DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	_	-			AND TRANSMITTAL TE SURVEY AGENCY		X68M cility ID: 00356
MEDICARE/MEDICAID PROVIDE (L1)		3. NAME AND AI (L3) GOOD SAM (L4) 410 SOUTH (L5) WARREN, M	IARITAN SOO MCKINLEY	CIETY - W	(L6) 56762	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 7. On-Site Visit	7 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 12/28 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	OWNERSHIP 3/2016 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEC 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	GORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	8. Full Survey After Co FISCAL YEAR ENDING 09/30	omplaint
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds	45 (L18)	Compliance X 1. A	equirements e Based On:		And/Or Approved Waivers Or 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural S) 5. Life Safety Code	7. Medical Direct	ces Limit tor
13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 45 (L37) (L38)	45 (L17) WN 19 SNF (L39)		and/or Applied V IID (L43)	-	* Code: A,1 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L12) (L15)	
16. STATE SURVEY AGENCY REM See Attached Remarks 17. SURVEYOR SIGNATURE				DATE):	18. STATE SURVEY AGENC	Y APPROVAL	Date:
Lisa Carey, HFE NEII		0	01/12/2017	(L19)	Mark Meath,	Enforcement Specialist	01/18/2017 - (L20
PA 19. DETERMINATION OF ELIGIBII _X	JTY Participate	20. COM	BY HCFA RE			ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HC	CFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 03/01/1991	23. LTC AGREED BEGINNING		4. LTC AGREEN ENDING DA		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbur	0 INVOLUNTA 05-Fail to Mee	ARY et Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS n of Admissions:	(L25)		03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	ion <u>OTHER</u>	_
28. TERMINATION DATE:	29). INTERMEDIARY/	(L45) CARRIER NO.		30. REMARKS		
31. RO RECEIPT OF CMS-1539	(L28) 32 (L32)	01/18/2017	I OF APPROVAL	L DATE (L33)	DETERMINATION APP	PROVAL	

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00356

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24 5550

Good Samaritan Society - Warren has been designated as a Special Focus Facility (SSF)

On December 28, 2016, the Department of Health completed a Post Certification Revisit (PCR) and on January 17, 2017 the Department of Public Safety completed a PCR to verify the facility achieved and maintained compliance with deficiencies issued pursuant to the extended survey completed on November 15, 2016. Based on our revisits we have found the facility achieved substantial compliance with deficiencies issued pursuant to the extended survey, effective January 5, 2017.

As a result of the revisit findings This department discontinued the Category 1 remedy of State monitoring. In addition, we recommended the following actions to the CMS Region V office:

- Civil money penalty for the deficiency cited at F323, be imposed. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F492, be imposed. (42 CFR 488.430 through 488.444)
- Discretionary Denial of Payment for New Medicare and Medicaid Admissions, effective December 26, 2016, be rescinded.

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

Effective January 5, 2017, the facility is certified for 45 skilled nursing facility beds.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245550

March 28, 2017

Ms. Judy Bernat, Administrator Good Samaritan Society - Warren 410 South McKinley Street Warren, Minnesota 56762

Dear Ms. Bernat:

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 January 5, 2017 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Weath

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

Email: mark.meath@state.mn.us

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 12, 2017

Ms. Judy Bernat, Administrator Good Samaritan Society - Warren 410 South McKinley Street Warren, Minnesota 56762

RE: Project Number S5550028, F5550028

Dear Ms. Bernat:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On December 6, 2016, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective December 11, 2016. (42 CFR 488.422)

In addition, on December 6, 2016, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F492. (42 CFR 488.430 through 488.444)
- Discretionary Denial of Payment for New Medicare and Medicaid Admissions, effective December 26, 2016.

Furthermore, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 15, 2016 as a result of the extended survey that identified Substandard Quality of Care (SQC).

This was based on the deficiencies cited by this Department for an extended survey completed on November 15, 2016. At the time of the extended survey conditions in the facility constituted both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ) to resident health and safety. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On December 28, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey completed on November 15, 2016. In addition, the life safety code deficiency issued pursuant to the extended survey has not yet been verified. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 5, 2017. Based on our revisit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to the extended survey completed on November 15, 2016. However, the life safety code deficiency issued pursuant to the extended survey completed November 9, 2016 have not yet been verified. The health deficiency not corrected and life safety code deficiency not yet verified, are as follows:

F0492 - S/S: C - 483.75(b) -- Comply With Federal/state/local Laws/prof Std K0347 - S/S: E - 483.70(a) -- NFPA 101 Smoke Detection

The health deficiency not corrected was found to be a widespread deficiency that constitute no actual harm with potential for no more than minimal harm (Level C), as evidenced by the attached CMS-2567, whereby corrections are required. The life safety code deficiency issued pursuant to the extended survey completed November 15, 2016 and has not yet been verified as of this notice was found to be a pattern deficiency that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections are required.

As a result of our findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of December 6, 2016:

- Civil money penalty for the deficiency cited at F323, remain in effect. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F492, remain in effect. (42 CFR 488.430 through 488.444)
- Discretionary Denial of Payment for New Medicare and Medicaid Admissions, effective December 26, 2016, remain in effect.

Furthermore, when a facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) requires that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be impose. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 15, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective February 15, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 15, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

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

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

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

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 electronic plan of correction should be directed to:

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program **Health Regulation Division** Minnesota Department of Health

Email: Lyla.burkman@state.mn.us

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

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 itseffectiveness. 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. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be

discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

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 May 15, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

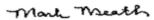
Questions regarding all documents submitted electronically as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,



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

Email: mark.meath@state.mn.us

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

PRINTED: 01/17/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TPLE CONSTRUCTION NG	X3) DATE SURVEY COMPLETED
		245550	B. WING _		R 12/28/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762	12/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
{F 000}	INITIAL COMMENT	ΓS	{F 00	0}	
	as a Special Focus An on-site post cert	ification revisit (PCR) was			
	to have corrected a result of the survey facility has again ac requirements of 42	8/16, and the facility was found II deficiencies issued as a exited on 11/15/16. The chieved full compliance with CFR Part 483, Subpart B, and ong Term Care Facilities.			
{F 492} SS=C	signature is not req page of the CMS-29 483.75(b) COMPLY		{F 49	2}	1/6/17
	compliance with all local laws, regulation accepted profession	perate and provide services in applicable Federal, State, and ons, and codes, and with nal standards and principles sionals providing services in			
	by: Based on interview facility failed to ensi service agency (SN properly registered commissioner, as re	NT is not met as evidenced and document review, the ure the supplemental nursing (SA) utilized by the facility was with the Minnesota equired. This had the II 30 residents who resided in		Preparation and execution of this response and plan of correction does constitute an admission or agreement the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan corrections is prepared and/or execusolely because the provision of Federand State Law requires it. For the pure	e of uted eral

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

Electronically Signed 01/16/2017

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

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245550	B. WING			R 12/28/2016	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/2	10/2010
					10 SOUTH MCKINLEY STREET		
GOOD S	AMARITAN SOCIETY	- WARREN			VARREN, MN 56762		
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{F 492}	confirmed the facilit Placement Inc., a stime registered nurs of nursing (DON) seconfirmed the DON RN. The administrated Healthcare Placement Currently registered Minnesota. The adronducted a succession but did not the were applicable became administrative nursiproviding direct care. The Good Samaritated Consulting Services facility had entered Healthcare Placements.	5 p.m. the administrator y utilized Go-To Healthcare taffing agency, to provide a full se (RN) as the interim director ervices. The administrator was a licensed Minnesota tor also stated, Go-To ent staffing agency was not as a SNSA with the state of ministrator explained they had esful background check for the ink the SNSA requirements cause the DON performed and duties and was not e services. In Society Professional agreement with Go-To ent, Inc. for interim director of 11/28/16. The document was	{F 4:	92}	of any substantial compliance with Federal requirements of participation plan of correction constitutes the far allegation of compliance in accordate with MN Department of Health. 1. Go-To Healthcare Placement, I not be used for direct care services 1/6/17 The Go-To Interim DNS was longer employed in the facility. A neinterim DNS was immediately put in on 1/6/17. 2. Future direct care supplementance on the Minnesota Departmental Nursing agency staff will be hired fragencies on the Minnesota Departmental Nursing Services Agray The HR Coordinator will be assuring supplemental nursing agency staff currently on the Minnesota Departmently on the Minnesota Departmental Nursing Services Agray A process has been developed to recurrent supplemental nursing agence monthly through QAPI to ensure the agency is still on the Minnesota Department of Health is Directory of Registered Supplemental Nursing Services Agency. 3. Education was provided on 12/by the Workforce Consultant to the Administrator and Human Resource Coordinator that agencies not regist on Minnesota Department of Health Directory of Registered Supplement Nursing Services Agency will not be supplemental Services	lnc. will so the control of the cont	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
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		245550	b. WING_		12/	28/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN		410 SOUTH MCKINLEY STREET		
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{F 492}	Continued From pa	ige 2	{F 49	for direct care with residents. 4. Each potential supplemental agency will be reviewed to ensur are on the Minnesota Departmer Health s Directory of Registered Supplemental Nursing Services a prior to allowing staff to work in the Current workers from supplement nursing agencies were verified of through the online Minnesota Deformental Nursing Services aby the Administrator. Audit result tracked and reviewed monthly by QAPI Committee for further recommendations. 5. 1/6/17	e they It of Agency ne facility. Ital n 1/7/17 partment red Agency is will be	

PRINTED: 01/09/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY IPLETED
		245550	B. WING				R 28/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		4	STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH MCKINLEY STREET WARREN, MN 56762		
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	completed on 12/28 to have corrected a result of the survey facility has again ac requirements of 42 Requirements for L Because you are el	rtification revisit (PCR) was 8/16, and the facility was found all deficiencies issued as a exited on 11/15/16. The chieved full compliance with CFR Part 483, Subpart B, and ong Term Care Facilities.					
{F 492} SS=C	page of the CMS-2 483.75(b) COMPLY	567 form.	{F 49	92}			
	compliance with all local laws, regulation accepted profession	perate and provide services in applicable Federal, State, and ons, and codes, and with nal standards and principles sionals providing services in					
	by: Based on interview facility failed to ens service agency (SN properly registered commissioner, as r	NT is not met as evidenced wand document review, the ure the supplemental nursing ISA) utilized by the facility was with the Minnesota required. This had the II 30 residents who resided in					
	Findings include:						
	On 12/27/16, at 2:1	5 p.m. the administrator					
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEPLAY OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245550	B. WING			R	
NAME OF I	PROVIDER OR SUPPLIER	243330	D: 111110	STREET ADDRESS, CITY, STATE, ZIP CODI		/28/2016	
GOOD S	AMARITAN SOCIETY	- WARREN		410 SOUTH MCKINLEY STREET WARREN, MN 56762			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
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POST-CERTIFICATION REVISIT REPORT

			_		
PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REVI	ISIT
IDENTIFICATION NUMBER	A. Building				
	· ·			40/00/0040	
245550 _{Y1}	B. Wing	\	Y2	12/28/2016	Y3
			-	<u> </u>	
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY	MADDEN	410 SOUTH MCKINLEY STREET			
GOOD SAWARITAN SOCIETY	- WARREN	410 300 TH WORNEL I STREET			
		WARREN, MN 56762			

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

ITE			DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix Reg. #	F0225 483.13(c)(1)(ii)- - (4)	(iii), (c)(2)	Correction Completed	ID Prefix Reg. #	F0226 483.13		Correction Completed	ID Prefix Reg. #	F0241 483.15(a)		Correction Completed
LSC			12/23/2016	LSC			12/23/2016	LSC			12/23/2016
ID Prefix Reg. #	F0282 483.20(k)(3)(ii)		Correction Completed	ID Prefix	F0323 483.25		Correction Completed	ID Prefix	F0441 483.65		Correction Completed
LSC			12/23/2016	LSC			12/23/2016	LSC			12/23/2016
ID Prefix	F0497 483.75(e)(8)		Correction	ID Prefix		(j)(2)(iv)	Correction	ID Prefix	F0513 483.75(k)(2)(iv)		Correction
Reg. #			Completed	Reg. #		(J/(=/(·*/	Completed	Reg. #			Completed
LSC			12/23/2016	LSC			12/23/2016	LSC			12/23/2016
ID Prefix Reg. #	F0514 483.75(l)(1)		Correction Completed	ID Prefix Reg. #			Correction Completed	ID Prefix Reg. #			Correction Completed
LSC			12/23/2016	LSC				LSC			
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REVIEW	ED BY	REVIEW	ED BV	DATE		SIGNATURE OF	CHRVEVOR			DATE	
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REVIEWS CMS RO	ED BY	REVIEW (INITIAL:		DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 11/15/2016						R ANY UNCORRECTED DEFICIENCI				YE:	s 🗆 NO

		POST-C	ERTIFIC	ATION REVISIT F	REPORT		
	ER / SUPPLIER			2.01		DATE C	OF REVISIT
245550		Y1 B. Wing	MAIN BUILDING	a U I		Y2 1/17/20)17 _{Y3}
NAME (F FACILITY			STREET ADDRESS, (CITY, STATE, ZIP COD	E	
GOOD	SAMARITAN S	OCIETY - WARREN		410 SOUTH MCKINLE	EY STREET		
				WARREN, MN 56762			
prograr corrector provision	n, to show thos ed and the date	e deficiencies previously e such corrective action v the identification prefix o	reported on the was accomplished	edicare, Medicaid and/or Clinic CMS-2567, Statement of Defic d. Each deficiency should be f hown on the CMS-2567 (prefix	iencies and Plan of (ully identified using e	Correction, that ither the regula	have been ation or LSC
ITI	EM	DATE	ITEM	DATE	ITEM		DATE
Y	4	Y5	Y4	Y5	Y4		Y5
ID Prefix	(Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	Completed	Reg. #		Completed
LSC	K0347	01/05/2017	LSC		LSC		
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REVIEW STATE	/ED BY AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	1	DATE	

Form CMS - 2567B (09/92) EF (11/06)

FOLLOWUP TO SURVEY COMPLETED ON

REVIEWED BY

(INITIALS)

REVIEWED BY

CMS RO

11/9/2016

Page 1 of 1

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

TITLE

DATE

EVENT ID:

X68M22

YES NO

DATE



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered: January 12, 2017

Ms. Judy Bernat, Administrator Good Samaritan Society - Warren 410 South McKinley Street Warren, Minnesota 56762

Re: Project # S5550028

Dear Ms. Bernat:

On December 28, 2016, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 15, 2016.

State licensing orders issued pursuant to the last survey completed on and found corrected at the time of this December 28, 2016, are listed on the electroncally delivered State Form Revisit Report.

Also, at the time of this reinspection completed on December 28, 2016, additional violations were cited as follows:

20005 -- S/S: -- MN Rule 4658.0015 -- Compliance With Regulations And Standards

They are delineated on the attached Minnesota Department of Health Statement of deficiencies-Licensing Orders Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction, however, when all orders are corrected, the order should be electronically submitted to this office at:

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

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

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

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

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

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

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

Sincerely,

Mark Meath

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

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE	OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
00356 _{Y1}	B. Wing	Y	12/28	3/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
NAIVIL OF FACILITY		STREET ADDRESS, OFF T, STATE, ZIF CODE			
GOOD SAMARITAN SOCIETY	- WARREN	410 SOUTH MCKINLEY STREET			
		WARREN, MN 56762			

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITE	М		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	20302		Correction	ID Prefix	20335		Correction	ID Prefix	20565		Correction
Reg. #	MN State Statu	te	Completed	Reg. #	MN Ru	le 4658.0130	Completed	Reg.#	MN Rule 4658.040 Subp. 3	05	Completed
LSC	-		12/23/2016	LSC			12/23/2016	LSC			12/23/2016
ID Prefix	20625		Correction	ID Prefix	20830		Correction	ID Prefix	21390		Correction
Reg. #	MN Rule 4658.0 Subp. 1 A-P	0450	Completed	Reg. #	MN Ru Subp.	le 4658.0520 1	Completed	Reg.#	MN Rule 4658.080 Subp. 4 A-I	00	Completed
LSC			12/23/2016	LSC			12/23/2016	LSC			12/23/2016
ID Prefix	21805		Correction	ID Prefix	21980		Correction	ID Prefix	22000		Correction
Reg. #	MN St. Statute Subd. 5	144.651	Completed	Reg. #	MN St. Subd.	Statute 626.557	Completed	Reg. #	MN St. Statute 62 Subd. 14 (a)-(c)	26.557	Completed
LSC			12/23/2016	LSC			12/23/2016	LSC			12/23/2016
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC			-	LSC			
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LSC				LSC			-	LSC			-
STATE A		REVIEW (INITIAL		DATE 01/11/2	017	SIGNATURE OF	SURVEYOR 34985			DATE 12/28	3/2016
REVIEW CMS RO	ED BY	REVIEW (INITIAL	/ED BY	DATE	· · · · · · · · · · · · · · · · · · ·	TITLE	3.330			DATE	
FOLLOW 11/15/20	VUP TO SURVE	Y COMPL	ETED ON	_	-	R ANY UNCORRE	-			☐ YE	s 🗆 no

Page 1 of 1 EVENT ID: X68M12

PRINTED: 01/17/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ R B. WING 00356 12/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **410 SOUTH MCKINLEY STREET GOOD SAMARITAN SOCIETY - WARREN** WARREN, MN 56762 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {2 000} Initial Comments {2 000} *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a

INITIAL COMMENTS:

An onsite follow-up visit was completed on December 28-30th 2016.

notice of assessment for non-compliance.

The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction

Minnesota Department of Health

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

01/16/17

(X6) DATE

TITLE

Electronically Signed

Minnesota Department of Health

STATEMEN	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER					SURVEY LETED		
					F			
		00356			12/2	8/2016		
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE				
GOOD S	AMARITAN SOCIETY	- WARREN	TH MCKINLEY STREET I, MN 56762					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE		
{2 000}	Continued From pa	ge 1	{2 000}					
		uired that the facility of the electronic documents.						
2 005	MN Rule 4658.0015 REGULATIONS AN	5 COMPLIANCE WITH ID STANDARDS	2 005			1/6/17		
	services in complia state, and local law and with accepted p	est operate and provide ance with all applicable federal, s, regulations, and codes, professional standards and to professionals providing ang home.						
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the supplemental nursing service agency (SNSA) utilized by the facility was registered with the Minnesota (MN) commissioner, as required. This had the potential to affect all 30 residents who resided in the facility and received services from the the supplemental staff.			Corrected				
	Findings include:							
	Subdivision 1, "a persupplemental nursing shall register with the failed to be in comparequirement as the services from Go-To	rate Statute 144A.71 erson who operates a ng service agency (SNSA) ne commissioner." The facility eliance with the SNSA facility obtained nursing o Healthcare Placement Inc., red by the Department of						

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
							3
		00356		B. WING		12/2	28/2016
NAME OF	PROVIDER OR SUPPLIER			DRESS, CITY, § T H MCKINLE	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN		, MN 56762	TOTALET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCI ' MUST BE PRECEDED B SC IDENTIFYING INFORN	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 005	Continued From part on 12/27/16, at 2:1 confirmed the facility Placement Inc., a stime registered nurs of nursing (DON) so confirmed the DON RN. In addition, the Healthcare Placement currently registered for Minnesota. The standard conducted a suffer the DON, and direquirements were performed administration providing direct. The Good Samarita Consulting Services facility had entered Healthcare Placements in the standard providing services on signed by both part. SUGGESTED MET The administrator of revise policies and utilized from SNSA registered agencies. The administrator of educate staff and described in the standard staff.	5 p.m. the administry utilized Go-To He taffing agency, to provide (RN) as the interpretation of the administrator verification of the services. The administrator verification of the services of the service	althcare rovide a full im director istrator nnesota ed Go-To gency was in the state ned they nd check of the DON is and was onal ged the with Go-To director of ument was of the staff of t	2 005			

6899

Minnesota Department of Health STATE FORM

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: X68M

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

		PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY	AGENCY		Fa	cility ID: 00356
MEDICARE/MEDICAID PROVIDE (L1) 245550	R NO.		3. NAME AND ADI (L3) GOOD SAM			REN		4. TYPE	E OF ACTION:	2 (L8) 2. Recertification
2.STATE VENDOR OR MEDICAID NO.			(L4) 410 SOUTH MCKINLEY STREET						mination	4. CHOW
(L2) 304842000			(L5) WARREN, M	IN		(I	.6) 56762	5. Vali		6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP		7. PROVIDER/SUF	PPLIER CATEGOR	Y 09 ESRD		L7) 22 CLIA		Site Visit Survey After Com	9. Other
6. DATE OF SURVEY 11	/15/2016	(L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF				
8. ACCREDITATION STATUS:	_	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		FISCAL Y	EAR ENDING D	DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Othe			04 SNF	08 OPT/SP	12 RHC	16 HOSPICI	E		09/30	
11LTC PERIOD OF CERTIFICATION	1		10.THE FACILITY	IS CERTIFIED AS:						
From (a):			A. In Compliar				proved Waivers Of	_	-	_
To (b):			Program Red Compliance	-			Technical Personnel		Scope of Service	
			_				24 Hour RN		Medical Directo	
12. Total Facility Beds	45	(L18)	1. A	acceptable POC		_	7-Day RN (Rural SN	_	Patient Room Si	ze
13. Total Certified Beds	45	(L17)	X B. Not in Com	pliance with Program	n	5. 1	Life Safety Code	9.	Beds/Room	
			Requirements a	and/or Applied Waiv	ers:	* Code:	B*	(L12)		
14. LTC CERTIFIED BED BREAKDO	WN					15. FACILIT	Y MEETS			
18 SNF 18/19 SN 45	NF	19 SNF	ICF	IID		1861 (e) (1)	or 1861 (j) (1):		(L15)	
(L37) (L38)		(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMA	ARKS (IF APPI	LICABLE S	HOW LTC CANCELL	ATION DATE):						
See Attached Remarks										
17. SURVEYOR SIGNATURE			Date :			18. STATE S	URVEY AGENCY	APPROVAL		Date:
Jana Bromenshenke	l, HFE NE	II	(01/09/2017		mark Meath, Enforcement Specialist				
					(L19)					(L20)
	PART	II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE O	R SINGLE ST	ATE AGENC	Y	
19. DETERMINATION OF ELIGIBIL	ITY			IPLIANCE WITH C	CIVIL		Statement of Fina Ownership/Contr			1512)
_X 1. Facility is Eligible to	Participate		RIGH	113 AC1.			Both of the Abov		uie suiii (TICIA-	1313)
2. Facility is not Eligib	le	(T.21)								
		(L21)								
22. ORIGINAL DATE	23. LTC	AGREEME	ENT 2	4. LTC AGREEM	ENT	26. TERMIN	NATION ACTION:		(L:	30)
OF PARTICIPATION	BE	GINNING I	DATE	ENDING DAT	Е	VOLUNTAR	<u>Y</u>	00	INVOLUNTA	<u>.RY</u>
03/01/1991						01-Merger, C	losure		05-Fail to Mee	t Health/Safety
(L24)	(L4	1)		(L25)		02-Dissatisfac	ction W/ Reimburse	ment	06-Fail to Mee	et Agreement
25. LTC EXTENSION DATE:	27. ALT	ERNATIVE	E SANCTIONS			03-Risk of Inv	oluntary Terminatio	n	OTHER	
			of Admissions:			04-Other Reas	son for Withdrawal		07-Provider S	tatus Change
				(L44)					00-Active	
(L27)	В. В	Rescind Susp	pension Date:							
				(L45)						
28. TERMINATION DATE:		29.	. INTERMEDIARY/C	ARRIER NO.		30. REMARK	KS			
			00140							
	(L28)				(L31)					
31. RO RECEIPT OF CMS-1539		32.	. DETERMINATION (OF APPROVAL DA	ΓE					
	(L32)				(L33)	DETERMI	NATION APPE	ROVAL		

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Facility ID: 00356

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5550

Good Samaritan Society - Warren has been designated as a Special Focus Facility (SSF)

On November 15, 2016, an extended 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. conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

As a result of the survey findings the facility would not be given an opportunity to correct before remedies are imposed. Since your facility meets the criterion remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

• State Monitoring effective December 11, 2016. (42 CFR 488.422)

In addition, the Department is recommending the enforcement remedies listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F492. (42 CFR 488.430 through 488.444)
- Discretionary Denial of Payment for New Medicare and Medicaid Admissions, effective December 26, 2016.

