worsening constipation; and (2) Triam Cream used long term could lead to thinning of the skin and recommended the cream be discontinued. Documentation was lacking to indicate that R16's blood pressure readings were fluctuating nor any recommendations for staff to monitor B/P readings more closely and/or report these abnormal readings to the physician for medication review and/or change. During interview with the pharmacy consultant on 8/14/14, at 10:45 a.m. it was verified that the identified fluctuating blood pressure readings documented for R16 should have been followed	F 428		

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F 428	Continued From page 22 up and the physician should have been contacted/made aware of this concern. The consultant stated that if she was aware of the B/P concerns she would have addressed them and made a recommendation for the facility to monitor them more frequently and left a message for the physician to evaluate.	F 428		

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GOOD SAMARITAN SOCIETY - WINTHROP	**506 HIGH STREET WINTHROP, MN 55396**

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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 August 20, 2014. At the time of this survey, Building 01 of Good Samaritan Society Winthrop 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		09/04/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/20/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Good Samaritan Society Winthrop is a one-story building with partial basement. The original building was constructed 1965, with building additions constructed in 1966, 1994 and 1995. All buildings are fully fire sprinkler protected and were determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 33 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to	K 051		9/23/14

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	245314	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/20/2014**

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K 051	Continued From page 2 NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain all components of the required automatic fire alarm system in conformance with the requirements at NFPA 101 (00) Chapter 19, Section 19.3.4. This deficient practice could adversely affect 12 of 37 residents. FINDINGS INCLUDE: On 08/20/2014 at 1:10 PM, observation revealed a manual fire alarm box on the West Corridor, and the operable portion of the fire alarm box measured 66 inches above the finished floor.	K 051	K-51 Fire Alarm pull to be relocated by the company that installed the pull to the appropriate height. ENS supervisor to monitor for compliance.	

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	245314	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/20/2014**

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K 051	Continued From page 3 The maximum mounting height is 54-inches above the floor. This deficient practice was not in conformance with the requirements at NFPA 72 (1999) Chapter 2, Section 2-8.1. This finding was confirmed with the environmental services director.	K 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING **02 - 2006 ADDITION** B. WING _____	**08/20/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 20, 2014. At the time of this survey, Building 02 of Good Samaritan Society Winthrop 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 Occupancies. Building 02 of Good Samaritan Society Winthrop consists of a six-bed resident room addition, constructed in 2006. Building 02 is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. All resident rooms in Building 02 are equipped with automatic smoke detection. The facility has a capacity of 37 beds and had a census of 33 at time of the survey.	K 000	EPOC	

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