Refer to the CMS 2567 for both health and life safety code, along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered December 6, 2016

Ms. Judy Bernat, Administrator Good Samaritan Society - Warren 410 South McKinley Street Warren, Minnesota 56762

RE: Project Number S5550028

Dear Ms. Bernat:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On November 15, 2016, an extended 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.

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

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on November 15, 2016, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: Lyla.burkman@state.mn.us

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

NO OPPORTUNITY TO CORRECT - REMEDIES

Because your facility is designated as a Special Focus Facility (SFF). CMS's policy of progressive enforcement means that your facility would not be given an opportunity to correct before remedies are imposed. Since your facility meets the criterion remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

• State Monitoring effective December 11, 2016. (42 CFR 488.422)

In addition, the Department is recommending the enforcement remedies listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F492. (42 CFR 488.430 through 488.444)
- Discretionary Denial of Payment for New Medicare and Medicaid Admissions, effective December 26, 2016.

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

SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Good Samaritan Society - Warren is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 15, 2016.

This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

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

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

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

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 remedy be imposed:

• 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. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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 February 15, 2017 (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 May 15, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal

dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 12/20/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED: `		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		245550	B. WING _		11/	15/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WARREN				STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ΓS	F 00	00		
	Focus Facility (SFF	ociety, Warren is a Special and a recertification survey Novmber 7th through the 15th,				
	(IJ) at F323 related comprehensivley as implement interven who had sustained of falls and was at swith significant injuradministrator and donotified of the IJ on	d in an Immediate Jeopardy to the facility's failure to ssess accidents and tions which placed a resident significant injuries as a result significant risk for repeat falls ry and/or death. The lirector of nursing (DON) were 11/10/16, at 4:00 p.m. and /15/16, at 3:27 p.m.				
	In addition, an exte on November 14 ar	nded survey was conducted nd 15, 2016.				
	as your allegation of Department's acceptor enrolled in ePOC, yat the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will tion of compliance.				
•	on-site revisit of you validate that substa regulations has bee your verification	acceptable electronic POC, an ur facility will be conducted to antial compliance with the en attained in accordance with				10/05 :: 5
F 225 SS=E	() () () (),	PORT	F 22	25		12/23/16
LABORATORY	/ DIDECTORIO OD DDOVIE	NED/CLIDDLIED DEDDESENITATIVE'S SIGN	LATUDE	TITI E		(Y6) DATE

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

Electronically Signed 12/14/2016

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

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245550	B. WING		11	/15/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 410 SOUTH MCKINLEY STREET WARREN, MN 56762		
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F 225	been found guilty of mistreating resider had a finding enter registry concerning of residents or mist and report any know court of law against indicate unfitness of other facility staff to or licensing author. The facility must entirely including injuries of misappropriation of immediately to the to other officials in through establishe State survey and of the facility must have a survey and of the facil	of employ individuals who have of abusing, neglecting, or his by a court of law; or have ed into the State nurse aide gabuse, neglect, mistreatment appropriation of their property; whedge it has of actions by a stan employee, which would for service as a nurse aide or the State nurse aide registry ities. Insure that all alleged violations nent, neglect, or abuse, funknown source and fresident property are reported administrator of the facility and accordance with State law diprocedures (including to the ertification agency). Insure evidence that all alleged oughly investigated, and must ential abuse while the progress. Investigations must be reported to other officials in accordance uding to the State survey and youthin 5 working days of the alleged violation is verified tive action must be taken.	F 2	25		
	by:	NT is not met as evidenced v and document review, the		Preparation and execution of	this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245550	B. WING		11/1	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	agency (SA), and/o incidents of potenti significant injuries a for possible mistrea 1 of 1 resident (R2) with serious injury a origin. In addition, report to the SA inco of 1 resident (R12)	nediately report to the State or thoroughly investigate all mistreatment related to and bruises of unknown origin atment and neglect of care for 3) who had unwitnessed falls and had bruises of unknown the facility failed to timely idents of missing money for 1 who reported money missing. ailed to ensure 1 of 5 agency N-A) had a criminal	F 225	response and plan of correction do constitute an admission or agreem the provider of the truth of the facts alleged or conclusions set forth in statement of deficiencies. The plan correction is prepared and/or exect solely because it is required by the provisions of federal and state law the purposes of any allegation that center is not in substantial complia with federal requirements of partice this response and plan of correction constitutes the center sallegation compliance in accordance with see 7305 of the State Operations Manual constitutes and plan of corrections.	tent by state of the uted state of the ince ipation, on of etion ual.	
	two unwitnessed fawere not reported to the R23's admission M 9/2/16, indicated R impairment, was rarequired extensive daily living (ADLs), fractures, and recemedications which R23's Diagnosis Re R23 was admitted following surgical rediagnoses which in hemorrhage and he the musculoskeleta	ses of unknown origin and had alls with significant injury which to the SA. inimum Data Set (MDS) dated 23 had severe cognitive arely or never understood, assistance with activities of had a history of falls with a ived anti-anxiety and diuretic could increase fall risk. eport dated 11/9/16, indicated to the facility in August 2016, epair of a fractured femur and cluded interoperable ematoma (bleed or bruise) of all structure, Alzheimer's nemia, pain, osteoarthritis,		1. R23□s fall with injury was filed the Office of Healthcare Facility Complaints (OHFC) on 12/10/16 b Administrator. R23□s injury of unknown origin (by was filed with the Office of Healthcare Facility Complaints (OHFC) on 12/2 by the Administrator. R12□s incident of missing money reported to the Office of Healthcare Facility Complaints (OHFC) on 8/1 by the Administrator and the incided investigated per facility policy/procularly LPN-A no longer works for The Gosamaritan Society □ Warren. 2. All incident reports since the lasurvey will be reviewed by the Administrator to ensure that in the incidents that should have been rewere reported to OHFC by 12/23/1 Good Samaritan Society □ Warrer	y the ruising) care (10/16) was e 5/2016 ent was edure. bod ast	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245550	B. WING		11/1	5/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		9,200
GOOD S	AMARITAN SOCIETY	- WARREN		110 SOUTH MCKINLEY STREET WARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 3	F 225			
	hearing loss and we	_		reviewed the current policy for staf agencies to staff the facility. All cur and future occurrences of staffing	rent	
	9/2/16, identified R2 cognitive impairmed R23 had a function motion, pain and ar without significant pand non-verbal. The had vision problems during tradue to recent hip froughter identified R2 to diuretic medication anti-anxiety medical increased R23's risuncident report r	noted in R23's medical record		have opportunity for deficient pract 3. Good Samaritan Society □ Wareviewed the current procedure for reporting un-witnessed fall with signification injury. The facility also reviewed the current procedure for reporting injury unknown origin. The facility also rethe current procedure for reporting incidents to OHFC. We identified good knowledge, which included knowled deficits of staff, DNS, and Administrational All current and future residents who un-witnessed falls with significant injuries of unknown origin will be reto OHFC per MN and Federal guida. The reporting process for the	nificant e nries of eviewed naps in dge crator. o have njury or eported	
	was noted to have upper back (in the sidentify the size/colbruises were identified origin. The facility of unknown origin to the an investigation on determined the bruise identified. On 11/10/16, at 10: confirmed the bruise were of an unknow	oruises on lower legs and spine area). The report did not oring of the bruises. The fied as being of an unknown lid not report the bruises of the SA. The facility completed 10/14/16, in which they ises to the lower legs may wheelchair legs, however, the to the spine was not		Vulnerable Adult Reporting (CMS algorithm) will be posted by the communication boards in the nursi stations and in the break room. The process includes immediate notification the Administrator and DNS during thours and placing an immediate can Administrator and DNS on evening weekends. Completed 12/9/2016 by DNS b. The internal Vulnerable Adult reporting process will be posted by communication boards in the nursi stations and in the break room. Completed 12/9/2016 by the DNS. c. Reporting process will be reviet the All Staff meeting scheduled 12/2016. The Process will stree required 2 and 24 hour guidelines.	ation of working all to the is and by the of the ing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245550	B. WING _		11/	15/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762	1	10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	JLD BE	(X5) COMPLETION DATE	
F 225	indicated R23 was 100-hallway floor a by nursing and ass via a mechanical liher right shoulder her forehead. R23 previously adminis 7:28 a.m. that more emergency depart returned from the indicated R23 had pathology noted. Toontinue to monito frontal hematoma to follow up with the R23's PN dated 10 the nurse was info dining room floor, heavy bloody nose assessed and R23 assisted into a dinilift. R23's nose corremoved from the at 6:30 p.m. indicad 4:45 p.m. and whill chair, R23 continuation through the nose, her room and in towas given to "settle nurse entered R23 amounts of blood clotted with blood.	te (PN) dated 10/30/16, found on her buttocks on the at 8:30 a.m. R23 was assessed sisted back into the wheelchair ft. R23 was noted to be holding and had a large hematoma to denied pain and had been stered Tylenol with codeine at ning. R23 was sent to ment (ED) for evaluation. R23 ED at 11:39 a.m. The note a Cat Scan with no acute the ED recommended staff r R23's neurological status and for skin breakdown and for R23 e clinic on 10/31/16. 2/30/16, indicated at 5:15 p.m. rmed R23 was found on the lying on her right side with a from both nostrils. R23 was a denied pain. R23 was fing room chair via a mechanical ntinued to bleed so R23 was dining area. A follow up noted ted the above fall occurred at e seated in the dining room ed to "head bob" and bleed therefore she was assisted to bed. An antianxiety medication e her." Once settled into bed, a 8's room, and observed large on R23's pillow and her nose R23's blood pressure was physician was notified and R23	F 22	reporting an OHFC incident. d. All new employees and age will have a background check of following Minnesota procedure is conducting background checks. e. All current agency/contract have been audited to ensure the specific procedures were follow obtaining employee background Completed 12/13/2016. All staff will be re-educated via Ameeting. A video will be available for those who did not attend the meeting. A knowledge verification required indicating that the video viewed and understood. All informities will be sent to those who did not the All Staff meeting or view the certified letter. To ensure the edwas received and understood stake and return a knowledge verthat will be included. This is to their understanding of what consignificant injury and an injury or origin by 12/23/2016. This is als ensure their understanding of the procedures as it relates to the Administrator and DNS notificat as the 2 and 24 hour required Coreporting of significant injuries a of unknown origin will be completed as the All Staff meeting, views the return the knowledge verification that was sent via registered main be able to return to work until consideration. All staff will also be educated of	empleted egarding employees estate ed for checks. Ill Staff esto watch All Staff on will be owas rmation attend video via ucation effication ensure estitutes a unknown of to estate the ed by attend video, or a sheet will not mpleted.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		E SURVEY PLETED
		245550	B. WING		11/-	15/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
00000	AMARITAN COCIETY	WADDEN		410 SOUTH MCKINLEY STREET		
GOOD S	AMARITAN SOCIETY	- WARREN		WARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 225	Continued From particles of the dead injury and poor The bleeding had of fluids. The hospital R23 and hopefully the next day. R23's PN dated 11 R23 was found on to the sink. No injurant assisted into the wasted into the wasted into the wasted investigation as to determine if neglect Review of the facilic lacked documental notified of R23's uninjury. On 11/09/16, at 1:3 (DON) stated she consulted to the SA injuries somewhat	,	F 225	DEFICIENCY)	rtable sed falls of urses mal eporting histrator actual he e de on e tual ng injury the 5/2016. dinator, and sultant r hecks.	DAIL
	a right frontal hema hospitalized after the The DON stated shall R23 was hospitalized that R23 had sustanted hematoma. She stanted a head sustained a head sust	atoma, nose bleed, and was ne second fall on 10/30/16. ne didn't previously know why ed and was unaware until now lined a right frontal scalp ated no one had told her R23 ematoma as she had just bump on her head. She stated		occurred, documentation is complete root cause analysis is determined plans updated, and OHFC is notification within 2 or 24 hours if required. A weekend incident reports will be a for documentation accuracy during following Monday morning meeting noted above, a phone call to the	leted, , care led ny .udited g the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG	` '	E SURVEY MPLETED
		245550	B. WING _		11/	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIF 410 SOUTH MCKINLEY STREET WARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 225	R23's hematoma s the SA. On 11/10/16, at 12: administrator were R23's injuries sustareported to the SA of how serious R23 confirmed the incid reported to the SA, administrator verificis immediately via texfalls on 10/30/16. In stated she hadn't convestigation for R2 she felt it needed to investigation, and scompleted the investigation for R2 she felt it needed to investigation, and scompleted the investigation to the inv	43 p.m. The DON and interviewed. Both confirmed ained on 10/30/16, were not because they were not aware it's injuries actually were, and ents should have been immediately. The DON and ed they were both notified it message after both R23's in addition, the administrator ompleted a root cause it's fall on 11/7/16, because to be a team effort stated she could have stigation but didn't. She stated eviewed falls during their setting, and stated because of a not hold their morning in Due to lack of investigation, it 3's care plan was	F 2:	administrator and DNS withe evenings and weeken notifications and further related in the evenings and further related in the even of the e	ds to provide eporting. npleted 5x/week 4 weeks, 1x/week for 2 or designee, will and e records to ance with state eackground s. cked and Quality mprovement	
	approximately 12:3 therapist (OT) conf limited, she had im no instruction/safet cued/instructed. Th bathroom was due (LPN)-B assisting Fher unattended. Th remember to use the state of the current of th	nitoring visit on 11/11/16, at 0 p.m. the occupational irmed R23's cognition was paired safety awareness and y measure recall after le OT stated R23's fall in the to licensed practical nurse R23 onto the toilet and leaving e OT stated R23 does not the call light to alert staff leded and would usually turn on				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	- WARREN		410	REET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH MCKINLEY STREET ARREN, MN 56762	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	the call light only to thereafter. On 11/11/16, at 12: had assisted R23 ounattended, howev Monday 11/7/16, or also confirmed R23 light to request ass On 11/14/16, at 11: on the scene for bo LPN-B stated the fareport major injuries wasn't followed. Sh care plan was follow 10/30/16, and state R23's major injuries On 11/15/16, at 10: administrator were they had completed 11/7/16, and had dherself to the bathroadminstrator stated injuries were not refalls were investigated followed, there was and R23 had been	shut if off herself, shortly 45 p.m. LPN-B confirmed she ento the toilet and had left her er, wasn't sure if it was a previous Monday. LPN-B did not always use the call istance when on the toilet. 34 a.m. LPN-B stated she was the of R23's falls on 10/30/16. acility policy directed them to se if a resident's care plan e stated she determined R23's wed for both R23's falls on the didn't report	F 2	25			
	directed staff to do falls with injury occi	ot aware what the facility policy when incidents of unwitnessed urred.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCT				E SURVEY PLETED
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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN			SS, CITY, STATE, ZIP COD CKINLEY STREET N 56762	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRE H CORRECTIVE ACTION SH REFERENCED TO THE APP DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 225	facility had knowled sustained a physical reasonably explain report the incident indicated if the faci "error," resulting in make a report to the The facility Abuse a 2/2013, directed stangeted violation neglect, or abuse in origin to be reported administrator and the SA timely. Review of the VA reincluded a report done ten dollar bills (for purse. R12 reported a suggestion or confacility did not reported to the SA timely. On 11/10/16, at 12 R12 had reported to the SA timely. On 11/10/16, at 12 R12 had reported to the SA timely.	dated, 9/15 indicated if the dge that a vulnerable adult had al injury which was not ed, the facility was required to to the SA. The policy further lity had reason to believe an harm or injury occurred must be SA. and Neglect policy dated aff to report alleged or as involving any mistreatment, including injuries of unknown and immediately to the facility he State agency. Sing money was not reported eports from 6/2016 - 11/2016, ated 8/14/16, in which R12 had missing one twenty dollar bill, live five dollar bills and three a total of \$58.00) from her ed the concern to the facility via incern form dated 8/14/16. The rt the concern to the SA until and the concern on Sunday, A was not notified until the next and the administrator confirmed the concern on Sunday, A was not notified until the next and the administrator stated	F 2	25				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY PLETED
		245550	B. WING		11/	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa immediately.	ge 9	F 2	25		
	identified misappropabuse and directed	resident property to the				
	Background Check	s:				
	confirmed licensed been contracted an 5/2/16, through 11/2 LPN-A had worked	8 a.m. the administrator practical nurse (LPN)-A had d worked at the facility from 2/16. The administrator stated on the nursing units providing and as the minimum data set				
		3 a.m. administrator confirmed conducted a back ground				
	dated 8/15, indicate	P/IMPLMENT	F 2	26		12/23/16
	policies and proced mistreatment, negle	evelop and implement written lures that prohibit ect, and abuse of residents on of resident property.				

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE COMF	SURVEY PLETED
		245550	B. WING		11/1	5/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762		
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F 226	This REQUIREMEI by: Based on interview facility failed to imp directed related to State agency of inju 1 resident (R23) idunknown origin; fai thoroughly investigation for possible mistres 1 of 1 resident who during unwitnessed report missing mor 1 resident (R12) who money and failed to	NT is not met as evidenced v and document review, the element their abuse policy as the immediate reporting to the tures of unknown origin for 1 of entified with bruising of led to immediately report and ate falls with significant injury atment and neglect of care for a sustained significant injures of falls. The facility failed to ney to the State agency for 1 of no had reported missing a conduct background checks taff members licensed practical to lacked a criminal	F 22	1. R23□s fall with injury was filed the Office of Healthcare Facility Complaints (OHFC) on 12/10/16 b Administrator. R23□s injury of unknown origin (br was filed with the Office of Healthc Facility Complaints (OHFC) on 12/by the Administrator. R12□s incident of missing money reported to the Office of Healthcare Facility Complaints (OHFC) on 8/1 by the Administrator and the incide investigated per facility policy/proce LPN-A no longer works for The Go Samaritan Society □ Warren. 2. All incident reports since the la survey will be reviewed by the Administrator to ensure that in the incidents that should have been rewere reported to OHFC by 12/23/1	y the ruising) care 10/16 was e 5/2016 ent was edure. Food	
	directed the staff to violations involving abuse including injure report immediately the State Agency (S The Abuse Definition identified misappro	ons policy dated 2/2013, priation of resident property as		Good Samaritan Society Warrer reviewed the current policy for staf agencies to staff the facility. All cur and future occurrences of staffing have opportunity for deficient pract Good Samaritan Society Wareviewed the current procedure for reporting un-witnessed fall with sig injury. The facility also reviewed the	rent needs iice. arren nificant	
	administrator and S	f resident property to the		current procedure for reporting injuunknown origin. The facility also re the current procedure for reporting incidents to OHFC. We identified gknowledge, which included knowled deficits of staff, DNS, and Administration	eviewed gaps in dge	

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		245550	B. WING		11/15/20	016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762	,	
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F 226	Continued From pa	_	F 226	All current and future residents who	o have	
	dated 8/15, indicated the facility would follow state specific procedures for obtaining employee back ground checks.			un-witnessed falls with significant in injuries of unknown origin will be re to OHFC per MN and Federal guid a. The reporting process for the	njury or ported	
	Findings include:			Vulnerable Adult Reporting (CMS algorithm) will be posted by the communication boards in the nursi		
		ses of unknown origin and had lls with significant injury which the SA.		stations and in the break room. The process includes immediate notific the Administrator and DNS during hours and placing an immediate can Administrator and DNS on evening	otification of ring working ate call to the	
	dated 10/10/16, at 6 noted to have bruis	w for R23, an incident report 6:07 p.m. indicated R23 was es on lower legs and upper rea (the report did not indicate		weekends. Completed 12/9/2016 by the DNS b. The internal Vulnerable Adult reporting process will be posted by the		
	the size of the bruis identified as being facility completed a	ses.) The bruises were of an unknown origin. The n investigation on 10/14/16, in ned the bruises to the lower		communication boards in the nursi stations and in the break room. Completed 12/9/2016 by the DNS. c. Reporting process will be revie	ng	
	however, the origin not identified. The bruises of unknown	for the wheelchair legs, for the bruise to the spine was facility did not report the origin to the State Agency.		the All Staff meeting scheduled 12/ and 12/20/16. The Process will stre required 2 and 24 hour guidelines to reporting an OHFC incident.	12/15/16 stress the es for	
	On 11/10/16, at 10:	signed the report on 10/14/16. 30 a.m. the administrator		d. All new employees and agency staff will have a background check completed following Minnesota procedure regarding conducting background checks.		
	were of an unknow reported to the SA t	es identified on 10/10/16, n origin and they were not timely nor were they ermine if abuse had occurred.		 e. All current agency/contract em have been audited to ensure the st specific procedures were followed obtaining employee background ch Completed 12/13/2016. 	ate for	
	Progress Note (PN R23 was found sea	w for R23, an entry in the dated 10/30/16, at 8:30 a.m. ted on the floor in the hallway bmoa on her right forehead.		All staff will be re-educated via All Smeeting. A video will be available to for those who did not attend the All meeting. A knowledge verification	o watch Staff	

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NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN			10 SOUTH MCKINLEY STREET VARREN, MN 56762		
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F 226	Continued From pa	ge 12	F 2	226			
		essed. R23 was sent to the r an evaluation which included			required indicating that the video w viewed and understood. All informability will be sent to those who did not att the All Staff meeting or view the vid certified letter. To ensure the education	ation end leo via	
	on the floor of the d sustained a bloody blood pressure drop	6, at 5:17 p.m. R23 was found ining room. R23 had nose. At 6:18 p.m. R23's pped to 87/54, she was then ospital to rule out head injury			was received and understood staff take and return a knowledge verifice that will be included. This is to ensure their understanding of what constitutions significant injury and an injury of undersign by 12/23/2016. This is also to ensure their understanding of the factors.	will ation ure utes a known	
	R23 was found on to the sink. No injur assisted into the whalthough no injuries medical record lack investigation as to the total terms of the sink of the sink. No injuries the sink of the sink of the sink of the sink of the sink. No injuries the sink of the	7/16, at 2:26 p.m. indicated he floor in her bathroom, next ies were sustained. R23 was neelchair via a mechanical lift. were sustained, R23's documentation of an he root cause of the fall and to t of care had occurred.			procedures as it relates to the Administrator and DNS notification as the 2 and 24 hour required OHF reporting of significant injuries and of unknown origin will be completed 12/23/2016. Staff who does not att the All Staff meeting, views the vide return the knowledge verification shall was sent via registered mail will be able to return to work until comp	C injuries d by end eo, or neet Il not	
	which the SA had b significant injury or	eports lacked documentation in een notified of R23's falls with an investigation to determine switnessed fall to determine if occurred.			All staff will also be educated on all suspected and actual OHFC report incidents which include un-witness and significant injury and injuries of unknown origin by 12/23/2016	able ed falls	
	confirmed R23 had from unwitnessed for the been reported to the by the policy.	5 p.m. the administrator sustained significant injury alls. The incidents had not e SA immediately as directed sing money was not reported			a. By 12/23/2016 all Licensed Nurwill be educated to follow the intern procedure for Vulnerable Adult Repwhich includes notifying the Adminiand DNS about all suspected and a OHFC reportable incidents once the resident is safe. A phone call to the Administrator and DNS will be madweekends and evenings to provide notification and reporting.	al porting strator actual e e e on	

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F 226	included a report of reported she was rone ten dollar bills (for purse. R12 reported a suggestion or confacility did not reported to suggestion or confacility had reported to suggestion or suggestion or confirmed licensed to suggestion or confirmed licensed practical reconfirmed licensed been contracted at 5/2/16, through 11/LPN-A had worked direct resident care (MDS) coordinator	eports from 6/2016 - 11/2016, ated 8/14/16, in which R12 had missing one twenty dollar bill, five five dollar bills and three a total of \$58.00) from her ed the concern to the facility via incern form dated 8/14/16. The int the concern to the SA until concern on Sunday, A was not notified until the next concern on Sunday, A was not notified until the next concerns of fresident property to the SA fresident property to the SA a.m. the administrator at practical nurse (LPN)-A had not worked at the facility from content on the nursing units providing and as the minimum data set in the set.	F 226	b. The Administrator and DNS we educated on all suspected and act OHFC reportable incidents includir un-witnessed falls with significant is and injuries of unknown origin by the Rehab/Skilled Consultant on 12/15 c. The Human Resources Coord Staff Development Coordinator, and Administrator were educated on 12/15/2016 by the Workforce Conson the state specific procedure for obtaining employee background of the DNS, or designee, to ensure protifications to DNS and/or Adminifications to DNS and/or Adminifications to DNS and/or Adminifications and the DNS a	ual ng njury ne si/2016. inator, nd sultant necks. ted by roper strator eted, care ed if eports day a I DNS and x/week for 2 ee, will	
		3 a.m. administrator confirmed conducted a back ground		ensure they are in compliance with specific requirements of background checks weekly x 12 weeks.		

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762	
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F 226	Continued From pa	ge 14	F 226	All audit results will be tracked and reviewed monthly by the Quality Assurance Performance Improveme Committee (QAPI) for further recommendations. 5. 12/23/2016	ent
F 241 SS=D	INDIVIDUALITY The facility must promanner and in an eenhances each res	AND RESPECT OF mote care for residents in a nvironment that maintains or dent's dignity and respect in s or her individuality.	F 24 ⁻		12/23/16
	by: Based on observat review, the facility fa seated at the same the same time as th meals observed for was observed seate meal while tablema eating. Findings include: R41's quarterly Min 10/14/16, indicated nutritional deficience severely impaired v	ion, interview and document ailed to ensure residents dining table were served at reir tablemates during 2 of 3 of 1 resident (R41) who ad without being served the tes had been served and were tes had seen served and were the tes had been served and were the test had been served and were the test had been served and test had been served a		1. R41 receives her meals when he tablemates receive their meals. In discussion with the resident, the searrangement has been changed to she is seated at a table where she conserved with her tablemates. Reside the checked on by Social Services was a weeks to ensure the changes reacceptable. R41 receives cueing while eating in accordance with her care plan. Resis able to feed herself. However residents are on her plate and where the located. The resident is at an assist dining table where she will receive from the CNA assisting with dining sat her table. All current residents who require currents.	ating ensure can be ent will veekly main ident ident hat ey are ed cueing seated

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F 241	R14's care plan da had a performance blindness. The plan up with meal tray, a encourage intake. able to feed self buitems were and who on 11/9/16, at 7:3 (NA)-J was observed to make a make and grape ju-At 7:38 a.m. dietal water and grape ju-At 7:43 a.m. R41 water while a table was eating the mean at the dining room. R41 t LPN-B returned to hat 8:17 a.m. R41's breakfast and left to observed to bring or oom and served the not been served he-At 8:27 a.m. NA-J dining room and on NA-J obtained a broast for R41. NA-J to the toast and ad exited the dining room table a total or room table a total of the communications.	ted 10/24/16, indicated R41 e deficit related eating due to in directed staff to provide set assist with meals and to The plan indicated R41 was it needed to be told what food ere they were located. 5 a.m. Nursing assistant ed to assist R41 to the dining lichair and positioned her at her Once at the table, NA-J left ry aide (DA)-A served R41 ice. was observed drinking her mate had been served and al. sed practical nurse (LPN)-B rovide R41 with her ook her medications and her medication cart. Is tablemate had finished her he table. Nursing staff were other residents into the dining em their breakfasts. R41 had	F 241	while eating have the potential to be affected. PCC care plan report for intervention will be run to identify we needs cueing. We will conduct audoutlined in #4 below. 2. Our dining room seating arranghas been reviewed and changed to ensure residents who require cuein and/or assistance during meal time 2 tables in the dining room. All residents will receive their meal same time that their tablemates retheir meals. Dietary and nursing staff will be ed on the expectation that all tablemate be served at the same time by the Development Coordinator/DNS by 12/23/2016. Nursing Staff will be re-educated oneed to follow care-plan interventic cueing by the DNS/Staff Development coordinator by 12/23/2016. CNAs, staff and dietary staff will be educated how to provide cueing by the DNS/Development coordinator or design 12/23/16. 3. Audits will be completed by the Director of Dietary, or designee, to all tablemates who are present receitheir meals at the same time at all daily for 2 weeks, 5x/week for 2 weand 3x/week for 4 weeks. Audit resident in the complete of the complete o	cho lits as gement or ng es sit at se sat the ceive ucated tes will Staff or nent nursing ted on staff nee by ensure eive meals eeks, sults will API	

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F 241	the dining room and residents have beed dining room and seprovided meals. -At 11:53 a.m. R41¹ lunch meal and beg. At 12:03 a.m. NAmeal and sat down dining table a total served or assisted tablemate had beed distributed by the company of the comp	3 a.m. NA-J assisted R41 to d positioned at her table. Other n observed arriving to the lated at other tables and stablemate was served her gan eating. K provided R41 with her lunch next to her. R41 sat at her of 20 minutes without being with her lunch meal after her in served. a.m. R41 stated most of the late long periods of time for her know why it took so long. R41 ere were a lot of other people is staff could take turns so she wait so long all the time. a.m. NA-J verified R41 was akfast until she returned to the ssisting other residents. NA-J not have to wait that long to be served all residents at the same table is going to another table. The late should not have to wait	F 2	4. Audit who is requiring cueing conduct observation audits each weeks, 5x/week for 2 weeks, and for 4 weeks by DNS or designee 5. 12/23/2016.	meal 2 d 3x/week	

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F 241	nursing (DON) verf served her meal tin have to wait over 4 the 20 minute wait unacceptable. The was for staff to ens timely and did not h meals.	ge 17 3:36 p.m. the director of ied R41 should have been nely and stated R41 should not 5 minutes to be served, even at lunch time was absolutely DON stated her expectation ure all residents were served have to wait to be served nity policy dated 2/2013,	F 2	41			
F 282 SS=D	directed staff to pro- enhanced resident aspects and to serv the same time, so r together. 483.20(k)(3)(ii) SER PERSONS/PER CA The services provided by	vide care in a manner that dignity regarding dietary ve all residents at the table at residents could their meals eat	F 2	82			12/23/16
	by: Based on observatoreview, the facility for and assistance dure care plan for 1 of 2 nutrition who was be provided with food addition, the facility interventions related pillows as directed.	NT is not met as evidenced tion, interview and document ailed to provide verbal cueing ing dining as directed by the (R41) residents reviewed for lind and observed to not be placement directives/cues. In failed to implement fall d to the placement of two body by the care plan for 1 of 2 iewed for accidents, and		1. Care plan interventing R23 have been reviewed updated to reflect currer 2. All current residents cueing at meal times an with fall interventions will plans reviewed and upd by 12/23/2016 by DNS of 3. All nursing staff will the SDC or designee, or	d and care put needs. It dependent all resider lated as need or designeed be educated.	plans t on nts care cessary d by	

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F 282	observed in bed win pillows. Findings include: R41's care plan day had a performance blindness, R41 coursely explained what food placement on the perovide set up with and to encourage in the complex of the complex	ted 10/24/16, indicated R41 deficit related eating due to all feed self after staff ds were served and food plate. The plan directed staff to meal tray, assist with meals antake. Solution as a substant (NA)-Justin self to the dining room via a positioned her at her dining at the table, NA-Justin the table, NA-Justin the dining ry aide (DA)-A provided R41 dice. The plan directed staff to meal tray, assist with meals are the dining ry aide (DA)-A provided R41 dice. The plan directed staff to meal the dining ry aide (DA)-A provided R41 dice. The provided R41 with her dining and her medication cart. The plan directed staff to meal the reduction cart and her medication cart. The plan directed R41 with her dining her medication cart. The plan directed R41 with her dining her medication cart. The plan directed staff to meal the dining her dining ry aide (DA)-A provided R41 with her dining her dining ry aide (DA)-B dining ry aide (DA)-A provided R41 with her dining ry aide (DA)-B dining ry aide (D	F 282	,	nalysis orocess of care t report months nts with uent that the ng at ure in or 2 Audit ed by the	
	-At 8:45 a.m. R41 finished drinking he	ms were placed in front of her. nad not eaten her hot cereal or er juice. NA-K approached R41 te was done, and proceeded to				

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F 282	observed to sit do assistance with co observation, staff or provide R41 as breakfast meal. On 11/9/16, at 8:5 nice to have some were located wher finding the foods to the DS stated R41 with providing cues to 1. The DS stated R4 required someone were located where also stated she would require to state the DON verfied R4 meals due to blind encourage R41 to food items were woon stated, even she still needed di DON confirmed st	age 19 he dining area. NA-K was not wn nor offer or provide empleting the meal. During the had not been observed to offer sistance or cueing with the 4 a.m. R41 stated it would be cone tell her where her foods a served as she had difficulty hat were placed in front of her. 2:19 p.m. the dietary supervisor was blind and staff should be ner during her meal service. 1 was able to feed herself but to tell her where her foods a placed in front of her. The DS bull expect staff to be assisting 36 p.m. the director of nursing a required assistance with liness and stated staff were to eat and inform her where her then placed in front of her. The thought R41 can feed herself, rection during meal times. The aff should have provided R41 es during her meal service as	F 2			
	residents would re	Plan policy dated 2/13, indicated aceive and be provided the ad services to attain or maintain				

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 282	pillows to be utilized implemented as dir R23's care plan dat had limited physica		F 2	82			
	bearing to right leg. had poor balance a assistance of one s reposition herself, g required stand-by a front-wheeled walke and was at risk for indicated R23 requilocomotion in her wincontinence related wore a brief all the night. The fall intervent physical therapy for alarm in her room the ducate/instruct R2 devices, and not to items but use a grafrom staff. Additional	The plan also indicated R23 nd unsteady gait and required taff to sit up, move in bed, get dressed and groomed, and assistance when using her er, a gait belt for transferring falls. The plan further ared cueing and guidance with theelchair. R23 had bladder do confusion and dementia, time, and used the bed pan at ventions identified included a strength and mobility, sensor to alert staff of any movement, and over to pick up dropped belt bend over to pick up dropped belt interventions included bed in the pillows to be place on both					
	sides of R23 when mattress on her be and symptoms of in motion at the time of On 11/8/16, at 10:1 asleep in bed on he pillow behind her. F bedroom door was	she was in bed, a raised edge d, and to observe for signs njury and check range of					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ^T A. BUILDI	TIPLE CONSTRUCTION NG			E SURVEY PLETED
		245550	B. WING			11 /	15/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 410 SOUTH MCKINLEY STREET WARREN, MN 56762	ODE		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 282	raised edge mattre was on, wheelchai	age 21 ess on her bed, sensor alarm r next to bed, and walker in the across from her bed.	F 2	82			
	asleep in bed on h standard white pille vertical above her on either side of he 3/4 closed, her bed bilateral grab bars mattress on her bed wheelchair next to of the room across alarm sounded, he assurance coordin room, and immedi	as p.m. R23 was observed er side with her head on a ow with one body pillow laying head. R23 had no body pillows er. R23's bedroom door was d was in lowest position, had she had a raised egged ed, sensor alarm was on, bed, and walker in the corner of from her bed. R23's sensor aman resources and quality ator (HR/QA) walked in R23's ately walked out to the nurses R23's audio alarm off.					
	sounded. R23 was side pulling up cov on the floor, bed ir mattress, bilateral	30 a.m. R23's sensor alarm s observed in bed on her left ters, with only one body pillow a lowest position, raised edge grab bars, walker in corner of her bed, and her wheelchair by					
	was in bed and ha and not two, as dir stated R23 had a li body pillow was in DON confirmed R2 should have both li all times. She state	08 p.m. LPN-B confirmed R23 d only one body pillow in place ected by the care plan. LPN-B bloody nose, and the other the laundry. At this time, the 23's care plan and stated R23 body pillows with her in bed at ed even they were being no excuse for R23 to be without					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245550	B. WING _		11/15/2016	
	ROVIDER OR SUPPLIER	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 22	F 28	32		
	have two body pillo and confirmed R23	p.m. NA-J stated R23 should ws in bed with her at all times, had no body pillows in bed and she did not know where				
	bed on her side, an place. R23's room was 3/4 closed, her bilateral grab bars, bed, her audio alarm	0 a.m. R23 observed asleep in d had no body pillows in was dark, her bedroom door bed was in lowest position, a raised edge mattress on her m was on, her wheelchair by alker in the corner of the room d.				
	was sounding. R23 no body pillows in p did not have any bolocated one body pland looked in sever confirmed she could	2 a.m. R23's sensor alarm was observed in bed and had blace. LPN-B confirmed R23 bdy pillows in bed with her and illow on top of R23's dresser ral locations in R23's room and dn't find another body pillow in d stated she would check with				
F 323 SS=J	Planning Training d would be trained or had basic knowledge plan and understoo influenced services 483.25(h) FREE OF HAZARDS/SUPER	VISION/DEVICES	F 32	23		12/23/16
	i ne facility must en	sure that the resident				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION			E SURVEY PLETED
		245550	B. WING			11/1	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP 6 410 SOUTH MCKINLEY STREET WARREN, MN 56762	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPE	BE	(X5) COMPLETION DATE
F 323	as is possible; and	age 23 ns as free of accident hazards each resident receives on and assistance devices to	F 3.	23			
	by: Based on observareview, the facility fassess, thoroughly implement intervenrisk of falls and injury who had repeated facility.	NT is not met as evidenced tion, interview, and document ailed to comprehensively investigate causal factors and tions in order to minimize the try for 1 of 1 resident (R23) falls with serious injuries which tervention. This resulted in an y situation for R23.		1. R23 had a comprehens assessment completed on care plan was updated to in cognition, interventional acresident interest, use of a grompted voiding with staff-release seat belt and bed reposition at appropriate letransfers. Guided maneuve will be utilized to assist with	11/13/16 nclude tivities of grabber, f present height vel for re ering of li	f s, self esident imbs	
	related to the facilit comprehensive ass factors and implement had sustained significant risk for significant risk	opardy (IJ) began on 11/7/16, y's failure to complete a sessment to determine causal ent interventions for R23 who difficant injuries from two falls 10/30/16, and another fall on of assessment placed R23 at serious injury and/or death. Attrator and director of nursing d of the IJ on 11/10/16, at 4:00 on 11/7/16, when R23 had be the sessment of causal factors and t		2. All residents who had f August, 2016 were reviewer residents who were identification comprehensive fall assession completed and care plan upons, or designee. a. Our process for root can and interventions was revisidentified areas for improve completely finishing incider a fall team huddle, and put interventions in place after cause analysis will be condeach fall to determine the call and the appropriate interventions in place after cause analysis will be condeach fall to determine the call and the appropriate interventions in place after cause analysis will be condeach fall to determine the call and the appropriate interventions in place after cause analysis will be condeach fall to determine the call and the appropriate interventions. The falls care place in the call and the appropriately. b. On the weekend, nursi	ed. Thre ed will ha ment pdated b ause ana ewed and ement. V nt reports appropr a fall. A ducted af cause of ervention plan will	e ave alysis d we We will s, hold riate root fter each as will then	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245550	B. WING		11/1	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	level of G, which in due to a hematoma during a fall which and interventions. R23's Diagnosis RR R23's diagnoses in fractures, interoper hematoma (bleed of musculoskeletal stranxiety, anemia, parand weakness. R23's progress not p.m. indicated R23 hospital following sright hip as a result was deaf and utilize board to communic was sometimes difficulty whisper tone speed to person and placeneed to use the barweight bearing and assist and use of a physical therapy duweight on restricted transfer. Immobilized R23's admission M	mained at a scope and severity dicated actual harm for R23 a and epistaxis sustained required medical assessment eport dated 11/9/16, indicated cluded subsequent right femurable hemorrhage and	F 323	,	e ate the day falls inary and the g. he DNS, e fall taff will by the dare planted on as, 2 Audit	
	was rarely or never indicated R23 requ activities of daily liv	erely impaired cognition, and runderstood. The MDS also ired extensive assistance with ring (ADLs), was incontinent of toileting program and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION NG	(X3) DATE SURVE COMPLETED	·Υ
		245550	B. WING _		11/15/2016	6
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP COI 410 SOUTH MCKINLEY STREET WARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLE	TION
F 323		ty and diuretic medications	F 32	23		
	9/9/16, indicated R	rea Assessment (CAA) dated 23 had difficulty maintaining impaired balance during				
	9/9/16, indicated R make self understo impairment. R23 w	ss/Dementia CAA dated 23 had decreased ability to ood, had pain, hearing or vision as non verbal and staff via a white board.				
	Treatment form da a fall risk, was com balance and poor s	erapy Evaluation and Plan of ted 9/30/16, indicated R23 was apletely deaf, had fair sitting standing balance, poor safety I not follow through with weight s.				
	had limited physical femur fracture and weight bearing to reassistance with mosupport. R23 utilized and required cuein confusion, impaired limited range of mosumpairment which refor bathing, bed mosupersonal hygiene a staff with front whe transfers. R23 had	ted 10/25/16, indicated R23 all mobility related to a right weakness and required partial ight leg only and one staff ability and weight bearing and guidance. R23 had a balance, limited mobility, and musculoskeletal required extensive staff assist ability, dressing, toileting, and stand by assistance of one eled walker and gait belt for bladder incontinence with a act infections and staff were				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	` '	TE SURVEY MPLETED
		245550	B. WING		11,	/15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (CEACH CORRECTIVE ACTION SHOUTH CORREST TO THE APPLICATION OF	ULD BE	(X5) COMPLETION DATE
F 323	during morning and in the evening/night product and staff wafter meals, before night at least at mid would also use the indicated R23 had which required surg to monitor for sign a complications, infer pneumonia. Staff ware R23 as necessary, monitor use of adallimb swelling and of actual fall with no infalls, poor balance, unsteady gait. The to have a physical that strength and mobility room to be on where of any movement, the bend over to pick use necourage use of gassistance. Staff worder to maximize a position and body position and staff worder to maximize a position and body pos	Ige R23 to drink more fluids afternoon hours and limit fluid t, she utilized an incontinent ere to check R23 before and and after activities, during the dnight and 4:00 a.m. R23 bedpan. The care plan also a hip fracture following a fall gical repair. Staff were directed	F3	23		

-	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	` '	ATE SURVEY OMPLETED
		245550	B. WING		1	1/15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CO 410 SOUTH MCKINLEY STREET WARREN, MN 56762		.,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	position, utilize rais and body pillows or in bed for her safety. R23's Falls Tool da one or more falls in high risk for falls du transfer problems rimpaired balance, we pain and took high had cognitive risk for restlessness, reduce a difficult time follows.	ed edge mattress on her bed, n each side of her in bed when	F3	23		
	R23 fell on 9/3/16, to self transfer and doorway of her bath R23 had previous in this type over the labowel, was not wearinjuries. Fall interve adding a motion se update R23's care anti-coagulant, diur medications and a fall. R23's care plar motion sensor. The signed the form 9/1	evestigation form indicated at 10:40 a.m. R23 attempted was found on the floor in the proom. The report indicated njuries from circumstances of lest 30 days, was incontinent of laring glasses, and had no entions included neuro checks, insor alarm to her bed, and plan. R23 had anti-anxiety, etic, cardiovascular laxative within 8 hours of the in was amended to include a administrator and DON 3/16.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245550	B. WING _	 	11,	/15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP COL 410 SOUTH MCKINLEY STREET WARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	R23 was found lying front of her wheelch and living area of roinjuries. R23 was as mechanical lift. Onco of bowel and stated bathroom. R23 was the incident. Call be R23's Fall Scene H dated 9/4/16, at 10: 1-7 were to be comduring the Fall Hudwas found on the flout or fell from the self transfer. A diagwas included. R23's bed bound, she had orientation to room/incontinent of bowe the last eight hours were initiated. Pote identified as "reside R23 had no injuries another resident's sanswer other alarm room, R23 was four assisted off the floor injuries. A subseque occupational therage	g on the floor in her room, in hair in between the bathroom from. R23 denied pain. No sesisted into bed via a see in bed, R23 was incontinent I she needed to use the swearing shoes at the time of the fall was within R23's reach. Buddle Worksheet (FSHW) 40 a.m. indicated questions pleted at the time of the fall, dle. The sheet indicated R23 for in her room. R23 had slid wheelchair when attempting to ram of the location of the fall is mobility was identified as dishoes on, she had finew admission and was al. Medications received within identified and neuro checks that root cause of the fall was that attempting to self transfer." 60/6/16, at 5:51 a.m. indicated for was alarming, along with sensor alarm. "Staff chose to first." When entered R23's and lying on the floor. R23 was for. Neuro checks started. No tent PN at 1:37 p.m. by the oy (OT) indicated R23 had a ling on light. R23 had been	F 3:	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245550	B. WING		11	/15/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CO 410 SOUTH MCKINLEY STREET WARREN, MN 56762			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	R23's Falls Tool dat at medium risk for f mobility and transfe restlessness, impai status and took high plan section was bland	ted 9/6/16, indicated R23 was alls due to recent falls, or problems, impaired balance, red sleep patterns, cognitive in risk medications. Fall action ank.	F 3.	23			
	at 4:00 a.m. R23 we room. The form ind incident, R23 had p circumstances of th R23 had just been to being found on the had gone off multip Another resident's r sensor sounded at went to answer the then responded to I position. The corrector R23 to have been room.	form dated 9/6/16, indicated as found on the floor in her icated this was a repeat revious injuries or his type in the last 30 days. Holled 15 minutes prior to floor. R23's motion sensor le times throughout the night. Hotion sensor and R23's the same time. Staff member other residents sensor first R23's. R23's bed was in low cive action implemented was a in low position when in it. The he DON both signed the form					
	found on the floor, I transfer, had been a prior, motion senso wearing glasses an the scene was draw and place prior to a root cause of the fa injuries sustained.	9/6/16, indicated R23 was nad been attempting to self assisted by staff 15 minutes r was alarming. R23 was not d was restless. A picture of vn. R23 was alert to person nd after the falls. Potential II was "possible anxiety." No The Fall Scene Investigation included root cause analysis					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245550	B. WING			11/	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		4	TREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH MCKINLEY STREET VARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	indicated R23 had I room beside left sid Bed in lowest positi indicated non verba or injuries. R23 was "reasonable" perso R23's Falls Tool dat high risk for falls and transfer proble bearing changes, to moderately impaire identified R23 had cincluded reduced in difficulty following in	ated 9/11/16, at 9:32 a.m. been found on the floor in le of bed, lying on stomach. on. No injuries noted. R23 ally she did not have any pain as assisted back to bed. All	F3	323			
	incident occurred a the floor next to her was not wearing he were working and F The report indicted R23 had previous in the last 30 days, an bed before. The rep deaf, rarely vocalize had no injuries. Fal checks, resident an body pillows on ead in bed was impleme anti-coagulant, diur						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245550	B. WING			11 /-	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		410	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH MCKINLEY STREET RREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 31	F3	23			
	p.m. indicated R23 to self transfer which 9/13/16. R23 was reduced in place and R23 along educated by nursing place and forgetful Neuro checks were bruise/hematoma fit.	tion report on 9/11/16, at 4:10 had a repeat incident of trying th was not investigated until estless with multiple falls. ace to detect movement, body 3 inconsistent with call light mattress was added to R23's with staff and family were g. R23 was alert to person and prior to and after the fall. Initiated. R23 had sustained a from the fall. Both the lirector of nurses signed this					
	the floor in her room assisted by staff on was working, she w was incontinent of a scene was drawn o to and after the fall. indicated "this is a r	V indicated R23 was found on n. was nonverbal and was last e hour prior. R23's alarms was not wearing glasses and urine. A description of the n the form. R23 was alert prior. The Comments section repeat incident." Medication last 8 hours indicated. Neuro o injury.					
	indicated R23's mo Upon entering R23'	10/20/16, at 5:23 p.m. tion sensor was sounding. Is room, R23 was found sitting her bed. No injuries. R23 was bed.					
		ted 10/20/16, indicated R23 for falls due to recent falls,					

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		245550	B. WING			11/	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, 410 SOUTH MCKINLEY STREE WARREN, MN 56762			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 323	mobility and transferobjects, impaired be changes, and took further identified R2 which included, corfollowing instruction light and assistive a section indicated R therapy. This was was currently received R23's Investigation p.m. indicated R23 her bed. The report help, and attempted balance, and her wifurther indicated this	er problems, difficulty seeing alance, weight bearing high risk medications. The tool 23 had cognitive risk factors of the factor of the f		323			
	previous injuries or 31-180 days. The redifficulties seeing of personal alarms we included neuro che on using call light for needed assistance area of the report we received narcotic at eight hours of the fat DON signed this for R23's FSHW dated indicated R23 was after attempting a seeing objects, lost and fall alarms were scene was drawn. It person, place and to	circumstances over the last eport identified R23 had bjects, had no injuries, and ere working. Fall interventions cks and R23 was re-educated or help, and reminded R23 she for transfers. The continence was left blank. R23 had nd diuretic medication within all. Both the administrator and					

AND DIAN OF CODDECTION DENTIFICATION NUMBER.		, ,	K2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		245550	B. WING			11/	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, 410 SOUTH MCKII WARREN, MN 5		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CC	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD FERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	Continued From pa injury. Neuro check	_	F 3	23			
	8:10 a.m. indicated wheelchair and witr shoe or the floor (ur room. The report fur repeat incident with circumstances over identified R23's har and continence are Fall interventions we calling or asking for seat belt was added educated on use ar seat belt. R23 had within eight hours of indicated a seat belt wheelchair, it was lanot applied until she 10/31/16, because in which it had finally	nn form dated 10/27/16, at R23 was seated in the nessed to reach towards her nknown) and fell in the dining rther indicated this was a previous injuries or the last 30 days. The report of was a little sore. The vision as of the report was left blank. Here R23 was re-educated on assistance, self-releasing to her wheelchair and R23 and R23 was able to release received diuretic medication of the fall. Although the report the was installed on R23's after revealed the seat belt was the returned from the hospital on the facility had to order a belt by been delivered. This form DON on 11/2/16, and the /3/16.					
	indicated R23 was and was lowered to scene of the incider was alert and orien prior to and after the	10/27/16, at 8:10 a.m. in the dining room, reaching, the floor. No injuries. The nt was drawn on the form. R23 ted to person, place and time e fall. Medication used plained hand was a little sore, to monitor mobility.					
		27/16, at 9:49 a.m. by licated R23 had fallen out of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245550	B. WING			11/·	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		41	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH MCKINLEY STREET /ARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	reaching and leaner reported right hand scale (10 worst pair increased over the tender to touch. R2 to have pain. This was to be seen on phys limitations to R23's subsequent PN writindicated R23 had have guarded used lower extremity. With due to R23 declining propel the wheelch. 6. R23's PN dated indicated R23 was 100-hallway on her back into the wheel R23 was noted to be and had a large her denied pain but Tyle at 7:00 a.m. R23 with department (ED) for at 11:39 a.m. indicated with no new orders which showed no at a CT of the spine with ED recommended monitor R23's neur hematoma for skin follow up with the Ereceived an X-factor medication).	ne dining room. R23 had been d too far forward. R23 pain at 4 of 10 on a 0-10 n). Pain was noted most 2nd metacarpal area and 3's right knee also continues was reported to nursing. R23 ician rounds. Pain created therapy session. A tten by OT at 11:34 a.m. fallen earlier. R23 was noted to of her right thumb and right neelchair mobility decreased ag to use right hand and foot to	F3	23			

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OATE SURVEY COMPLETED
		245550	B. WING				11/15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN			RESS, CITY, STATE, ZIP COD MCKINLEY STREET MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	PROVIDER'S PLAN OF CORRI CH CORRECTIVE ACTION SI SS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	indicated at 9:30 a. in the hallway after she attempted to tr The report indicate with previous injurie last 30 days. The reno injuries, and R2 locked. The vision a report was left blan personal alarms we included R23 was rof asking for help, a needed assistance received diuretic, c. medications, and a	m. R23 was found on the floor she had slipped or tripped and ansfer herself or ambulate. d this was a repeat incident es or circumstances over the eport further identified R23 had 3's wheelchair brakes were not and continence areas of the k, and did not identify R23's ere working. Fall interventions e-educated on the importance and was re-educated that she with all transfers. R23 had ardiovascular and narcotic laxative within eight hours of ON and administrator signed		23			
	indicated R23 was hallway and had slipped and whunlocked. A diagrar R23 was alert to perfect Medications admin hours identified. No section indicated Rattempted to ambut A second Investiga 5:00 p.m. indicated forward in her chair self releasing seat be reeducated. The section indicated R so far forward and recommended in the section indicated R so far forward an	I 10/30/16, at 9:50 a.m. found on the floor in the tor fell out of wheelchair. R23 heelchair brakes were m of the scene was drawn. erson and forgetful. istered within previous eight o injury. The Comments 23 does not ask for help and late and transfer self. tion form dated 10/30/16, at R23 was leaning too far and fell. R23 was to have a belt installed and R23 was to expect Results of Investigation 23 was reeducated to not lean to ask for assistance. Seat belt ir. Demonstrated and					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245550	B. WING		11	/15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIF 410 SOUTH MCKINLEY STREET WARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 323	understanding by re Staff will continue to signed the form on on 11/3/16. Although belt was added to Finvestigation reveal ordered and had not and applied to R23 ordered and had not and applied to R23. 7. R23's PN dated indicated R23 was room lying on her rinose from both nos was assisted into a mechanical lift. How to bleed. R23 was reached a R23 was room lying on her rinose from both nos was assisted into a mechanical lift. How to bleed. R23 was room lying on her rinose from both nos was assisted into a mechanical lift. How to bleed. R23 was reached however continued through her nose. Fand assisted into be antianxiety medicated R23 was found in hamounts of blood of clotted with blood. If R7/54. The on call proposition was taken back to subsequent note in the hospital for obspossible urinary trainad ceased and should be reached to subsequent note in the hospital for obspossible urinary trainad ceased and should be reached to reach the reached to reached the reached to reach the reached to reach the reached to reach the reached to reach the reached to reached the reached to reach the reached to reached the reached to reached the reached to reached the reached to reached the reached the reached the reached to reached the reac	se. R23 demonstrated eleasing seat belt per self. o monitor weekly. The DON 11/2/16, and the administrator the form indicated a seat R23's wheelchair, further led a seat belt had been bet been delivered to the facility swheelchair until 10/31/16. 10/30/16, at 5:15 p.m. found on the floor in the dining ight side with a heavy bloody strils. R23 denied pain. R23 dining room chair via a wever, R23's nose continued removed from the dining area. Itled "Late Entry" at 6:30 p.m. and sustained a was assisted into a dining chair to "head bob" and bleed R23 was returned to her room ed. R23 was given antion to "settle" her. At this time, her bed with with large on her pillow and her nose R23's blood pressure was onlysician was notified and R23 the ED for evaluation. A dicated R23 was admitted to ervation of a head injury and ct infection. R23's bleeding e was receiving fluids. An a hematoma but no	F3			
		I 10/30/16, at 6:00 p.m. or fell from wheelchair and was				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245550	B. WING		11	/15/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP COD 410 SOUTH MCKINLEY STREET WARREN, MN 56762			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	found on the floor in wheelchair brakes of the scene was draw Medications used windicated. R23 had Comments sections reevaluate R23's wis smaller one. R23's Falls Tool day was at medium risk mobility and transfer and took high risk midentified R23 had concluded, poor ment following instruction assistive devices, a medications. The AR23 to therapy, how receiving therapy see R23's Falls Tool day was at low risk (desirisk previously) for took high risk medicated R23 forgod assistive devices, and Action plan was to a R23's PN dated 10/2 physical therapy incomplete the proposed R	the dining room. R23's were unlocked. A diagram of wn. R23 was alert but forgetful. within last eight hours were a bloody nose. The sindicated therapy to heelchair for a possible ted 10/30/16, indicated R23 for falls due to recent falls, or problems, impaired balance, nedications. The tool further cognitive risk factors which mory, impulsive, difficulty as, forgot to use the call light or and received high risk ction Plan listed was to refer vever, R23 was currently	F 3.	23			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245550	B. WING			11/	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH MCKINLEY STREET VARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	R23's PN dated 10 R23 had a fall the obloody nose and di large lump on her f ED/hospitalized. The medications and di currently resting in	age 38 /31/16, at 3:38 p.m. indicated day prior and sustained a d hit her head. R23 had a orehead and was seen in the ne physician evaluated R23's scontinued a few. R23 is bed. Nose is still bleeding ded and call light within R23's	F 3	23			
	was at medium risk mobility and transfe objects, not wearing balance, and took if further indicated R2 which included poo	dated 11/7/16, indicated R23 c for falls due to recent falls, er problems, difficulty seeing g her glasses, impaired nigh risk medications. The tool 23 had cognitive risk factors or memory, impulsiveness, and equipment. The Action Plan therapy.					
	a.m. indicated R23 bathroom in front of indicated R23 did not transferred herself. This was a repeat in circumstances over identified R23 was not identify if R23's sounding and the cowas left blank. The injuries, and fall interpretable R23. R23 had diure thours of the fall. The section was blank. form was also blank.	form dated 11/7/16, at 8:15 was found on the floor in her f the toilet and sink. The report not call for assistance, and The report further indicated ncident with previous injuries or r the last 30 days. The report not wearing her glasses, did personal alarms were continence area of the report report indicated R23 had no ervention was to re-educate etic medication within eight ne Results of Investigation The signature section of the k. R23's record lacked a fall investigation in order to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED			
		245550	B. WING			11/·	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		410	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH MCKINLEY STREET RREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	determine causal faimplemented. R23's PN dated 11/	actors and interventions to be 7/16, at 10:13 a.m. by physical	F 3	23			
	with self transferring bathroom floor. R23 right knee rated a 5 appear sore as well together. R23 was a educated on import	23 had a fall in the bathroom g. She was found on the 3 stated she had pain in her 5 out of 10. R23's hands I as R23 keeps rubbing them agreeable to therapy. R23 was cance of asking for assistance pathroom. R23 was unaware of					
	OT indicated OT ar R23's wheelchair a attempting to self tr	7/16, at 12:27 p.m. written by and nursing both responded to larm and found R23 ansfer from the wheelchair to formed OT of R23's fall that					
	indicated R23 was had attempted self glasses and had sli was drawn. R23 wa and was forgetful. In previous eight hour pain. The Commen	11/7/16, at 3:30 p.m. found on the bathroom floor, transfer, was not wearing pped. A diagram of the scene as alert to person and place Medication given within s identified. No injury and no ts section indicated R23 did d self transferred. No further ed.					
	dining room, seated	p.m. R23 was observed in the d in her wheelchair. The ile at the table and R23 had a					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		245550	B. WING _		11	/15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CO 410 SOUTH MCKINLEY STREET WARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	the alarm unit attac wheelchair. R23 ha her right eye which	belt fastened around her with hed to the left side of the d a large purple bruise over extended down the right side so had a large purple goose	F 32	23		
	bed, asleep. She had positioned behind he bedroom door was were noted on the aposition, a four weathe audio alarm wa	4 a.m. R23 was observed in ad only one body pillow her. R23's room was dark, her 3/4 closed, bilateral grab bars bed frame, bed was in lowest lige mattress was on her bed, is on, her wheelchair was next ker was in the corner of the her bed.				
	bed, asleep. One bher head. R23 had of her. R23's bedro bed was in lowest pbars, four wedge bewas on, wheelchair in the corner of the During this observations sounded. The humassurance coordina R23's room, and impurses station and -At 2:07 p.m. R23's information managego into R23's room.	3 p.m. R23 was observed in ody pillow laid vertically above no body pillows on either side om door was 3/4 closed, her osition, had bilateral grabed mattress, sensor alarm was next to bed, and walker room across from her bed. tion, R23's audio alarm an resources and quality ator (HR/QA) walked into imediately walked out to the turned R23's audio alarm off. sensor alarm sounded, health ement (HIM) was observed to immediately walk out and nurses station and turned				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245550	B. WING		11	/15/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 410 SOUTH MCKINLEY STREET WARREN, MN 56762			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	Nursing assistant (R23's room and im to the nurses station, resheard to call out from to NA-H, "Did sheard walked over a -At 2:56 p.m. R23's Registered nurse (which was next to witnessed the survimmediately turned station. RN-B did rational room and turned of immediately walked the nurses station you help her? RA-	s sensor alarm sounded. (NA)-H was observed to enter imediately exit walking directly on. On NA-H's way to the ident assistant (RA)-A was om outside the nurses station roll over?" NA-H stated, "Yes," and turned R23's alarm off. Is sensor alarm was sounding. (RN)-B came out of her office the nurses station. RN-B had reyor exit R23's room and the alarm off at the nurses not go to R23's to check on her. Is sensor alarm sounded. In R23's call light and dout of R23's room towards and loudly stated to RA-A, "can-A replied, "Yes," LPN-B off R23's alarm. RA-A entered	F 32	3			
	sounded. R23 was side, pulling up cov noted on the floor, four wedge mattre	30 a.m. R23's motion alarm sobserved in bed on her left vers. One body pillow was her bed was in lowest position, as on bed, bilateral grab bars, froom across from her bed, r was by her bed.					
	edge of her bed, in wheelchair was ne applied R23's rubb	was observed seated on the her night gown. R23's ear with the brakes on. LPN-B per soled slippers, applied a gait cked back slightly, paused for a					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245550	B. WING			11/15/2016	
NAME OF PROVIDER O		- WARREN		4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH MCKINLEY STREET VARREN, MN 56762		
PREFIX (EACH	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
second, and assist both of hunched unsteady favored handle a released LPN-B reslowly so wheelchaself-released LPN-B pi Velcro thidentify the chair handle a released LPN-B pi Velcro thidentify the chair hands of stretched were ber gait belt assisted unsteady guide he Following at a high	Is while LP sted R23 ir er knees by leaned over and did not need the step of t	d herself slowly up with both of N-B lifted her up with gait belt nto her wheelchair. R23 kept bent during the transfer, was er and leaned forward, was ot stand up straight. R23 during the transfer. Once in binted to R23's left brake lled the long handle and to with her head down while rright wheelchair brake. R23 self back twice in her lled the right half of her belt around her right side while of stogether. R23's failed to he self releasing seat belt. was observed to enter R23's B exited. R23 was assisted bserved standing up in front of the self the doorway. R23 had both lichair handles and was wheelchair seat. R23's legs the sees. NA-H held on to R23's dia clean brief and then the wheelchair. R23 was red NA-H to hold onto her and wheelchair during the transfer. Total NA-H verified R23 was list and required staff ADLs. NA-H stated he was not sees.	F3	323			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245550	B. WING _		11/	15/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 323	stated R23 transfer have had to stop he moved quickly and stated R23 unfortur sleep and was also why her seatbelt wainterventions were He stated he did not interventions to prestated the last time 11/7/16, in which R got off the toilet beat toilet bowl and the bathroom. He state her bathroom that r with her back agair rack and her legs walarms were sound nurse in because hon her head and he caused the bump of pulled R23's small from a bag in the bowrote time to eat or -At 7:58 a.m. R23 wher wheelchair slow the dining room. R2 and fastened correher left leg and foot grabbed the right sherself along until tound her seat at the	d that got in the way. NA-H red pretty well, however, staff er from self-transferring. R23 did not wait for staff. He nately always thought about confused sometimes as to as on. He stated R23's fall her seat belt and wall alarm. It know of any other vent R23 from falling. NA-H R23 self transferred was on 23 must have fallen when she cause there was stool in the water was running in the d he found her on the floor in morning at about 8:00 a.m. let the wall under the towel were out by the toilet and no ing. NA-H stated he called the e was worried about the bump ed did not know if that fall had ir another fall had. NA-H white communication board ack of R23's wheelchair and in it for R23 to read. vas observed self propelling vly down the hallway towards 23's self releasing seat belt on ctly. R23 used both arms, and it to propel herself. R23 ide hallway rail and pulled he railing ended and she lied dining room table. R23 was staff as she self propelled from	F 32	3			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245550	B. WING		11/	15/2016	
-	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 323	On 11/09/16, at 8:5 was observed to a hallway outside of belt and lifted/assis stooped over and knee. R23 took sm to favor her left leg with her left hand, with her right hand ahead of her walke buckle. R23 walke was not standing s down to the floor o ahead. R23 walked feet before she slo assisted her with g Once in the wheele rubbed her right le pain, and stated sh walked if she had a no. PT asked R23 medication from the unable to commun pain or desire for p did not know what stated communica and felt R23 had s related to dementic interventions were and walk inside he follow through. She R23 did not follow because of her cognot to. PT stated F close to her body f held it way out. PT account for improving walker was closer	age 44 63 a.m. physical therapist (PT) mbulate with R23 in the R23's room. PT applied a gait sted R23 to stand up. R23 was both legs remained bent at the rall, slow steps. and appeared . PT held on to R23's gait belt and pushed R23's wheelchair . PT stated R23 liked to get er, and her right side tended to d stooped over, legs bent and traight up. R23's eyes looked r her feet and R23 did not look d like this for approximately 30 wed way down, and PT ait belt into her wheelchair. chair, R23 grimaced and g. PT confirmed R23's signs of he asked R23 before she any pain, and R23 had told her if she wanted some pain e nurse, however, R23 was icate with PT regarding her hain medication. PT stated she R23's cognition was, and tion was a determining barrier ome degree of impairment a. She stated R23's fall to educate her to call for help, r walker, but R23 just did not e stated she was not sure if through after being educated gnition or if it was her choice 23 did not hold her walker or safety when using it rather, also stated R23 was unable to ed walking ability when her to her. She stated R23 also more because R23 sustained	F 323				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			E SURVEY IPLETED
		245550	B. WING			11/	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE 410 SOUTH MCKINLEY STREI WARREN, MN 56762			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 323	a right hip fracture in August 2016, and his was at high risk for transfers and R23 right assistance. PT con transfer unsafely ar because of R23's in she definitely require stated she thought transferred was 11/fallen. PT stated she bathroom. She would get better an but stated she did right.	n March of 2016, and again in lead pain. Pt confirmed R23 falls related to unsafe self not wanting to wait for staff firmed R23 continued to self nd without staff assistance and inpaired ambulation and gait red staff assistance. She the last time R23 self 7/16, at which time, R23 had e thought R23 took herself to stated staff had hoped she d go back to assisted living, not feel it was possible now.	F3	323			
	fall interventions indalert staff when she when R23 did not use added a self-releas been leaning too fa and had fallen out. seat belt, R23 had wheelchair. PT stainjury after she fell to the hospital. R23 transfer, always loo a history of falls inc. March and August chistory of being dever previously sustaine fracture in a car acc R23 had been put of was supposed to use know when she was transferred from the back to her room.	200 a.m. the PT stated R23's cluded a room sensor to help a was trying to self transfer se her call light, staff also ing seat belt because R23 had a forward in her wheelchair PT stated despite adding the fallen two more times from her ted R23 sustained a head out of her wheelchair and went always attempted to self ked down at her feet, and had luding two hip fractures in of 2106. PT stated R23 had a relopmentally delayed and had d a traumatic injury/skull cident. She stated on 11/7/16, on the toilet by staff and R23 se her call light to let staff so done but had not and self et toilet and fell before staff got she stated a restorative and staff assistance were					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245550	B. WING		11	/15/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CO 410 SOUTH MCKINLEY STREET WARREN, MN 56762			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	for R23. PT did not pillows, grab bars, mattress as addition. On 11/09/16, at 12:	roaches to prevent further falls identify R23's reacher, body or bed position and raised nal fall interventions.	F 32	3			
	transfers. She state bearing (NWB) for unable to participal they tried to commo written cues, visual cues and were uns R23 was admitted weight on her right fracture, surgical pacognition and commo slowly improved and therapy on 11/11/16 R23 would not be a because she had page falls. She stated R2 wheelchair brakes	to safe ambulation and ed R23 was non-weight a long time because R23 was the in NWB training. PT stated unicate with R23 and tried demonstration, and manual uccessful. PT stated when she was not able to bear leg related to a repeat right hip ain, weakness, and impaired munication. PT stated R23 had ad would be discharged from 5. She stated she was afraid able to return to assisted living poor safety recall and continued 23 had to be cued to put her on, and required one staff or with all transfers and					
	sounded. R23 was wedged raised mat place, no body pillo position, wheelchai	p.m. R23's sensor alarm observed in bed with a stress, bilateral grab bars in lows in place, bed in lowest for by her bed, and her walker in som across from her bed.					
	bed, asleep. There	0 a.m. R23 was observed in were no body pillows in place care plan. R23's room was					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		245550	B. WING _		1.	1/15/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	dark, her bedroom was in lowest posi place, a raised edg sensor alarm was and her walker in the from her bed. On 11/10/16, at 9:1 was sounding. R2:1 body pillows in planot have any body located one body pland also looked in R23's room and consecond body pillow with laundry. On 11/09/16, at 12 was admitted from had sustained her year. She stated Fwould fall again, gragain. She stated cognitive impairment assistance with all was so impulsive the with her at all time admitted they checand educated R23 she started falling. At 1:34 p.m. R23's incident reports, in interventions imple DON who stated the	door was 3/4 closed, her bed tion, bilateral grab bars in ge mattress on her bed, her on her wheelchair by her bed, the corner of the room across 22 a.m. R23's sensor alarm 3 was observed in bed with no ce. LPN-B confirmed R23 did pillows in bed with her. LPN-B billow on top of R23's dresser several other locations in onfirmed she couldn't find the wand stated she would check 2:58 p.m. the DON stated R23 assisted living facility after she 3rd fall and broken hip this 22's physician was afraid R23 et injured, and may never walk R23 was deaf and had mild ent, and required staff ADLs. The DON stated R23 hat staff tried to have someone s. She stated when R23 was cked on her more frequently, is on the use of her call light and exercise the staff aforementioned falls including vestigation reports and emented were reviewed with the	F 32	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245550	B. WING		· · · · · · · · · · · · · · · · · · ·	11/15/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH MCKINLEY STREET VARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	and felt that was wid DON stated every to re-educated R23 or up or walk on her or initiated neuro check alarm to her bed are -9/6/16, 4:00 a.m. to information and state caused R23 to self. She confirmed neuthenew fall interver position when R23 -9/11/16, 8:00 a.m. information and state initiated and fall interpillows along side to staff education9/13/16, 4:10 p.m. information and state call light use. Staff use. The DON state implemented were resident/employee/addition of a raised -10/20/16, 3:30 p.m. this time due to the available for review provided on 11/10/27/16, 8:10 a.m. information and state calling/asking for her releasing seat belt in the state of	hink R23 used her call light by R23 had so many falls. The ime after R23 fell, the staff in the fact that she couldn't get win. She stated staff had eks and added the sensor indupdated her care plan. The DON verified the fall ted she thought anxiety etransfer and fall out of bed. To checks were initiated, and intion was to keep bed in low was in bed. The DON verified the fall ted neuro checks were erventions included two body he resident when in bed and The DON verified the fall ted R23 was inconsistent with reeducated R23 on call light ed fall interventions neuro checks, family education and the edged mattress to R23's bed. The information was not by yet. The information was	F3	323			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245550	B. WING		 	11/1	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH MCKINLEY STREET VARREN, MN 56762		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	information and state implemented was for the importance of a needed assistance -10/30/16, at 5:00 pfall information and -11/7/16, 8:15 a.m. information and state call light and verifice completed nor were implemented except reminding her to us The DON stated shown complete the fall imponsion to the polymer of the poly	a. the DON confirmed the fall ted the fall intervention or R23 to be reeducated on sking for help and that she with all transfers. b.m. the DON confirmed the subsequent hospitalization. the DON confirmed the fall ted R23 never, never used her d an investigation was not e new interventions of for re-educating R23 and the the call light to ask for help, the had not had a chance to vestigation report yet. The d not know what else to do to	F3	323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245550	B. WING	·····	11	/15/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 410 SOUTH MCKINLEY STREET WARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	were at. She stated remove it on her of velcro strap on her her velcro shoes, so NA-J stated she has fallen and stated Fellin the dining rostated when there the other NA's wot also a Kardex in the review if they need the check the Kardex stated was somethin resident she might. On 11/10/16, at 7:4	d and was not sure where they at R23 had a seat belt and can wn and liked to grab at the shoes, but if she did not wear she did not reach for her feet. ad been on duty when R23 had R23 usually fell out of her wheel R23 did not fall in her room, but om, and in the hallway. She were changes to resident care all discuss it, and there was be charting room for staff to led to. She stated she did not when she was working, but if ng strange going on with a	F 3.	23		
	on 11/10/16, at 8:1 leave R23 alone in would fall. NA-L si the bathroom when not leave R23's be on 11/10/16, at 8:4 remove her seat be wheeled herself froseen her take it off was not ok for staft the toilet by hersel	g her call light. She stated it go far when R23 was in her elf. I1 NA-L stated she would not her bathroom because she tated she may just step outside in R23 was on the toilet, but did				

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F 323	impulsive and wou he wasn't sure if R on 11/7/16, and state alarms were going floor in her bathroot to waste water and faucet on he wasn the water on for he the water on. On 11/10/16, at 12 administrator were confirmed R23 also and stated R23 where bed after she stipped over. She stid not call for help Fall interventions in R23 on using here R23 she needed a checks were also in documentation of whot. The DON state investigate R23's fibecause she had because R23's ala person must have DON and administ should have been causal factors and implemented. The completed the investigate she felt it stated she could his	Id self transferred. He stated 23 was left alone on the toilet ated it was possible because no off when he found her on the om. He also stated R23 hated when he found her water to sure if a staff person turned at and left, or if R23 had turned at a staff person turned at and left, or if R23 had turned at a staff person turned at a staff person turned at a staff left her alone on the floor next to be found attempted to self transfer. Included were to re-educate at all light for help, and reminded assistance for transfers. Neuro on the head not had time to all on 11/7/16, at 8:15 a.m. be en working on the medication and she thought R23 had been be breakfast, was left alone, and fell. The DON stated at the transfer turned off, a staff left her alone on the toilet. The artor confirmed this incident investigated to determine interventions to be Administrator stated she hadn't estigation for the fall on 11/7/16, needed to be a team effort and	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245550	B. WING		11/	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	meeting and because held their morning in Additionally, the DC seat belt was order arrive at the facility not affixed to R23's. The DON stated the try for R23 was to a bathroom because reach into the bathroam alarm shot to prevent R23's fawould order an alar the DON confirmed but did not have the directions. The DO completed a compress the facility had not a comprehensive fall	g their morning huddle se of the survey, they had not meetings this week. ON admitted R23's alarming ed on 10/27/16, and did not until 10/31/16, therefore was wheelchair until 10/31/16. The next intervention they would add a sensor alarm in R23's R23's current sensor did not room and other than the e had no idea what else to do ls. The DON stated they m for R23's bathroom. Lastly, R23 understood directions ability to remember to follow N was asked if the facility had be ehensive fall assessment and edid not know if they had, but seessment discussions sidents. The DON confirmed completed a overall assessment.	F 32	3		
	approximately 12:3 had impaired cogni awareness and no recall after cued/ins discharge from the R23's fall in the bat assisting R23 onto unattended. The Oremember to use the assistance was need to be a sistance which was need to be a sistance was need	nitoring visit on 11/11/16, at 0 p.m. the OT confirmed R23 tion, had impaired safety instruction/safety measure structed. She R23 would be rapy today. The OT stated hroom resulted from LPN-B the toilet and leaving her T stated R23 did not ne call light to alert staff eded and would usually turn on shut if off herself, shortly				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG	TRUCTION		E SURVEY MPLETED
		245550	B. WING			11/	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		410 SOUT	DDRESS, CITY, STATE, ZIP CODE TH MCKINLEY STREET N, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 323	had assisted R23 ounattended, howeved Monday 11/7/16, or also confirmed R23 light to request assist The Fall Prevention dated 5/2016, indicaccountable for fall The policy indicated experience impaire loss of independent cause of their death identified as: vision transfer problems, equipme problems, equipme problems, environm problems and conticuted an accident occurrent identify environment identified an "avoidat an accident occurrent identify environment identifying a potentiment identification identificati	ge 53 45 p.m. LPN-B confirmed she nto the toilet and had left her er, was not sure if it was a previous Monday. LPN-B did not always use the call stance when on the toilet. I and Management policy ated the facility was prevention and management. If after a fall, a resident may differed function, decreased mobility, be, sustain injuries or be the notation. Fall risk factors were problems, mobility and cognitive problems, sleep and assistive device nental problems. The policy ole" accident (fall) meant that and because the facility failed nental hazards and individual wing an accident, evaluate or and risks, implement ding adequate supervision that the residents needs, goals, rrent standards of practice, or eness of the interventions in risk of an accident. The policy acility would take a proactive vention which included all risk and taking steps to fore actual harm occurred, and what might cause a resident to can be taken to prevent it.	F 3	23			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION IG		E SURVEY IPLETED
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F 323	at 3:27 p.m. after the following intervention plan: -R23 was comprehensive.	ge 54 m. was removed on 11/15/16, he facility completed the ons as part of their removal ensively assessed for falls as updated to reflect R23's	F 32	23		
F 441 SS=D	assessed risks for finterventions -Staff were educate -On 11/15/16 from 3 care staff, including interviewed regardinaterviewed staff we falls, and fall preven R23's safety.	falls and fall prevention and on R23's fall interventions 3:03 p.m. to 3:19 P.M. direct Ilicensed nursing staff were and R23's safety risks. All of the are aware of R23's risk for antion interventions to ensure I CONTROL, PREVENT	F 44	.1		12/23/16
	Infection Control Pr safe, sanitary and of to help prevent the of disease and infection (a) Infection Control The facility must es Program under which (1) Investigates, con in the facility; (2) Decides what pr should be applied to	I Program tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective affections.				
	(1) When the Infect	ion Control Program esident needs isolation to				

PRINTED: 12/20/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245550	B. WING			11/1	5/2016
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	isolate the resident. (2) The facility must communicable dise from direct contact direct contact will tr (3) The facility must hands after each dishand washing is incorposed practical (c) Linens Personnel must han transport linens so infection. This REQUIREMENT by: Based on observative review, the facility faisolation precaution the provision of direction the provision of direction in contact precent findings include:	of infection, the facility must t prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted se. Indle, store, process and as to prevent the spread of NT is not met as evidenced sion, interview and document ailed to ensure contact s were implemented during ect resident contact for 1 of 1 erved during personal care and autions.	F 4	441	1. Proper hand hygiene will be utili. The resident identified as R26 has paway. 2. All current and future residents protected from infection through the of proper hand hygiene. 3. Nursing staff will be educated by Staff Development Coordinator, or designee, on proper hand hygiene a contact precautions by 12/23/16.	will be use	
	8/10/16, indicated F impairment and requirement and requiremen	,			4. Hand hygiene observation audit be completed by a trained staff men 2x/day for 2 weeks, 1x/day for 2 weeks/week for 2 weeks, and 2x/week f weeks. Audit results will be tracked	nber ek, for 4 and	
		p.m. during the initial tour, an c container with personal			reviewed monthly by the QAPI Com for further recommendations.	mittee	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		TE SURVEY MPLETED
		245550	B. WING			11	/15/2016
	PROVIDER OR SUPPLIER			410	REET ADDRESS, CITY, STATE, ZIP CODE D SOUTH MCKINLEY STREET ARREN, MN 56762	·	
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F 441	R26's room. The indicated the individual contact precaution care of patients kn serious illness eas contact or by indire patient's environm (LPN)-A stated R2 methicillin-resistan (MRSA) at his sup	age 56 ent) was observed outside of cart contained a sign which dual in the room required s (precautions used during own or suspected to have a sily transmitted by direct patient ect contact with items in the ent). Licensed practical nurse 6 had tested positive for t staphylococcus aureus rapubic catheter (urinary into the bladder from the belly)	F 4		5. 12/23/16		
	call for assistance (NA)-M entered R2 proceeded to emp drainage bag. NA washed her hands proceeded to mak areas of the bed ir and pillows. When talked to R26 while his body then exite observed to wash she left the room a residents room (R2)	o p.m. R26 was observed to At 1:53 p.m. nursing assistant 26's room, apply gloves and ty R26's suprapubic catheter M removed her gloves and Without gloved hands, NA-M e R26's bed touching multiple cluding the covers, bed rails n completed the task, NA-M e touching his wheelchair and d the room. NA-M was not her hands or use sanitizer as and walked into another 5). NA-M was about to touch Agency staff asked to speak to					
	not washed her ha room. She confirm contact precaution	D p.m. NA-M verified she had nds prior to leaving R26's ned R26 currently required s related to MRSA and stated rashed her hands when she					

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F 441	Continued From pa	ge 57	F 44	11		
	confirmed R26 had catheter cite and the considered contamination	p.m. registered nurse (RN)-B MRSA at the suprapubic e linens on his bed were inated. She confirmed the were to be washing their or R26.				
	nurses(DON) verifice precautions for MRs site. The DON con washed her hands it	0 a.m. the director of ed R26 required contact SA at his suprapubic catheter firmed NA-M should have in an attempt to minimize R26's prior to leaving the				
	was requested and 483.75(b) COMPLY FEDERAL/STATE/L The facility must op compliance with all local laws, regulation accepted profession	nfection control/hand hygiene none was provided. WITH LOCAL LAWS/PROF STD erate and provide services in applicable Federal, State, and ons, and codes, and with nal standards and principles sionals providing services in	F 49	02		12/26/16
	by: Based on interview facility failed to ensi service agency (SN	NT is not met as evidenced and document review, the ure the supplemental nursing SA) utilized by the facility was Minnesota commissioner, as		Go-To Healthcare Placement, In not be used for direct care services LPN-A is no longer a provider of directare.		

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F 492	Continued From pa	ige 58	F 4	192					
	required. This had residents who residents	the potential to affect all 33 led in the facility and received ne supplemental staff.	potential to affect all 33 In the facility and received applemental staff. 2. Future direct care supplemental staff. 3. Future direct care supplemental staff will be agencies on the Minnesota Health□s Directory of Regis Supplemental Nursing Servi The HR Coordinator will be		2. Future direct care supplementa nursing agency staff will be hired fr agencies on the Minnesota Departi Health s Directory of Registered	om			
	Findings include:				Supplemental Nursing Services Ag The HR Coordinator will be assurin supplemental nursing agency staff	g each			
	3:18 p.m. the admir nursing (DON) state Go-To Healthcare It to provide nursing of verified by the Minr Directory of Registe Services Agency th	Iministrator and director of stated the facility utilized the re Placement, Inc. staffing agency ng coverage. The administrator linnesota Department of Health's gistered Supplemental Nursing y that Go-To Healthcare		the entrance conference on 11/716, at m. the administrator and director of (DON) stated the facility utilized the Healthcare Placement, Inc. staffing agency de nursing coverage. The administrator by the Minnesota Department of Health's ry of Registered Supplemental Nursing s Agency that Go-To Healthcare ent, Inc. was not one of the approved es listed.			currently on the Minnesota Department of Health Directory of Registered Supplemental Nursing Services Agency. A process has been developed to review current supplemental nursing agency staff monthly through QAPI to ensure their agency is still on the Minnesota Department of Health Directory of Registered Supplemental Nursing Services Agency.		
	confirmed licensed worked full-time at 11/2/16, and stated	8 a.m. the administrator practical nurse (LPN)-A had the facility from 5/2/16 - LPN-A had provided care on lso functioned as the minimum ordinator.			3. Education was provided by 12/by the Workforce Consultant to the Administrator and Human Resourc Coordinator that agencies not regis on Minnesota Department of Health Directory of Registered Supplemer Nursing Services Agency will not be for direct care with residents.	es stered n⊟s stal			
					4. Each potential supplemental not agency will be reviewed to ensure that are on the Minnesota Department of Health supplemental Nursing Services Ages prior to allowing staff to work in the Current workers from supplemental nursing agency was verified on 12/through the online Minnesota Departmental Nursing Services Agency Supplemental Nursing Services Agency was verified on 12/through the online Minnesota Departmental Nursing Services Agency was verified on 12/through the online Minnesota Departmental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to ensure the supplemental Nursing Services Agency will be reviewed to	ency facility. I 12/16 artment			

Facility ID: 00356

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		SURVEY PLETED
		245550	B. WING		11/1	5/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN	4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH MCKINLEY STREET VARREN, MN 56762		
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F 492	Continued From pa	ge 59	F 492	by the Administrator. Audit results vertracked and reviewed monthly by the QAPI Committee for further recommendations.		
F 497 SS=E	483.75(e)(8) NURS REVIEW-12 HR/YF	E AIDE PERFORM R INSERVICE	F 497	5. 12/26/16		12/26/16
	of every nurse aide months, and must peducation based or reviews. The in-se sufficient to ensure nurse aides, but muper year; address a determined in nurse and may address thas determined by thaides providing services.	at least once every 12 provide regular in-service in the outcome of these revice training must be the continuing competence of just be no less than 12 hours pareas of weakness as a aides' performance reviews the special needs of residents the facility staff; and for nurse vices to individuals with the ints, also address the care of aired.				
	by: Based on interview facility failed to ensevaluations were coassistants (NA-B, Narequired. In additional to the service of	NT is not met as evidenced and document review, the ure annual performance empleted for 5 of 5 nursing IA-C, NA-D, NA-E, NA-F) as n, the facility failed to ensure ce training was provided for 1 unts (NA-C) as required.		1. All Certified Nursing Assistants employed longer than 1 year will ha performance evaluation completed 12/26/16 by DNS, or designee. All Certified Nursing Assistants that require the 12 hour training will have required training completed by 12/2 by DNS, or designee.	by e their	
	Findings include:			2. All employees have the potential affected and will have an annual	al to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245550	B. WING _		11/	15/2016	
	ROVIDER OR SUPPLIER	- WARREN		STREET ADDRESS, CITY, STATE, ZIP COD 410 SOUTH MCKINLEY STREET WARREN, MN 56762			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 497	indicated there were available for this end indicated there were available for this end indicated there were available for this end indicated NA-C had required 12 hours of the indicated there were available for this end indicated there were available for this end indicated the date of evaluation was 6/3/2 NA-F was hired on indicated the date of evaluation was 3/17. On 11/14/2016, at 17 resources coordinated the date of evaluation was 3/17. On 11/14/2016, at 17 resources coordinated the performance evaluation was 3/17. All lacked a current HRC also stated Natracked on the cale	1/23/14. Her personnel file e no performance evaluations aployee. 10/8/14. Her personnel file e no performance evaluations aployee. In addition, the n Report by Employee I only completed 10 of the of in-service training for 2015. 11/5/13. Her personnel file e no performance evaluations aployee. 6/13/88. Her personnel file of her last performance 14. 3/9/89. Her personnel file of her last performance 14. 11:45 a.m. the human tor (HRC) stated the facility	F 49	performance evaluation comp 12/26/16 if employed more that All Certified Nursing Assistants potential to be effected by the requirements of training. All C Nursing Assistants that require hour training will have the requirements of training training completed by 12/26/10. 3. All supervisors will be edue the policy and procedure regat performance evaluations by 13 the Administrator. All staff will educated on the process regat performance evaluations by 13 Human Resources Coordinated Certified Nursing Assistants were educated regarding the 12 hours annual calendar will be provided Certified Nursing Assistants by Development Coordinator to noth hour training requirement for the 2017. 4. Performance evaluations audited by the Human Resour Coordinator 1x/month for 3 meansure completion of annual pervaluation. The Human Resour Coordinator will audit the train confirm each Certified Nursing has completed the 12 hours of training by 12/26/16. Audit restracked and reviewed by the Committee for further recommendates.	an a year. Is have the Certified Is the 12 Idired Is a cated on right of the 12 Idire		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		E SURVEY IPLETED
		245550	B. WING		11/	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		OULD BE	(X5) COMPLETION DATE
F 507 SS=E	indicated a job-spectorm would be used more frequent performaddition, the Certific description dated 3 responsibilities incluin-services, training location policy and requirements. 483.75(j)(2)(iv) LAE LAB NAME/ADDRE	Evaluation policy dated 3/2014, cific performance evaluation of for post-orientation, annual or permance evaluations. In the land of the land of the land of l	F 4			12/26/16
	by: Based on interview facility failed to ensit the address of the presidents (R12, R2, were reviewed which performing laborate Findings include: R12's medical recount following laboral lacked the address	AT is not met as evidenced and document review, the ure laboratory reports included performing laboratory for 4 of 4 R30, R41) whose records the lacked the identity of the ery. And was reviewed and revealed tory reports dated 11/2/16, of the performing laboratory: Metabolic Panel (CMP) (a		 R12□s laboratory reports for 11/16/16 on will include the addressing laboratory. R2□s laboratory reports from 1 will include the address of the taboratory. R30□s laboratory reports from on will include the address of thaboratory. R41□s laboratory reports from on will include the address of thaboratory. All current and future residuatoratory reports from 11/16/1 include the address of the testing the state of the stat	Iress of the 1/16/16 on esting 11/16/16 ne testing 11/16/16 ne testing ents = 6 will	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION			SURVEY PLETED
		245550	B. WING			11 /1	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 507	electrolyte and fluid liver function)Complete Blood (with diff) (measures white blood cells, phematocrit. Many tiscreening test as a infections)Thyroid Stimulatir the amount of thyroblood) R2's medical record the following laboral lacked the addressHemoglobin (Hgb diagnose, or monited diseases that affect the amount of hemBasic Metabolic Fineasures sugar (gfluid balance, and Fineasures sugar (gfl	Isures sugar (glucose) level, a balance, kidney function, and Count with Differential (CBC is the levels of red blood cells, latelet levels, hemoglobin and mes it is ordered as a nanemia check or detection of the Hormone (TSH) (measures bid stimulating hormone in the distribution of the performing laboratory: a) (test used to screen for, for a number of conditions and the red blood cells (RBCs) and/or oglobin in blood) anel (BMP) (blood test that lucose) level, electrolyte and kidney function) the address of the performing ard revealed the following acked identification of the performing laboratory: and revealed the following acked identification Ratio is to measure the bloods ability the logological performing laboratory in the laboratory	F 5	laboratory. 3. A discussion was he parties to ensure there of the testing laboratory reports. We have ident service as the only testi without an address on the Health Information Cool Licensed Nurses will be lab reports require an aceducation will be provided designee, by 12/26/16. missing on the specific address stamp (or label for the Licensed Nurses 4. Audits will be compireport 5x/week for 4 we weeks, 2x/week for 2 weeks. Audit resu and reviewed monthly b Committee for further results.	will be the a on the laborator ified one lab ing laborator he lab report rdinator and e educated to ddress. This ed by the D If an address lab reports, by will be pro- s/HIM to use leted on lab eks, 3x/wee eeks, and 1 lts will be tro by the QAPI	ddress pratory ry rts. The l hat all s NS, or s is an vided e. oratory ek for 4 x/week acked	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245550	B. WING _		11/	15/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 507	the following laboral lacked the perform Comprehensive I blood test that mea electrolyte and fluid liver function) Complete Blood with diff) (measure white blood cells, phematocrit. Many the screening test as a infections) Brain Natriuretic that measures the made by the heart higher when in heart higher when heart hi	ord was reviewed and revealed atory reports dated 9/14/16, ing laboratory's address: Metabolic Panel (CMP) (a asures sugar (glucose) level, d balance, kidney function, and Count with Differential (CBC s the levels of red blood cells, blatelet levels, hemoglobin and imes it is ordered as a an anemia check or detection of Peptide (BNP) (a blood test levels of protein called BNP, and blood vessels. Levels are art failure) 11:24 a.m. the health mator (HIC) confirmed the ports did not include the forming laboratory. 2:36 p.m. the administrator ratory reports did not contain	F 50	7		
	indicated laborator filed in the residen	y reports would be dated and t's medical record and should and address of the issuing				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION ()	(3) DATE SURVEY COMPLETED
		245550	B. WING		11/15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN	4	STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH MCKINLEY STREET WARREN, MN 56762	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 507 F 513 SS=D	IN RECORD-SIGNAThe facility must file record signed and cother diagnostic service. This REQUIREMENT by: Based on interview facility failed to ensure were signed and date (R41) records reviee. Findings include: R41's quarterly Min 10/14/16, indicated nutritional deficience. R41's Clinic Referrate follow-up chest X-rate addition to the follow being sent to the nutritional description and fluid liver function) Comprehensive Molood test that mean electrolyte and fluid liver function) Complete Blood Cowith diff) (measures)	RAY/DIAGNOSTIC REPORT (DATED) In the resident's clinical dated reports of x-ray and rvices. In the resident's clinical dated reports of x-ray and rvices. In the resident's clinical dated reports of x-ray and rvices. In the resident's clinical dated reports with reports of x-ray and reports dated reports of x-ray and	F 507		rill nd ssed rith all rill be sts e. re igned ior 4 k for Audit
	writte blood cells, pl	atelet levels, hemoglobin and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245550	B. WING _		11	/15/2016
	PROVIDER OR SUPPLIER	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762		10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 513	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 51	3		

		A. BUILDIN	IG	COM	IPLETED
	245550	B. WING _		11/	15/2016
PROVIDER OR SUPPLIER	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CO 410 SOUTH MCKINLEY STREET WARREN, MN 56762		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
483.75(I)(1) RES RECORDS-COMP LE	LETE/ACCURATE/ACCESSIB	F 5 ⁻	4		12/23/16
resident in accorda standards and practaccurately docume	ance with accepted professional ctices that are complete; ented; readily accessible; and				
information to identification resident's assessminer services provided; preadmission screen	tify the resident; a record of the nents; the plan of care and the results of any ening conducted by the State;				
by: Based on interview facility failed to ens complete and all di progress reports w 4 residents (R12, F	v and document review, the cure the medical record was agnostic reports and provider ere readily accessible for 4 of R2, R30, R41) whose records		received. R2 progress notes have bee R30 progress notes have be	en received. en received.	
at approximately 10 progress visit note was not available. On 11/15/16, at 11: coordinator (HIC) of	0:00 a.m. The provider from a visit dated 10/27/16, 15 a.m. the health information confirmed R12 had been seen		parties to ensure progress n received. All current and futunotes will be tracked within 1 provider visit by HIM. HIM welinic if progress notes are n 1 week. HIM will alert the Ad progress notes are not received weeks and the administrator with the clinic.	otes are ure progress I week of vill call the ot received in ministrator if ved after 2 will follow-up	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE 483.75(I)(1) RES RECORDS-COMP LE The facility must m resident in accorda standards and prace accurately docume systematically orgath The clinical recorda information to idented and all districts assessments assessments as services provided; preadmission screet and progress notes. This REQUIREME by: Based on interview facility failed to ensemble and all districts progress reports with a residents (R12, Findings include: R12's medical recordate approximately 10 progress visit note was not available. On 11/15/16, at 11: coordinator (HIC) of by the nurse practice.	AMARITAN SOCIETY - WARREN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the medical record was complete and all diagnostic reports and provider progress reports were readily accessible for 4 of 4 residents (R12, R2, R30, R41) whose records were reviewed which did not include the reports. Findings include: R12's medical record was reviewed on 11/15/16, at approximately 10:00 a.m. The provider progress visit note from a visit dated 10/27/16, was not available. On 11/15/16, at 11:15 a.m. the health information coordinator (HIC) confirmed R12 had been seen by the nurse practitioner (NP) on 10/27/16,	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. 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On 11/15/16, at 11:15 a.m. the health information coordinator (HIC) confirmed R12 had been seen	AMARITAN SOCIETY - WARREN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the medical record was complete and all diagnostic reports and provider progress reports were readily accessible for 4 of 4 residents (R12, R2, R30, R41) whose records were reviewed which did not include the reports. Findings include: F514 1. R12□s progress notes have be R30 progress	AMARITAN SOCIETY - WARREN STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MIN 56762 SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRICEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION] 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the medical record was complete and all diagnostic reports and provider progress reports were readily accessible for 4 of 4 residents (R12, R2, R30, R41) whose records were reviewed which did not include the reports. Findings include: F514 F514 1. R12□s progress notes have been received. R2 progress notes have been received. R2 progress notes have been received. R30 progress notes have been received. R41 progress notes have been received. R42 progress notes have been received. R43 progress notes have been received. R44 progress notes have been received. R44 progress notes have been received. R45 progress notes have been received. R46 provider visit by HIM. HIM will call the clinic if progress notes are received. All current and future progress include within 1 week of provider visit by HIM. HIM will all the Administrator if progress notes are not received and the received and the administrator if progress notes are not received and the administrator will follow-up with the clinic if progress notes are not received. R514 R514 R514 R514

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	245550		B. WING			11/15/2016	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WARREN				4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH MCKINLEY STREET VARREN, MN 56762		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	documentation of the R2's chart was review approximately 10:20 note from a visit on On 11/15/16, at 11:1 was seen by the NF had not yet received visit. The HIC state the information baccontacted the proviethe progress notes however, the information baccontacted the proviethe progress notes however, the information baccontacted the proviethe progress notes however, the information R30's clinic referral R30 was scheduled results to follow in second 1:30 p.m. R30's accessible in R30's accessible in R30's accessible in R30's mammogram 7/13/16, and the material record.	ewed on 11/15/16 at 0 a.m. The provider progress 10/11/16, was not available. 16 a.m. the HIC confirmed R2 on 10/11/16, but the facility of the documentation from the ed they had difficulty receiving k in a timely fashion. 5 p.m. the HIC stated she had der office to obtain copies of for R12 and R2's visits, nation was not available. form dated 7/13/16, indicated I for a mammogram with seven to ten days. rd was reviewed on 11/15/16, mammogram results were not	F 5	14	expectations of progress notes rec within 1 week of an appointment or follow up call will be placed to the provider s facility by the HIM at the and notification of the administrator will follow up with the other facility, occur after 2 weeks. 4. Audits to ensure progress note received within a 1 week after a res visit. Audits will be completed 5x/w 4 weeks, 3x/week for 4 weeks, 2x/s for 2 weeks, and 1x/week for 2 week Audit results will be reviewed by the for further recommendations. 5. 12/23/16	et time or, who will s are sidents week for week eks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
	245550		B. WING			11/15/2016		
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		STREET ADDRESS, CITY, STATE, Z 410 SOUTH MCKINLEY STREET WARREN, MN 56762				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI) TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 514	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 68 R41's clinic referral form dated 10/6/16, indicated R41 was scheduled for a clinic visit. R41's medical record was reviewed on 11/15/16, at 11:00 a.m. R41's provider progress notes, and X-ray results for the above visits were not accessible in R41's medical record. On 11/15/2016, at 11:24 a.m. the HIC confirmed R41's medical record lacked documentation of provider visits and diagnostic reports and stated the provider progress notes were requested from the provider for the visits on the above dates to include the X-ray results. On 11/15/16, at 2:32 p.m. the administrator confirmed the facility had not been receiving medical documentation back in a timely fashion and stated she would expect within two weeks of a visit, the documentation would be available in the resident medical record The Maintenance of Active Medical Records policy dated 9/2013, indicated medical records would be maintained on each resident in accordance with accepted professional standards and practices that were complete, accurately documented, readily accessible and systematically organized.		F5	14				

F5550028

PRINTED: 01/09/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES		, , ,	ONB NO. 0938-0
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A, BUILDING	(X3) DATE SURVEY COMPLETED	
		245550	B. WING		11/09/2016
	ROVIDER OR SUPPLIER	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉ
K 000	INITIAL COMMEN	TS	K 000		
	FIRE SAFETY				
	01 Main Building				
	ALLEGATION OF ODEPARTMENT'S A SIGNATURE AT THE	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS F COMPLIANCE.			
; ! :	ONSITE REVISIT (CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.			
	Minnesota Departn Fire Marshal Division Good Samaritan So was found not in su requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National	at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC),			
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY		EPO(
	Health Care Fire In State Fire Marshal 445 Minnesota Stre St. Paul, MN 5510	Division eet, Suite 145			

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

TITLE

(X6) DATE

Electronically Signed

12/14/2016

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:	I ` ′	TIPLE CONSTRUCTION NG 01 - Main Building 01		E SURVEY IPLETED
		245550	B. WING		11/	09/2016
	PROVIDER OR SUPPLIER	- WARREN		STREET ADDRESS, CITY, STATE, ZIP CO 410 SOUTH MCKINLEY STREET WARREN, MN 56762		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ACTION CORRECTION OF THE ACTION OF T	SHOULD BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1	K 0	00		
	Or by e-mail to: Marian.Whitney@s and Angela.Kappenma	•				
		PRRECTION FOR EACH BT INCLUDE ALL OF THE DRMATION:				
	A description of to correct the defication.	what has been, or will be, done iency.				
	2. The actual, or p	roposed, completion date.				
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency				
		spected as 1 building with the November 1, 2016				
	was built in 1968 a basement and was construction. In 19 constructed to the was determined to In 2010 a kitchen a north of the origina 1-story, no baseme construction. In 20 constructed to the hospital with the fano basement and building is divided hour fire rated bare	society Warren (Marshal Manor) is a 1-story building without a state determined to be Type II (111) 73 a 1-story addition was east of the original building and be Type II (000) construction. addition was constructed to the all building's dining room. It is ent and Type II (000) 13 a connecting link was east connecting link was east connecting the new acility. This addition is i-1story, Type II (000) construction. The into 6 smoke zones with 1/2 riers. An apartment building is uthwest wing that is separated parrier.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG 01 - Main Building 01		SURVEY PLETED	
	245550		B. WING	<u></u>	11/0	11/09/2016	
	PROVIDER OR SUPPLIER	- WARREN		STREET ADDRESS, CITY, STATE, ZIP COI 410 SOUTH MCKINLEY STREET WARREN, MN 56762			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
K 000	The facility is completely protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code (1999 edition) with automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 45 beds and had a census of 35 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 Smoke Detection		KO	00			
K 347 SS=E			К 3	Preparation and execution or response and plan of correct constitute an admission or ago the provider of the truth of the alleged or conclusions set for statement of deficiencies. The correction is prepared and/or solely because it is required a provisions of federal and state the purposes of any allegations.	ion does not greement by e facts rth in the e plan of executed by the te law. For	1/5/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245550	B. WING	_		11/0	9/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN		41	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH MCKINLEY STREET /ARREN, MN 56762		
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K 347	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 Findings include: On the facility tour between 8:00 am to 12:00 pm on 11/9/2016 observations and staff interview revealed there were only two smoke detectors, one on each end, in the corridor of wing 200 which exceeded 30 feet apart. This deficient condition was confirmed by the Facility Administrator and the Environmental Service Director.		K	347	center is not in substantial complia with federal requirements of partic this response and plan of correctic constitutes the center's allegation compliance in accordance with se 7305 of the State Operations Man 1. The facility has contracted wit licensed electrical company to add smoke detectors and move 3 smodetectors to ensure proper spacin 30 foot requirement. The facility is additional smoke detectors that ne different placement. The placeme these smoke detectors will be inst with the original smoke detectors for correction have been ordered electrician has been contracted. 2. Installation of the additional structure at the proper 30 foot space began on 12/13/2016. 3. Work will be expected to be completed by 1/5/17. 4. The Director of Environmenta Services, or designee, will be response.	ipation, on of ction ual. h a d 7 ke g to the dentified eeded nt of called Parts and the moke acing	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered December 6, 2016

Ms. Judy Bernat, Administrator Good Samaritan Society - Warren 410 South McKinley Street Warren, MinnesotagN 56762

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5550028

Dear Ms. Judy Bernat:

The above facility was surveyed on November 7, 2016 through November 15, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

Good Samaritan Society - Warren December 6, 2016 Page 2

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at (21/) 308-2104 or email: lyla.burkman@state.mn.us.

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

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

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

Sincerely,

Mark Meath

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

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 01/18/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00356 11/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **410 SOUTH MCKINLEY STREET GOOD SAMARITAN SOCIETY - WARREN** WARREN, MN 56762 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to

INITIAL COMMENTS:

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota

the Department within 15 days of receipt of a notice of assessment for non-compliance.

Minnesota Department of Health

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

TITLE (X6) DATE

Electronically Signed

12/14/16

PRINTED: 01/18/2017 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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2 000	Department of Hea you electronically. is necessary for Sta enter the word "context. You must then State licensure procompletion date, the corrected prior to el Minnesota Departmonth on November 7, 8, 2016, surveyors of the above provider orders are issued. electronic plan of coreviewed these ordered they will be completed. Minnesota Departmonth of the State Licensing federal software. The assigned to Minnesota Departmonth of the State Licensing federal software. The assigned to Minnesota Departmonth of the State Licensing federal software. The assigned to Minnesota Departmonth of the State Licensing federal software. The assigned tag is not column entitled "ID statute/rule out of complete state of the statement of the Suggested	Ith orders being Although no plar ate Statutes/Rule rected" in the bo indicate in the expess, under the reds, under the reds, under the reds, under the reds and the following Please indicate prection that you ers, and identify ted. The of Health is Correction Orders, and identify ted. The opportunity and the following Please indicate prection that you ers, and identify ted. The of Health is Correction Orders and the statute with the statute of Deficiencies of Comply" portions column also in violation of the rection. This Rule is now the surveyord the s	of correction es, please x available for electronic neading rs will be mitting to the late of the mitting to the late of the l	2 000			
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Minnesota Department of Health STATE FORM

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er train ISEASE OR RELATED INING: 44.6503 cility serves persons with d disorders, whether in a neral unit, the facility's direct sors must be trained in dement ired training include: n of Alzheimer's disease and ; th activities of daily living; ng with challenging behaviors; on skills. all provide to consumers in nic form a description of the the categories of employees ency of training, and the basic	2 302			12/26/16
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Minnesota Department of Health

STATE FORM 6899 X68M11 If continuation sheet 3 of 70

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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2 302	Continued From particles of the particle	and document revide the required rsing assistants of (DA-A). This last and the received the required the received the required the received the required a.m. administration of the received the Alzen starting in their resource coording. HRC received the the Alzen starting. HRC received in their HRC stated NA reted the training. The correct templo of the received in their resource coording. The course training of the training of	eview, the Alzheimer's (NA-A) and 1 had the ho resided in A-A lacked juired A-A lacked juired tor stated all heimer's r respective nator (HRC) hipleted the confirmed yees of the respective -A and DA-A der Training cility staff er's disease with state	2 302	Corrected 12/26/16		
	SUGGESTED MET	HOD FOR COE	RECTION:				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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2 302 2 335	The director of nursimplement policies Alzheimer's training quality assessment could perform rand compliance. TIME PERIOD FOR (21) days.	ge 4 sing (DON) could develop and and procedures related to the program requirements. The and assurance committee om audits to ensure C CORRECTION: Twenty-one C Employees' Personnel	2 302			12/26/16
	for each employee manner. The person most recent three-ymaintained by the right must be available to department and must. A. the person's number, gender, Mor registration number, gender, Mor registration number, and precently held, hour ecords; and D. the date of recently held, hour ecords; and D. the date of recently held, hour ecords and D. the date of recently held, hour ecords and D. the date of recently held, hour ecords and D. the date of recently held, hour ecords and D. the date of recently held, hour ecords and D. the date of recently held, hour ecords and D. the date of recently held, hour ecords and D. the date of recently held, hour ecords and D. the date of recently held, hour ecords and D. the date of recently held, hour ecords and D. the date of recently held and D.	nursing home. The records or representatives of the				

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This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure annual performance evaluations were completed for 5 of 5 nursing assistants (NA-B, NA-C, NA-D, NA-E, NA-F) as required. In addition, the facility failed to ensure 12 hours of in-service training was provided for 1 of 5 nursing assistants (NA-C) as required. NA-B was hired on 1/23/14. Her personnel file indicated there were no performance evaluations available for this employee. NA-C was hired on 10/8/14. Her personnel file indicated there were no performance evaluations available for this employee. In addition, the undated Completion Report by Employee indicated NA-C had only completed 10 of the required 12 hours of in-service training for 2015. NA-D was hired on 11/5/13. Her personnel file indicated there were no performance evaluations available for this employee. NA-E was hired on 6/13/88. Her personnel file indicated the date of her last performance evaluation was 6/3/14. NA-F was hired on 3/9/89. Her personnel file indicated the date of her last performance	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						SURVEY PLETED
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2 335	Continued From pa	ge 6		2 335			
	resources coordina had recognized the performance evalua confirmed NA-B, NA	ations not being don A-C, NA-D, NA-E, a performance evalua A inservice training v ndar year and confir	e facility e and nd NA-F ation. vas med NA-C				
	The Performance Evaluation policy dated 3/2014, indicated a job-specific performance evaluation form would be used for post-orientation, annual or more frequent performance evaluations. In addition, the Certified Nursing Assistant job description dated 3/2016 indicated basic responsibilities included: meets requirements for in-services, training and meeting attendance per location policy and state and federal requirements.						
	The administrator of revise policies and education for staff reformance evaluation training. The Quality	ould do random aud	view and vide n of annual inservice Assurance				
	TIME PERIOD FOR (21) days.	R CORRECTION: To	wenty One				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	SURVEY PLETED			
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2 565	Continued From pa	ge 7		2 565			
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comp	orehensive	2 565			12/26/16
	Subp. 3. Use. A comust be used by all care of the resident	personnel invo					
	This MN Requirements: Based on observation review, the facility from the facility from the facility from the facility from the facility intervention who was bounded with food provided in food with facility interventions related pillows as directed (R23) residents revolutions.	on, interview ar ailed to provide ing dining as dir (R41) residents lind and observolacement direct failed to implement to the placement by the care plar iewed for accide	nd document verbal cueing rected by the s reviewed for ed to not be ctives/cues. In nent fall ent of two body in for 1 of 2 ents, and		Corrected 12/26/16		
	Findings include:						
	R41's care plan dat had a performance blindness, R41 cou explained what food placement on the p provide set up with and to encourage in	deficit related ed ld feed self after ds were served late. The plan dimeal tray, assis	eating due to r staff and food lirected staff to				
	On 11/9/16, at 7:35 was observed to as						

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
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2 565	her wheelchair and room table. Once a room. -At 7:38 a.m. dietar water and grape juiAt 7:43 a.m. R41 water. -At 7:59 a.m. licens was observed to promedications. R41 to LPN-B returned to late 8:27 a.m. NA-Judining room and ob NA-Judining room and observed to sit down asked her if shuding her from the observed to sit down assistance with conobservation, staff her or provide R41 assibreakfast meal. On 11/9/16, at 8:54 nice to have some of were located when finding the foods the one of the DS stated R41 was providing cues to her the DS stated R41 was providing cues to her the DS stated R41.	positioned her at her t the table, NA-J left t y aide (DA)-A provide ce. vas independently dri ed practical nurse (LI	ed R41 nking her PN)-B and er the her table. ereal and er and jelly NA-J R41 ont of her. cereal or ched R41 ceeded to vas not ering the d to offer or the could be foods fficulty of her. upervisor uld be ervice. self but	2 565			

Minnesota Department of Health

STATE FORM 6899 X68M11 If continuation sheet 9 of 70

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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2 565	were located when also stated she wou R41 at meal time. On 11/09/16, at 3:3 (DON) verfied R41 meals due to blindn encourage R41 to e food items were wh DON stated, even t she still needed dire DON confirmed sta assistance and cue directed by the care. The facility Care Plaresidents would reconcessary care and the highest practical R23 was identified a pillows to be utilized implemented as directed as directed as directed as directed.	placed in front of all expect staff to all expect staff to all expect staff to all expect staff to all expect and inform he expect and inform he expection during mean expection during mean expection during her mean expection at risk for falls are discovered by the care expected by the care expected by the care expected in front or all e	or of nursing nce with staff were to er where her at of her. The feed herself, al times. The ovided R41 al service as 1/13, indicated rided the in or maintain and two body ere not explan.	2 565	DEFICIENCY)		
	had limited physical fracture and weakn bearing to right leg. had poor balance a assistance of one s reposition herself, grequired stand-by a front-wheeled walke and was at risk for indicated R23 requilecomotion in her w	I mobility related ess and was par The plan also in nd unsteady gait taff to sit up, more dressed and essistance when er, a gait belt for falls. The plan fured cueing and g	to right hip tial weight dicated R23 and required ve in bed, groomed, and using her transferring rther juidance with				

Minnesota Department of Health

STATE FORM 6899 X68M11 If continuation sheet 10 of 70

Minnesota Department of Health

A. BUILDING:	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	5/2010	
410 SOUTH MCKINI FY STREET		
GOOD SAMARITAN SOCIETY - WARREN WARREN, MN 56762		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 565 Continued From page 10 incontinence related to confusion and dementia, wore a brief all the time, and used the bed pan at night. The fall interventions identified included physical therapy for strength and mobility, sensor alarm in her room to alert staff of any movement, educate/instruct R23 on safe use of assistive devices, and not to bend over to pick up dropped items but use a grabber or ask for assistance from staff. Additional interventions included bed in lowest position, body pillows to be place on both sides of R23 when she was in bed, a raised edge mattress on her bed, and to observe for signs and symptoms of injury and check range of motion at the time of the fall. On 11/8/16, at 10:14 a.m. R23 was observed asleep in bed on her side with only one body pillow behind her. R23's room was dark, her bedroom door was 3/4 closed, had bilateral grab bars, her bed was in lowest position, she had a raised edge mattress on her bed, sensor alarm was on, wheelchair next to bed, and walker in the corner of the room across from her bed. On 11/08/16, at 1:33 p.m. R23 was observed asleep in bed on her side with her head on a standard white pillow with one body pillow on either side of her. R23's bedroom door was 3/4 closed, her bed was in lowest position, had bilateral grab bars, she had a raised egged mattress on her bed, sensor alarm was on, wheelchair next to bed, and walker in the corner of the room across from her bed. R23's sensor alarm sounded, human resources and quality assurance coordinator (HR/QA) walked in R23's room, and immediately walked out to the nurses		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		D.	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			ľ	20.23				
		00356	E	B. WING		11/1	5/2016	
NAME OF	PROVIDER OR SUPPLIER				TATE, ZIP CODE			
GOODS	AMARITAN SOCIETY	- WARREN		I MCKINLE' MN 56762	Y STREET			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 565	Continued From page 11			2 565				
	sounded. R23 was side pulling up cove on the floor, bed in mattress, bilateral (30 a.m. R23's sensor ala observed in bed on her ers, with only one body p lowest position, raised e grab bars, walker in corn ner bed, and her wheeld	left billow edge ner of					
	On 11/09/16, at 2:08 p.m. LPN-B confirmed R23 was in bed and had only one body pillow in place and not two, as directed by the care plan. LPN-B stated R23 had a bloody nose, and the other body pillow was in the laundry. At this time, the DON confirmed R23's care plan, and stated R23 should have both body pillows with her in bed at all times. She stated even if they were being washed that was no excuse for R23 to be without her body pillows.							
	On 11/9/16, at 3:04 p.m. NA-J stated R23 should have two body pillows in bed with her at all times, and confirmed R23 had no body pillows in bed with her at that time and she did not know where they were.							
	bed on her side, ar place. R23's room was 3/4 closed, her bilateral grab bars, bed, her audio alar	30 a.m. R23 observed as and had no body pillows in was dark, her bedroom or bed was in lowest position a raised edge mattress m was on, her wheelchaalker in the corner of the ed.	door tion, on her iir by					
	was sounding. R23	02 a.m. R23's sensor ala 3 was observed in bed ar olace. LPN-B confirmed	nd had					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '			SURVEY PLETED
		00356	B. WING		11/1	15/2016
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN	UTH MCKINLE EN, MN 56762	Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 565	did not have any bo located one body pi	ge 12 ody pillows in bed with her an illow on top of R23's dresser ral locations in R23's room an				
	confirmed she could	dn't find another body pillow i d stated she would check wit	n			
	Planning Training d would be trained on had basic knowledg plan and understoo	by policy, Optional/Care ated 2/14, indicated staff in resident care plans so they ge of the purpose of the care d how the care plan provided to residents.				
	SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise policies and procedures related to the implementation of the care plan to ensure care is provided as directed by the care plan. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan.		s on			
	TIME PERIOD OF (21) Days.	CORRECTION: Twenty-one				
2 625	MN Rule 4658.0450 Contents; In General	0 Subp. 1 A-P Clinical Record al	2 625			12/26/16
	record, including not A. the condition admission; B. temperature	neral. Each resident's clinica ursing notes, must include: n of the resident at the time o g, pulse, respiration, and bloo g to part 4658.0520,	f			

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
				71. BOILDING.			
		00356		B. WING		11/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN		H MCKINLE MN 56762	Y STREET		
(X4) ID		TEMENT OF DE	FICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L			PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 625	Continued From pa	ge 13		2 625			
	subpart 2, item	I;					
	C. the resident						
	according to part 4						
	and attitudes;	's general co	ndition, actions,				
	E. observations	s, assessmei	nts, and				
	interventions provid						
	responsible						
	for care of the i		the exception of				
	religious perso		.11				
			on, for example,				
	behavior, orientatio						
	nursing home,						
	G. date, time, of method of administ						
	the signature o						
	persons who admir						
	H. a report of a						
	three months prior		n, as described				
	in part 4658.08 I. reports of lab		ninations:				
	J. dates and tir						
	dressings;						
	K. dates and tin		oy all licensed				
	health care practition		lo:				
	L. visits to clinion M. any orders of						
	comprehensive pla		o relative to the				
	N. any change		nt's sleeping				
	habits or appetite;						
	O. pertinent tac resident's general o		ng changes in the				
	P. results of the						
	resident assessme						
	comprehensive		ts as described in				
	part 4658.0400.						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00356		B. WING		11/1	5/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN		H MCKINLE	Y STREET		
0.0.15	CLIMANA DV CTA	TEMENT OF DEFICI		, MN 56762	PROVIDER'S PLAN OF CORRECTI	ON	0/5)
(X4) ID PREFIX TAG		TEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 625	Continued From pa	ge 14		2 625			
	This MN Requirements: Based on interview facility failed to ensure complete and all diaprogress reports we 4 residents (R12, R) were reviewed which	and document ure the medical agnostic reports ere readily acce 2, R30, R41) w	review, the record was and provider ssible for 4 of hose records		Corrected 12/26/16		
	Findings include:						
	R12's medical reco at approximately 10 progress visit note to was not available.	0:00 a.m. The p	rovider				
	On 11/15/16, at 11: coordinator (HIC) coordinator (HIC) coopy the nurse practit however the facility documentation of the	onfirmed R12 h ioner (NP) on 10 had not receive	ad been seen 0/27/16,				
	R2's chart was revieus approximately 10:20 note from a visit on	0 a.m. The prov	vider progress				
	On 11/15/16, at 11: was seen by the NF had not yet received visit. The HIC state the information bac	on 10/11/16, bed the document and they had difficed they have a supplication the supplication they have a supplication the supplication they have a supplication they have a supplication	ut the facility ation from the culty receiving				
	On 11/15/16, at 2:2	5 p.m. the HIC s	stated she had				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00356	B. WING		11/1	5/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- WARREN	H MCKINLE , MN 56762	Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 625	Continued From pa	ge 15	2 625			
	the progress notes	der office to obtain copies of for R12 and R2's visits, nation was not available.				
	R30's clinic referral form dated 7/13/16, indicated R30 was scheduled for a mammogram with results to follow in seven to ten days.					
	R30's medical record was reviewed on 11/15/16, at 1:30 p.m. R30's mammogram results were not accessible in R30's medical record.					
	On 11/15/16, at 1:38 p.m. the HIC confirmed R30's mammogram had been completed on 7/13/16, and the mammogram results were not available to the facility, nor accessible in R30's medical record.					
	R41's clinic referral form dated 9/14/16, indicated R41 was scheduled for a follow up chest X-ray and clinic visit.					
	R41's clinic referral R41 was scheduled	form dated 10/6/16, indicated for a clinic visit.				
	at 11:00 a.m. R41's	rd was reviewed on 11/15/16, provider progress notes, and above visits were not medical record.				
	R41's medical reco	11:24 a.m. the HIC confirmed rd lacked documentation of diagnostic reports and stated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00050	B. WING		44.4	5 /0040
		00356			11/1	5/2016
	PROVIDER OR SUPPLIER	410 SOUT	TH MCKINLE	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN	, MN 56762			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 625	Continued From pa	ge 16	2 625			
	the provider progress notes were requested from the provider for the visits on the above dates to include the X-ray results.					
	confirmed the facili- medical documents and stated she wou	2 p.m. the administrator ty had not been receiving ation back in a timely fashion ald expect within two weeks of the nation would be available in all record.				
	The Maintenance of Active Medical Records policy dated 9/2013, indicated medical records would be maintained on each resident in accordance with accepted professional standards and practices that were complete, accurately documented, readily accessible and systematically organized.					
	DON and/or design revise policies and maintenance of acc organized clinical ir resident. The DON perform audits of re	THOD OF CORRECTION: The lee could could review and procedures related to the curate, complete, and information about each or designee could also esident records and report ity assurance committee.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			12/26/16

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00356	B. WING		11/1	5/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN 410 SOUT	DRESS, CITY, S H MCKINLE MN 56762	STATE, ZIP CODE Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CORRECTION (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
2 830	Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, thoroughly investigate causal factors and implement interventions in order to minimize the risk of falls and injury for 1 of 1 resident (R23) who had repeated falls with serious injuries which required medical intervention. This resulted in an immediate jeopardy situation for R23. Findings include:			Corrected 12/26/16		
	The Immediate Jec related to the facility comprehensive ass factors and implem had sustained signi which occurred on 11/7/16. The lack osignificant risk for s The facility adminis (DON) were notified	epardy (IJ) began on 11/7/16, y's failure to complete a sessment to determine causal ent interventions for R23 who ficant injuries from two falls 10/30/16, and another fall on of assessment placed R23 at erious injury and/or death. trator and director of nursing d of the IJ on 11/10/16, at 4:00 on 11/7/16, when R23 had				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00356		B. WING		11/	15/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN		TH MCKINLE , MN 56762	Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE / MUST BE PRECEDE SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From partial fallen and the facility comprehensive assorted to R23's consimplement interven R23's risk for further on 11/15/16, at 3:27 non-compliance replevel of G, which induce to a hematomate during a fall which rand interventions. R23's Diagnosis Res R23's diagnoses in fractures, interoper hematoma (bleed of musculoskeletal stranxiety, anemia, parand weakness. R23's progress note p.m. indicated R23 hospital following stright hip as a result was deaf and utilized board to communic was sometimes diff whisper tone speed to person and placeneed to use the bat weight bearing and assist and use of a physical therapy duweight on restricted transfer. Immobilized R23's admission M	y failed to composessment of cauntinued falls, in a tions to minimizer falls. The IJ was a manager of a manager dated actual has and epistaxis serequired medical eport dated 11/9, cluded subsequable hemorrhager bruise) of the ructure, Alzheimin, osteoarthritiste (PN) dated 8/1 was admitted from the admitted from the admitted from the actual repair of a fall while at the common atte. R23 did specificult to understate. R23 was please. R23 was ableathroom. R23 was would be transformechanical lift are to R23 consist right leg with a fall who are noted or the actual repair of a fall while at the repair o	sal factors a effort to e the risk of vas removed be and severity arm for R23 ustained I assessment (16, indicated ent right femure e and er's disease, s, hearing loss 6, at 8:01 om the a fractured chome. R23 nunication eak, however, and due to asant and alert to verbalize s currently non erred with staff as directed by tently putting tempted to a right leg.				
	R23's admission M 9/2/16, indicated R2						

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00356	B. WING		11/1	5/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN 410 SOUT	DRESS, CITY, S TH MCKINLE , MN 56762	STATE, ZIP CODE Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 830	fractures, had seve was rarely or never indicated R23 requ activities of daily liv urine, was not on a received anti-anxie which could increas R23's Falls Care Ar 9/9/16, indicated R3 sitting balance and transition.	rely impaired cognition, and understood. The MDS also ired extensive assistance with ing (ADLs), was incontinent of toileting program and ty and diuretic medications	2 830			
	9/9/16, indicated Ramake self understo impairment. R23 was communicated to s R23's Physical The Treatment form data a fall risk, was combalance and poor s	23 had decreased ability to od, had pain, hearing or vision as non verbal and taff via a white board. rapy Evaluation and Plan of ed 9/30/16, indicated R23 was pletely deaf, had fair sitting tanding balance, poor safety not follow through with weight				
	had limited physica femur fracture and weight bearing to ri assistance with mo support. R23 utilize and required cueing confusion, impaired limited range of mo impairment which r	red 10/25/16, indicated R23 I mobility related to a right weakness and required partial ght leg only and one staff bility and weight bearing d a wheelchair for locomotion g and guidance. R23 had I balance, limited mobility, tion and musculoskeletal equired extensive staff assist bility, dressing, toileting.				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B. WING			
		00356	b. WING		11/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN	H MCKINLE	Y STREET		
	0.0000000000000000000000000000000000000		MN 56762			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 20	2 830			
2 830	personal hygiene ar staff with front whee transfers. R23 had history of urinary tradirected to encoura during morning and in the evening/night product and staff wafter meals, before night at least at mid would also use the indicated R23 had a which required surg to monitor for sign a complications, infect pneumonia. Staff w R23 as necessary, monitor use of adaptimb swelling and or actual fall with no infalls, poor balance, unsteady gait. The to have a physical t strength and mobilit room to be on wher of any movement, the bend over to pick upencourage use of g assistance. Staff we order to maximize sposition and body p while in bed. Staff we	and stand by assistance of one eled walker and gait belt for bladder incontinence with a act infections and staff were ge R23 to drink more fluids afternoon hours and limit fluid, she utilized an incontinent ere to check R23 before and and after activities, during the night and 4:00 a.m. R23 bedpan. The care plan also a hip fracture following a fall lical repair. Staff were directed	2 830			
	11/9/16, (tool nursing care), indicated R23	de Kardex Report dated ag assistants use to direct 3 was partial weight bearing to ed the assistance of one staff				

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STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00356	B. WING		11/1	5/2016
	PROVIDER OR SUPPLIER	- WARREN 410 SOUT	DRESS, CITY, S TH MCKINLE , MN 56762	STATE, ZIP CODE Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	person for all mobil toileting, dressing a indicated R23 was position, utilize raise	ity, transfers, repositioning, and grooming. The document to have her bed in lowest ed edge mattress on her bed, n each side of her in bed when	2 830			
	R23's Falls Tool dated 8/26/16, indicated R23 had one or more falls in last three months, R23 was at high risk for falls due to recent falls, mobility and transfer problems related to muscle weakness, impaired balance, weight bearing ability changes, pain and took high risk medications. R23 also had cognitive risk factors which included restlessness, reduced insight, impulsiveness and a difficult time following instructions. Fall action plan was to refer R23 to therapy and update R23's care plan.					
	Fall incidents:					
	R23 fell on 9/3/16, at to self transfer and doorway of her bath R23 had previous in this type over the labowel, was not wear injuries. Fall interve adding a motion se update R23's care panti-coagulant, diur medications and a fall. R23's care planting transfer and t	at 10:40 a.m. R23 attempted was found on the floor in the person. The report indicated njuries from circumstances of ast 30 days, was incontinent of aring glasses, and had no entions included neuro checks, nsor alarm to her bed, and plan. R23 had anti-anxiety, retic, cardiovascular laxative within 8 hours of the n was amended to include administrator and DON 3/16.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00356		B. WING		11/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN		TH MCKINLE , MN 56762	Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH OF CROSS-REFERENCED TO THE APPLICATION OF THE APPL	ULD BE	(X5) COMPLETE DATE
2 830	R23's PN dated 9/3 R23 was found lying front of her wheelch and living area of roinjuries. R23 was as mechanical lift. Onco of bowel and stated bathroom. R23 was the incident. Call be R23's Fall Scene H dated 9/4/16, at 10: 1-7 were to be com during the Fall Hudw was found on the floout or fell from the vaself transfer. A diag was included. R23's bed bound, she had orientation to room/incontinent of bowe the last eight hours were initiated. Potel identified as "reside R23 had no injuries another resident's sanswer other alarm	/16, at 11:02 a.m g on the floor in hair in between the floor. R23 denied assisted into bed were in bed, R23 was also be eithed as wearing shoes a sell was within R23 within R23 was idea at the time or in her room. For wheelchair when ram of the locations and the locations and the locations recommended and new third root cause of the locations recommended and the locations recom	er room, in e bathroom pain. No ria a as incontinent se the at the time of ris reach. (FSHW) I questions of the fall, dicated R23 R23 had slid attempting to on of the fall entified as ad nd was beeived within uro checks of the fall was self transfer." m. indicated along with aff chose to be red R23's	2 830	DEFICIENCY)		
	room, R23 was four assisted off the floo injuries. A subseque occupational therap fall earlier after putt rubbing knee and re	nd lying on the flor. Neuro checks: ent PN at 1:37 p.i oy (OT) indicated ing on light. R23	or. R23 was started. No m. by R23 had a				

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-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00356	B. WING		11/15/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN	H MCKINLE MN 56762	Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 23	2 830			
	at medium risk for f mobility and transfe restlessness, impai	ted 9/6/16, indicated R23 was alls due to recent falls, or problems, impaired balance, red sleep patterns, cognitive th risk medications. Fall action ank.				
	R23's Investigation form dated 9/6/16, indicated at 4:00 a.m. R23 was found on the floor in her room. The form indicated this was a repeat incident, R23 had previous injuries or circumstances of this type in the last 30 days. R23 had just been toileted 15 minutes prior to being found on the floor. R23's motion sensor had gone off multiple times throughout the night. Another resident's motion sensor and R23's sensor sounded at the same time. Staff member went to answer the other residents sensor first then responded to R23's. R23's bed was in low position. The corrective action implemented was for R23 to have bed in low position when in it. The administrator and the DON both signed the form on 9/13/16.					
	found on the floor, I transfer, had been a prior, motion senso wearing glasses an the scene was draw and place prior to a root cause of the fainjuries sustained.	9/6/16, indicated R23 was nad been attempting to self assisted by staff 15 minutes r was alarming. R23 was not d was restless. A picture of wn. R23 was alert to person nd after the falls. Potential II was "possible anxiety." No The Fall Scene Investigation included root cause analysis				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00356		B. WING		11/1	5/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- WARREN		TH MCKINLE , MN 56762	YSTREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDEI SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	Continued From para 3. R23's PN note day indicated R23 had be room beside left side Bed in lowest position indicated non verbator injuries. R23 was "reasonable" personable pers	ated 9/11/16, at 9 been found on the le of bed, lying or on. No injuries noully she did not has assisted back to assisted back to assisted back to be seen found on the least to recent fall ms, impaired balance of high risk med did cognition. The cognitive risk fact is sight, impulsiven astructions and ung alarms. The Act of the least to the	e floor in a stomach. The stomach. The stomach. The stomach. The stomach are any pain to bed. All atted R23 was a s, mobility ance, weight ications and tool further ors which ess and a stafe use of the stomach, R23 and alarms and of urine. It incident and stances over out of her d R23 was call light. R23 aluded neuro cation, and en she was anti-anxiety, ant alt hours of	2 830			

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-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/ IDENTIFICAT	SUPPLIER/CLIA FION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00356		B. WING		11/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN		TH MCKINLE , MN 56762	Y STREET		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ıge 25		2 830			
	A second Investiga p.m. indicated R23 to self transfer whice 9/13/16. R23 was r Sensor device in ple pillows utilized. R23 use. A raised edge bed and R23 along educated by nursin place and forgetful Neuro checks were bruise/hematoma f administrator and common 9/13/16.	had a repeat in the was not invested as with mace to detect respectively. The was also with staff and g. R23 was also prior to and after initiated. R23 rom the fall. B	ncident of trying estigated until ultiple falls. movement, body with call light added to R23's family were ent to person and ter the fall. had sustained a both the				
	The undated FSHV the floor in her roor assisted by staff or was working, she was incontinent of scene was drawn of to and after the fall indicated "this is a administered in the checks initiated. Not 4. R23's PN dated indicated R23's mo	m. was nonverled hour prior. Fives not wearing urine. A descripton the form. R2. The Commer repeat incident least 8 hours in prior injury.	bal and was last R23's alarms g glasses and ption of the R23 was alert prior at section the R23 medication andicated. Neuro R23 p.m. as sounding.				
	Upon entering R23 on the floor next to assisted back into I	's room, R23 wher bed. No in bed. ted 10/20/16, i	vas found sitting juries. R23 was ndicated R23				
	was at medium risk mobility and transfe objects, impaired b	er problems, di	fficulty seeing				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00356		B. WING		11/	15/2016
NAME OF	PROVIDER OR SUPPLIER			DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	GOOD SAMARITAN SOCIETY - WARREN			MN 56762	TOTALLI		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	Continued From parchanges, and took of further identified R2 which included, confollowing instruction light and assistive disection indicated R2 therapy. This was right was currently received R23's Investigation p.m. indicated R23 her bed. The report help, and attempted balance, and her was further indicated this previous injuries or 31-180 days. The redifficulties seeing of personal alarms were included neuro cheer on using call light for needed assistance area of the report was received narcotic are eight hours of the faton both signed this for R23's FSHW dated indicated R23 was fafter attempting a seeing objects, lost and fall alarms were scene was drawn. In person, place and the faton beautiful and the fall meds in jury. Neuro check	high risk medic 3 had cognitive fusion, poor medicates. The Ac 23 would be refund a new interving therapy selform dated 10/was found on the indicated R23 do transfer here working. Falce working. Falce and R23 working. Falce and R23 working. Falce and R23 working. Falce and rem 10/27/16. 10/20/16, at 5: found on floor in elf transfer. R2 balance, walked working. A de R23 was alert a time, was forget administered ic	e risk factors emory, difficulty use the call tion Plan ferred to ventions as R23 rvices. 20/16, at 3:20 he floor next to did not call for rself, lost her er. The report incident with over the last R23 had njuries, and Il interventions as re-educated ninded R23 she he continence t23 had lication within ministrator and 30 p.m. n own room 3 has difficulty er tipped over escription of the and oriented to tful prior to and	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00356	B. WING		11/15/2016	
NAME OF PF	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY	- WARREN	H MCKINLE , MN 56762	Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
	8:10 a.m. indicated wheelchair and witr shoe or the floor (ur room. The report fur repeat incident with circumstances over identified R23's har and continence are Fall interventions we calling or asking for seat belt was added educated on use ar seat belt. R23 had within eight hours or indicated a seat belt wheelchair, it was lanot applied until she 10/31/16, because in which it had finall was signed by the I administrator on 11. R23's FSHW dated indicated R23 was and was lowered to scene of the incider was alert and orient prior to and after the identified. R23 com "hurts a little." Staff R23's PN dated 10/physical therapy incher wheelchair in the	on form dated 10/27/16, at R23 was seated in the nessed to reach towards her nknown) and fell in the dining or the indicated this was a previous injuries or the last 30 days. The report of was a little sore. The vision as of the report was left blank. Here R23 was re-educated on assistance, self-releasing to the wheelchair and R23 and R23 was able to release received diuretic medication of the fall. Although the report the was installed on R23's after revealed the seat belt was a returned from the hospital on the facility had to order a belt by been delivered. This form DON on 11/2/16, and the	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00356		B. WING		11/	15/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN		TH MCKINLE , MN 56762	YSTREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCY MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	Continued From paraincreased over the tender to touch. R2 to have pain. This was to be seen on physilimitations to R23's subsequent PN writindicated R23 had four have guarded used lower extremity. With due to R23 declining propel the wheelchas of the second of the sec	2nd metacarpal ar 3's right knee also was reported to nuiteran rounds. Pain therapy session. Atten by OT at 11:34 allen earlier. R23 of her right thumb and the part of her right thumb and the selchair mobility of the selchair of the selchair via a mechane holding her right matoma to her force and had been prevant the emerging revaluation. A substant was also negginal status and the selchair via a mechane revaluation. A substant was also negginal status and the selchair via a selcontinuological status and breakdown and for D on 10/31/16, as and highlight and the selchair via a selcontinuological status and the selchair via a selchair via	continues rsing. R23 created A a.m. was noted to and right decreased d and foot to assisted nical lift. shoulder chead. R23 viously given ency osequent PN from the ED the head athology and ative. The ue to I frontal r R23 to R23 oagulant				
	she attempted to tra The report indicated with previous injurie	ansfer herself or a d this was a repea	mbulate. t incident				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00356		B. WING		11/1	5/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- WARREN		H MCKINLE	Y STREET		
	AMAIIIIAN SOCIETI	- WAILIEN	WARREN	MN 56762			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 29		2 830			
	last 30 days. The reno injuries, and R23 locked. The vision a report was left bland personal alarms we included R23 was rof asking for help, a needed assistance received diuretic, camedications, and a the fall. Both the Dethe form 10/31/16.	eport further identifications in the property of the property	es were not as of the fy R23's erventions mportance d that she 23 had arcotic t hours of				
	R23's FSHW dated indicated R23 was thallway and had slith had slipped and whunlocked. A diagran R23 was alert to pe Medications adminition hours identified. No section indicated R2 attempted to ambul	found on the floor in or fell out of wheel eelchair brakes we n of the scene was rson and forgetful. stered within previous injury. The Commo 23 does not ask for	n the chair. R23 re drawn. ous eight ents help and				
	A second Investigat 5:00 p.m. indicated forward in her chair self releasing seat to be reeducated. The section indicated R3 so far forward and to added to wheelchait educated R23 on usunderstanding by restaff will continue to signed the form on on 11/3/16. Althoug belt was added to F	R23 was leaning to and fell. R23 was to belt installed and R2 Results of Investig 23 was reeducated to ask for assistance. The Demonstrated are se. R23 demonstrated are beleasing seat belt per to monitor weekly. The season of the add the form indicated	oo far oo have a 23 was to eation to not lean e. Seat belt d ted er self. he DON ministrator d a seat				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPL	(X3) DATE SURVEY COMPLETED	
00356 B. WING 11/1/	- (004.0	
00000	5/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET		
GOOD SAMARITAN SOCIETY - WARREN WARREN, MN 56762		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
investigation revealed a seat belt had been ordered and had not been delivered to the facility and applied to R23's wheelchair until 10/31/16. 7. R23's PN dated 10/30/16, at 5:15 p.m. indicated R23 was found on the floor in the dining room lying on her right side with a heavy bloody nose from both nostrils. R23 denied pain. R23 was assisted into a dining room chair via a mechanical lift. However, R23's nose continued to bleed. R23 was removed from the dining area. A subsequent PN titled "Late Entry" at 6:30 p.m. indicated R23 tell at 4:45 p.m. and sustained a bloody nose. R23 was assisted into a dining chair however continued to "head bob" and bleed through her nose. R23 was returned to her room and assisted into bed. R23 was given an antianxiety medication to "settle" her. At this time, R23 was found in her bed with with large amounts of blood on her pillow and her nose clotted with blood. R23's blood pressure was 87/54. The on call physician was notified and R23 was taken back to the ED for evaluation. A subsequent note indicated R23 was admitted to the hospital for observation of a head injury and possible urinary tract infection. R23's bleeding had ceased and she was receiving fluids. An earlier CT revealed a hematoma but no hemorrhaging on the brain. R23's FSHW dated 10/30/16, at 6:00 p.m. indicated R23 bid of fell from wheelchair and was found on the floor in the dining room. R23's wheelchair brakes were unlocked. A diagram of the scene was drawn. R23 was alert but forgetful. Medications used within last eight hours were indicated. R23 had a bloody nose. The		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00356	B. WING		11/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN	H MCKINLE MN 56762	Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 31	2 830			
	was at medium risk mobility and transfe and took high risk n identified R23 had o included, poor mem following instruction assistive devices, a medications. The A	ted 10/30/16, indicated R23 for falls due to recent falls, or problems, impaired balance, nedications. The tool further cognitive risk factors which nory, impulsive, difficulty as, forgot to use the call light or and received high risk ction Plan listed was to refer vever, R23 was currently ervices.				
	R23's Falls Tool dated 10/31/16, indicated R23 was at low risk (despite being identified as high risk previously) for falls due to recent falls, and took high risk medications. The tool further identified R23 forgot to use the call light or assistive devices, and was incontinent. The Fall Action plan was to refer R23 to therapy.					
	physical therapy inc the hospital for obs	/31/16, at 11:58 a.m. by dicated R23 was admitted to ervation after having two falls jury and significant bloody				
	R23 had a fall the obloody nose and did large lump on her for ED/hospitalized. The medications and discurrently resting in	31/16, at 3:38 p.m. indicated lay prior and sustained a d hit her head. R23 had a prehead and was seen in the le physician evaluated R23's scontinued a few. R23 is bed. Nose is still bleeding ded and call light within R23's				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00356		B. WING		11/	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN	410 SOU	DRESS, CITY, S FH MCKINLE , MN 56762	STATE, ZIP CODE Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIE	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pareach. 8. R23's Falls Tool		ndicated R23	2 830			
	was at medium risk mobility and transfe objects, not wearing balance, and took if further indicated R2 which included poowas unsafe to use was to refer R23 to	for falls due to r problems, diffigher glasses, in high risk medica 3 had cognitive r memory, impulequipment. The	recent falls, culty seeing npaired tions. The tool risk factors lsiveness, and				
	R23's Investigation a.m. indicated R23 bathroom in front or indicated R23 did not transferred herself. This was a repeat in circumstances over identified R23 was not identify if R23's sounding and the cowas left blank. The injuries, and fall interpretable R23. R23 had diure thours of the fall. The section was blank form was also blank form was also blank documentation of a determine causal faimplemented.	was found on the fithe toilet and so to call for assist. The report furthe cident with prevente last 30 days not wearing her personal alarms ontinence area continence area for report indicated ervention was to exic medication where Results of Invalue and the signature so the Results of Invalue and the signature so the signature	ne floor in her ink. The report ance, and her indicated ious injuries or s. The report glasses, did as were of the report R23 had no re-educate within eight estigation ection of the acked in in order to				
	R23's PN dated 11/ therapy indicated R with self transferring bathroom floor. R23 right knee rated a 5	23 had a fall in t g. She was foun 3 stated she hac	he bathroom d on the I pain in her				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00356	B. WING		11/	15/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN 410 S	ET ADDRESS, CITY, S SOUTH MCKINLE REN, MN 56762			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
2 830	appear sore as well together. R23 was a educated on import when going to the bipoor safety. R23's PN dated 11/OT indicated OT ar R23's wheelchair al attempting to self tr	ge 33 I as R23 keeps rubbing the agreeable to therapy. R23 ance of asking for assistar bathroom. R23 was unaward 7/16, at 12:27 p.m. written and nursing both responded arm and found R23 ansfer from the wheelchair formed OT of R23's fall that	was nce re of by to			
	indicated R23 was had attempted self glasses and had sli was drawn. R23 wa and was forgetful. No previous eight hour pain. The Commen	11/7/16, at 3:30 p.m. found on the bathroom flootransfer, was not wearing pped. A diagram of the scens alert to person and place Medication given within s identified. No injury and respection indicated R23 did self transferred. No furthed.	ene e no d			
	dining room, seated brakes were off whi self-releasing seat the alarm unit attac wheelchair. R23 ha her right eye which	p.m. R23 was observed in din her wheelchair. The lile at the table and R23 had belt fastened around her whed to the left side of the dalarge purple bruise ove extended down the right siso had a large purple goos ehead.	d a ith er de			
		4 a.m. R23 was observed i ad only one body pillow	in			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00356		B. WING		11/	15/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN		TH MCKINLE , MN 56762	Y STREET		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From particles positioned behind hedroom door was were noted on the knosition, a four were the audio alarm was to the bed, and wall room across from home from from hom	der. R23's room 3/4 closed, bilated frame, bed lage mattress was son, her wheel ker was in the closer bed. 3 p.m. R23 was ody pillow laid was not bed was next to be room across frottion, R23's audian resources are ator (HR/QA) was mediately walk turned R23's audian resources are sensor alarm sement (HIM) was immediately walk turned R23's audian resources are sensor alarm sement (HIM) was mediately walk turned R23's audian resources are sensor alarm sement (HIM) was mediately exit was non NA-H's walk dent assistant (moutside the roll over?" NA-Hid turned R23's and turned R23's	teral grab bars was in lowest as on her bed, chair was next corner of the sobserved in rertically above on either side (4 closed, her ateral grab ensor alarm d, and walker om her bed. io alarm off audio alarm off. sounded, health as observed to alk out and and turned sounded. erved to enter valking directly ray to the RA)-A was surses station stated, "Yes," alarm off.	2 830	BENOTENOT)		
	Registered nurse (F						

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00356	B. WING		11/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN	H MCKINLE MN 56762	Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	which was next to t witnessed the surve immediately turned station. RN-B did not a station. R23's room and turned or immediately walked the nurses station a you help her? RA-proceeded to turn or R23's room and closs of the station	he nurses station. RN-B had eyor exit R23's room and the alarm off at the nurses of go to R23's to check on her. sensor alarm sounded. nurse (LPN)-B entered R23's in R23's call light and dout of R23's room towards and loudly stated to RA-A, "can A replied, "Yes," LPN-B off R23's alarm. RA-A entered is ed the door. O a.m. R23's motion alarm observed in bed on her left ers. One body pillow was ner bed was in lowest position, is on bed, bilateral grab bars, room across from her bed,	2 830			

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STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00356	B. WING		11/1	5/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN 410 SOUT	DRESS, CITY, S TH MCKINLE MN 56762	STATE, ZIP CODE Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 830	wheelchair, and pul self-releasing seat LPN-B pulled the le Velcro the belt stray identify the use of the -At 7:39 a.m. NA-H	ge 36 led the right half of her belt around her right side while ft side strap of her seatbelt os together. R23's failed to he self releasing seat belt. was observed to enter R23's B exited. R23 was assisted	2 830			
	the toilet while facir hands on the whee stretched over the were bent at her kn gait belt and applied assisted her into the unsteady and requi	bserved standing up in front of ag the doorway. R23 had both lchair handles and was wheelchair seat. R23's legs ees. NA-H held on to R23's d a clean brief and then e wheelchair. R23 was red NA-H to hold onto her and wheelchair during the transfer.				
	at a high risk for fall assistance with all assistance with all asure what R23's counable to speak an stated R23 transfer have had to stop he moved quickly and stated R23 unfortur sleep and was also why her seatbelt was interventions were He stated he did not interventions to prestated the last time 11/7/16, in which R2	evation, NA-H verified R23 was ls and required staff ADLs. NA-H stated he was not gnition was because R23 was d that got in the way. NA-H red pretty well, however, staff er from self-transferring. R23 did not wait for staff. He nately always thought about confused sometimes as to as on. He stated R23's fall her seat belt and wall alarm. It know of any other vent R23 from falling. NA-H R23 self transferred was on 23 must have fallen when she cause there was stool in the				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00356	B. WING		11/1	5/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WARREN 410 SOUT	DRESS, CITY, S TH MCKINLE MN 56762	STATE, ZIP CODE Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	toilet bowl and the vibathroom. He state her bathroom that rivith her back again rack and her legs walarms were sound nurse in because hon her head and he caused the bump opulled R23's small from a bag in the bawrote time to eat or -At 7:58 a.m. R23 viber wheelchair slow the dining room. R2 and fastened correct her left leg and foot grabbed the right si herself along until the timot supervised by si	water was running in the d he found her on the floor in morning at about 8:00 a.m. ast the wall under the towel were out by the toilet and no ing. NA-H stated he called the e was worried about the bump of did not know if that fall had a ranother fall had. NA-H white communication board ack of R23's wheelchair and in it for R23 to read. Was observed self propelling by down the hallway towards 23's self releasing seat belt on cally. R23 used both arms, and to propel herself. R23 de hallway rail and pulled the railing ended and she lie dining room table. R23 was taff as she self propelled from	2 830			
	was observed to an hallway outside of F belt and lifted/assis stooped over and b knee. R23 took smale to favor her left leg. with her left hand, a with her right hand. ahead of her walke buckle. R23 walked was not standing st down to the floor or	3 a.m. physical therapist (PT) nbulate with R23 in the R23's room. PT applied a gait ted R23 to stand up. R23 was oth legs remained bent at the all, slow steps. and appeared PT held on to R23's gait belt and pushed R23's wheelchair PT stated R23 liked to get r, and her right side tended to I stooped over, legs bent and raight up. R23's eyes looked her feet and R23 did not look like this for approximately 30				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPP		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION	NUMBER:	A. BUILDING:		COMP	LETED
		00256		B. WING		44/4	E/0016
		00356				11/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			410 SOUT	H MCKINLE	Y STREET		
GOOD S	AMARITAN SOCIETY	- WARREN		MN 56762			
040.15	CLIMMA DV CTA	TEMENT OF DEFICIENC			DDOVIDEDIS DI ANI OF CODDECTI	N.	()(5)
(X4) ID PREFIX		MUST BE PRECEDED	-	ID PREFIX	PROVIDER'S PLAN OF CORRECTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFOR		TAG	CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
2 830	Continued From pa	go 20		2 830			
2 030	Continued From pa	ge so		2 030			
	feet before she slow	ved way down, and	d PT				
	assisted her with ga	ait belt into her who	eelchair.				
	Once in the wheelc	hair, R23 grimaced	d and				
	rubbed her right leg						
	pain, and stated sh	e asked R23 befor	e she				
	walked if she had a						
	no. PT asked R23 i						
	medication from the						
	unable to communi						
	pain or desire for pa						
	did not know what F						
	stated communicat						
	and felt R23 had so						
	related to dementia						
	interventions were t						
	and walk inside her						
	follow through. She						
	R23 did not follow t						
	because of her cog						
	not to. PT stated Ra						
	close to her body for						
	held it way out. PT						
	account for improve walker was closer to						
	favored her left leg						
	_						
	a right hip fracture i						
	August 2016, and h						
	was at high risk for						
	transfers and R23 r						
	assistance. PT con						
	transfer unsafely ar						
	because of R23's in						
	she definitely requir						
	stated she thought						
	transferred was 11/						
	fallen. PT stated sh						
	the bathroom. She						
	would get better an						
	but stated she did r	ot feel it was poss	ible now.				

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STATEMEN	TO DEPARTMENT OF THE OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00256	B. WING		44/4	E/0016
		00356	D. W.KG		11/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN	TH MCKINLE , MN 56762	YSTREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 39	2 830			
	fall interventions incalert staff when she when R23 did not u added a self-releas been leaning too fa and had fallen out. seat belt, R23 had f wheelchair. PT stainjury after she fell to the hospital. R23 transfer, always loo a history of falls inc. March and August of history of being deversiously sustained fracture in a car acc R23 had been put to was supposed to us know when she was transferred from the back to her room. Sonursing program, and recommended appring for R23. PT did not pillows, grab bars, of mattress as additional too.	200 a.m. the PT stated R23's cluded a room sensor to help was trying to self transfer se her call light, staff also ing seat belt because R23 had r forward in her wheelchair PT stated despite adding the fallen two more times from her ted R23 sustained a head out of her wheelchair and went always attempted to self ked down at her feet, and had luding two hip fractures in of 2106. PT stated R23 had a relopmentally delayed and had d a traumatic injury/skull cident. She stated on 11/7/16, on the toilet by staff and R23 se her call light to let staff is done but had not and self e toilet and fell before staff got she stated a restorative and staff assistance were roaches to prevent further falls identify R23's reacher, body or bed position and raised nal fall interventions.				
	had many barriers to transfers. She state bearing (NWB) for a unable to participate they tried to commularitten cues, visual cues and were unsular transfers.	25 p.m. PT confirmed R23 to safe ambulation and ed R23 was non-weight a long time because R23 was e in NWB training. PT stated unicate with R23 and tried demonstration, and manual uccessful. PT stated when the was not able to bear				

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weight on her right leg related to a repeat right hip

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STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00356	B. WING		11/1	5/2016
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY	- WARREN	H MCKINLE MN 56762	Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
	cognition and common slowly improved and therapy on 11/11/16 R23 would not be a because she had potalls. She stated R2 wheelchair brakes operson to assist herambulation. On 11/9/16, at 3:00 sounded. R23 was ewedged raised mattally place, no body pillow position, wheelchair the corner of the root of the corner of the root of the corner of the corner of the corner and her walker in the from her bed. On 11/10/16, at 9:02 was sounding. R23 body pillows in place not have any body plocated one body pillowal and also looked in sR23's room and corner	ge 40 ain, weakness, and impaired nunication. PT stated R23 had d would be discharged from a. She stated she was afraid ble to return to assisted living for safety recall and continued a had to be cued to put her on, and required one staff with all transfers and p.m. R23's sensor alarm observed in bed with a tress, bilateral grab bars in ws in place, bed in lowest by her bed, and her walker in om across from her bed. D a.m. R23 was observed in were no body pillows in place are plan. R23's room was door was 3/4 closed, her bed on, bilateral grab bars in the mattress on her bed, her on her wheelchair by her bed, her on her was observed in bed with no her was observed in bed with her and stated she would check	2 830	BELLICITY STATES AND ADDRESS OF THE PROPERTY O		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SI IDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00356		B. WING	····	11/1	5/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
		WADDEN		H MCKINLE			
GOOD S	AMARITAN SOCIETY	- WARREN	WARREN	, MN 56762			
(X4) ID PREFIX TAG		TEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 41		2 830			
	On 11/09/16, at 12: was admitted from had sustained her 3 year. She stated R2 would fall again, ge again. She stated I cognitive impairment assistance with all A was so impulsive the with her at all times admitted they check and educated R23 she started falling.	assisted living f Brd fall and brok 23's physician w t injured, and m R23 was deaf a nt, and required ADLs. The DOI at staff tried to . She stated wh	acility after she ten hip this vas afraid R23 tay never walk nd had mild staff N stated R23 have someone ten R23 was e frequently,				
	At 1:34 p.m. R23's incident reports, invinterventions impler DON who stated the	restigation report mented were re	rts and				
	-9/3/16, the DON versitated she did not the and felt that was who DON stated every the re-educated R23 or up or walk on her or initiated neuro check alarm to her bed and	hink R23 used I ny R23 had so r ime after R23 fo n the fact that sl wn. She stated ks and added t	her call light many falls. The ell, the staff he couldn't get staff had he sensor				
	-9/6/16, 4:00 a.m. the information and state caused R23 to self. She confirmed neuron the new fall interver position when R23	ted she thought transfer and fal ro checks were ntion was to kee	t anxiety I out of bed. initiated, and				
	-9/11/16, 8:00 a.m. information and sta initiated and fall int	ted neuro checl	ks were				

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WARREN (A4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFEX TAG CONTINUED FROM DATE 2 830 Continued From page 42 pillows along side the resident when in bed and staff education. -9/13/16, 4:10 p.m. the DON verified the fall information and stated R23 was inconsistent with call light use. Staff reeducated R23 on call light use. The DON stated fall interventions implemented were neuro checks, resident/employee/family education and the addition of a raised edged mattress to R23's bed. -10/20/16, 3:30 p.m. fall incident not discussed at this time due to the fall information was not available for review yet. The information was provided on 11/10/16. -10/27/16, 8:10 a.m. the DON confirmed the fall information and stated R23 was reeducated on calling/asking for help. The DON stated as elf releasing seat belt was added to R23's wheelchair and R23 was educated on the use. -10/30/16, 9:30 a.m. the DON confirmed the fall information and stated the fall intervention implemented was for R23 to be reeducated on the importance of asking for help and that she needed assistance with all transfers.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
August South Mckinley Street Warren Warr			00356		B. WING		11/	15/2016
XAI ID PROVIDER'S PLAN OF CORRECTION XIS SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE 2 830 Continued From page 42 2 830 Pollows along side the resident when in bed and staff education. -9/13/16, 4:10 p.m. the DON verified the fall information and stated R23 was inconsistent with call light use. Staff reducated R23 on a call light use. The DON stated fall interventions implemented were neuro checks, resident/employee/family education and the addition of a raised edged mattress to R23's bed. -10/20/16, 3:30 p.m. fall incident not discussed at this time due to the fall information was not available for review yet. The information was provided on 11/10/16. -10/27/16, 8:10 a.m. the DON confirmed the fall information and stated R23 was reeducated on calling/asking for help. The DON stated a self releasing seat belt was added to R23's wheelchair and R23 was educated on the use. -10/30/16, 9:30 a.m. the DON confirmed the fall information and stated the fall intervention implemented was for R23 to be reeducated on the importance of asking for help and that she needed assistance with all transfers.	NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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pillows along side the resident when in bed and staff education. -9/13/16, 4:10 p.m. the DON verified the fall information and stated R23 was inconsistent with call light use. Staff reeducated R23 on call light use. The DON stated fall interventions implemented were neuro checks, resident/employee/family education and the addition of a raised edged mattress to R23's bed. -10/20/16, 3:30 p.m. fall incident not discussed at this time due to the fall information was not available for review yet. The information was provided on 11/10/16. -10/27/16, 8:10 a.m. the DON confirmed the fall information and stated R23 was reeducated on calling/asking for help. The DON stated a self releasing seat belt was added to R23's wheelchair and R23 was educated on the use. -10/30/16, 9:30 a.m. the DON confirmed the fall information and stated the fall intervention implemented was for R23 to be reeducated on the importance of asking for help and that she needed assistance with all transfers.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDE	ENCIES ED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	IOULD BE	COMPLETE
-10/30/16, at 5:00 p.m. the DON confirmed the fall information and subsequent hospitalization. -11/7/16, 8:15 a.m. the DON confirmed the fall information and stated R23 never, never used her call light and verified an investigation was not completed nor were new interventions implemented except for re-educating R23 and reminding her to use the call light to ask for help. The DON stated she had not had a chance to complete the fall investigation report yet. The DON stated she did not know what else to do to	2 830	pillows along side the staff education. -9/13/16, 4:10 p.m. information and state call light use. Staff ruse. The DON state implemented were resident/employee/addition of a raised -10/20/16, 3:30 p.m. this time due to the available for review provided on 11/10/1 -10/27/16, 8:10 a.m. information and state calling/asking for her releasing seat belt wheelchair and R23 -10/30/16, 9:30 a.m. information and state implemented was for the importance of a needed assistance -10/30/16, at 5:00 p. fall information and state call light and verifice completed nor were implemented excepted in the poon stated shoomplete the fall intograph of the staff of the poon stated shoomplete the fall intograph.	the DON verificated R23 was increeducated R23 ed fall intervention neuro checks, family education edged mattress at fall incident nor fall information yet. The information yet. The information yet. The information yet. The DON confitted R23 was receip. The DON stawas added to R23 was educated at the fall interver R23 to be reesting for help at with all transfers with all transfers of the DON confirted R23 never, and an investigation report of the call light to the call light to the had not had a vestigation report.	ed the fall consistent with on call light ons and the sto R23's bed. It discussed at was not ation was ation was ation was arred the fall educated on ated a self 23's on the use. I med the fall vention aducated on and that she so. Infirmed the fall never used her on was not ons ask for help. I chance to ret yet. The				

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MAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WARREN 11/15/2016 SUMMARY STATEMENT TO DEFICIENCIES PRIEFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION 2 830 Continued From page 43 minimize R23's continued falls. On 11/9/16, at 2:50 p.m. trained medication administration (TMA) stated R23 set off her sensor alarm by her bed all the time. She stated R23 also had a seat belt alarm on her wheelchair now. She stated R23 played with the alarm belt, and continued to go right back to her room. On 11/9/16, at 3:04 p.m. NA-J stated any movement in R23's room would set off the sensor alarm by R23's bed. She stated R23 should have two body pillows in bed with her at all times, and confirmed R23 did not currently have two body pillows in bed with her at all times, and confirmed R23 did not currently have two body pillows in bed with her at all times, and confirmed R23 did not currently have two body pillows in bed and was not sure where they were at. She stated R23 do not were they were at. She stated R23 do not were they were at. She stated R23 do not will when R23 had fallen and stated R23 unally fell out of her wheel chair. She stated R23 do not will when R23 had fallen and stated R23 unally fell out of her wheel chair. She stated R23 do not staff to the willow she stated when there were changes to resident care the other NA's would discuss it, and there was a also a Kardex in the charting room for staff to review if they needed to. She stated she did not check the Kardex when she was working, but if there was something strange going on with a		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
AMAE OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WARREN STREET ADDRESS, CITY, STATE, ZIP CODE 410 SOUTH MCKINLEY STREET WARREN, MN 56762 PREPRIX REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 43 minimize R23's continued falls. On 11/9/16, at 2:50 p.m. trained medication administration (TMA) stated R23 set off her sensor alarm by her bed all the time. She stated R23 also had a seat belt alarm on her wheelchair now. She stated R23 played with the alarm belt, and continued to transferred herself. She stated staff just kept an eye on her. In addition, after meals R23's wanted to go right back to her room. On 11/9/16, at 3:04 p.m. NA-J stated any movement in R23's room would set off the sensor alarm by R23's bed. She stated R23 could sit up in bed by herself and could also read her white communication board. She stated R23 should have two body pillows in bed with her at all times, and confirmed R23 did not currently have two body pillows in be and was not sure where they were at. She stated R23 and a seat belt and can remove it on her own and liked to grab at the velcro strap on her shoes, but if she did not wear her velcro shoes, she did not reach for her feet. NA-J stated she had been on duty when R23 had fallen and stated R23 divent fall in her room, but fell in the dining room, and in the hallway. She stated when there were changes to resident care the other NA's would discuss it, and there was also a Kardex in the charing room to staff to review if they needed to. She stated she did not check the Kardex when she was working, but if there was something strange going on with a				7. BOILDING.			
SUMMARY STATEMENT OF DEFICIENCIES TAG			00356	B. WING		11/1	5/2016
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On 11/9/16, at 2:50 p.m. trained medication administration (TMA) stated R23 set off her sensor alarm by her bed all the time. She stated R23 also had a seat belt alarm on her wheelchair now. She stated R23 played with the alarm belt, and continued to transferred herself. She stated staff just kept an eye on her. In addition, after meals R23 wanted to go right back to her room. On 11/9/16, at 3:04 p.m. NA-J stated any movement in R23's room would set off the sensor alarm by R23's bed. She stated R23 could sit up in bed by herself and could also read her white communication board. She stated R23 should have two body pillows in bed with her at all times, and confirmed R23 did not currently have two body pillows in bed and was not sure where they were at. She stated R23 had a seat belt and can remove it on her own and liked to grab at the velcro strap on her shoes, but if she did not wear her velcro shoes, she did not reach for her feet. NA-J stated she had been on duty when R23 had fallen and stated R23 usually fell out of her wheel chair. She stated R23 did not fall in her room, but fell in the dining room, and in the hallway. She stated when there were changes to resident care the other NA's would discuss it, and there was also a Kardex in the charting room for staff to review if they needed to. She stated she did not check the Kardex when she was working, but if there was something strange going on with a	2 830	Continued From pa	 uge 43	2 830			
administration (TMA) stated R23 set off her sensor alarm by her bed all the time. She stated R23 also had a seat belt alarm on her wheelchair now. She stated R23 played with the alarm belt, and continued to transferred herself. She stated staff just kept an eye on her. In addition, after meals R23 wanted to go right back to her room. On 11/9/16, at 3:04 p.m. NA-J stated any movement in R23's room would set off the sensor alarm by R23's bed. She stated R23 should have two body pillows in bed with her at all times, and confirmed R23 did not currently have two body pillows in bed with her at all times, and confirmed R23 did not currently have two body pillows in bed and was not sure where they were at. She stated R23 had a seat belt and can remove it on her own and liked to grab at the velcro strap on her shoes, but if she did not wear her velcro shoes, she did not reach for her feet. NA-J stated she had been on duty when R23 had fallen and stated R23 usually fell out of her wheel chair. She stated R23 did not fall in her room, but fell in the dining room, and in the hallway. She stated when there were changes to resident care the other NA's would discuss it, and there was also a Kardex in the charting room for staff to review if they needed to. She stated she did not check the Kardex when she was working, but if there was something strange going on with a		minimize R23's con	ntinued falls.				
On 11/10/16, at 7:40 a.m. LPN-B stated R23 was		administration (TMA sensor alarm by her R23 also had a sea now. She stated R2 and continued to trastaff just kept an eymeals R23 wanted. On 11/9/16, at 3:04 movement in R23's alarm by R23's bed in bed by herself and communication boas have two body pillow and confirmed R23 body pillows in bed were at. She stated remove it on her ow velcro strap on her her velcro shoes, sl NA-J stated she has fallen and stated R2 chair. She stated R2 chair. She stated R2 fell in the dining roo stated when there we the other NA's woul also a Kardex in the review if they needed check the Kardex we there was somethin resident she might.	A) stated R23 set off her in bed all the time. She stated at belt alarm on her wheelchair 23 played with the alarm belt, ansferred herself. She stated in on her. In addition, after to go right back to her room. In p.m. NA-J stated any is room would set off the sensor it. She stated R23 could sit up indicated and also read her white and. She stated R23 should with her at all times, and do not currently have two and was not sure where they indicate and it is shoes, but if she did not wear he did not reach for her feet. In the shoes, but if she did not wear he did not fall in her room, but om, and in the hallway. She were changes to resident care lid discuss it, and there was a charting room for staff to ed to. She stated she did not when she was working, but if ing strange going on with a				

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Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SI IDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00356		B. WING		11/1	15/2016	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WARREN		ΓΗ MCKINLE , MN 56762	Y STREET			
(X4) ID PREFIX TAG		TEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 830	pretty good at using staff usually did not bathroom by hersel On 11/10/16, at 8:1 leave R23 alone in would fall. NA-L stathe bathroom when not leave R23's become of the bathroom when her seat be wheeled herself froseen her take it off was not ok for staff the toilet by herself. R23 alone in her bathroom when her wasn't sure if R23 alone and would he wasn't sure if R23 alone in her bathroom wasn't sure if R25 alone in her bathroom wasn't sure i	g her call light. So go far when R2 f. 1 NA-L stated sher bathroom bated she may ju R23 was on the droom. 4 a.m. NA-H stated with the dining room a couple times. To leave R23 urangles in NA-H stated heathroom becaused self transferre 23 was left alone	he would not ecause she st step outside toilet, but did atted R23 could with it when she om and had He stated it nattended on e did not leave e R23 was ad. He stated e on the toilet	2 830				
	on 11/7/16, and sta alarms were going floor in her bathrooto waste water and faucet on he wasn't the water on for her the water on. On 11/10/16, at 12: administrator were confirmed R23 also and stated R23 water bed after she stipped over. She stadid not call for help Fall interventions in R23 on using her call she needed as	off when he foum. He also state when he found a sure if a staff per and left, or if Research and left, or if Research and and attempted all light for help,	nd her on the ed R23 hated her water verson turned 123 had turned 123 had turned 124 had turned 125 had turned 126 had turned					

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STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00356	B. WING		11/1	5/2016
NAME OF PROVIDER OR SU	PPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		410 SOUT	H MCKINLE	Y STREET		
GOOD SAMARITAN SO	CIETY	- WARREN WARREN,	MN 56762			
PREFIX (EACH DEF	ICIENC	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830 Continued Fr	om pa	ge 45	2 830			
checks were documentation. The DOI investigate Researched because she cart. The DOI put on the toil self transferre because R23 person must DON and additionally and held their moderate and held thei	also in of what state 23's far had be N state 23's far have I hav	nitiated. There was no whether R23 was incontinent or and she had not had time to all on 11/7/16, at 8:15 a.m. een working on the medication and she thought R23 had been are breakfast, was left alone, at fell. The DON stated ms were turned off, a staff eft her alone on the toilet. The ator confirmed this incident extension for the fall on 11/7/16, needed to be a team effort and and the stigation for the fall on 11/7/16, needed to be a team effort and and the completed the donor. She stated staff typically gother morning huddle se of the survey, they had not meetings this week. On admitted R23's alarming ed on 10/27/16, and did not until 10/31/16, therefore was wheelchair until 10/31/16. The next intervention they would add a sensor alarm in R23's R23's current sensor did not soom and other than the enhad no idea what else to do ls. The DON stated they m for R23's bathroom. Lastly, R23 understood directions ability to remember to follow N was asked if the facility had ehensive fall assessment and ended to the donor would be sessment discussions sidents. The DON confirmed completed a overall	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00356		B. WING		11/	15/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN		TH MCKINLE , MN 56762	Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEI MUST BE PRECEDEI SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 46		2 830			
	comprehensive fall	assessment.					
	During a facility mo approximately 12:30 had impaired cogni awareness and no recall after cued/ins discharge from their R23's fall in the bat assisting R23 onto unattended. The Oremember to use the sistance was need the call light only to thereafter.	0 p.m. the OT co tion, had impaired instruction/safety structed. She R23 rapy today. The Chroom resulted fithe toilet and lear stated R23 did not call light to ale eded and would ution, had seed and would ution, had income the call light to ale eded and would ution.	nfirmed R23 d safety measure B would be OT stated rom LPN-B ving her not rt staff isually turn on				
	On 11/11/16, at 12: had assisted R23 o unattended, howeve Monday 11/7/16, or also confirmed R23 light to request assi The Fall Prevention dated 5/2016, indica accountable for fall The policy indicated experience impaire loss of independent cause of their death identified as: vision transfer problems, o problems, equipme problems, environm problems and conti	nto the toilet and er, was not sure a previous Mono did not always ustance when on and Manageme ated the facility was prevention and red function, decrece, sustain injuried. Fall risk factors problems, mobilicognitive problems, and assistive contal problems,	had left her if it was day. LPN-B ise the call the toilet. Int policy vas nanagement. sident may ased mobility, es or be the s were ity and ns, sleep device medical				
	problems and conti defined an "avoidal an accident occurre to: identify environn	nence problems. ble" accident (fall) ed because the fa	The policy meant that acility failed				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SI IDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00356		B. WING		11/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN		H MCKINLE , MN 56762	Y STREET		
(X4) ID PREFIX TAG		TEMENT OF DEFICI 'MUST BE PRECED SC IDENTIFYING INI	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From paresident risks of har analyze the hazards interventions, including was consistent with plan of care and cumonitor the effective order to reduce the also indicated the far approach to fall precidentifying a potentimitigate the risk between they would predict of all and what action. The immediate jeogrammed they would predict of all and what action. The immediate jeogrammed they would predict of all and what action. The immediate jeogrammed they would predict of all and what action. The immediate jeogrammed they would predict of a size plan was sessed risks for finterventions. -R23 was comprehened they are educated to a size plan was assessed risks for finterventions. -Staff were educated they are staff, including interviewed staff we falls, and fall preventable. SUGGESTED MET director of nursing of the size plan was assessed.	ving an accidents and risks, impling adequate so the residents in the residents in the residents of the interest of an accident accility would take vention which in all risk and taking fore actual harm what might cause can be taken to be accility completed as part of the ensively assess as updated to reside and fall president and fall president and fall president accident and fall president accident accident and fall president accident acci	lement upervision that upervision that upervision that upervision that leeds, goals, of practice, or erventions in lent. The policy e a proactive ncluded ag steps to a occurred, and se a resident to prevent it. In ted on don 11/15/16, eted the eir removal leed for falls effect R23's evention linterventions 9 P.M. direct ag staff were risks. All of the 3's risk for as to ensure				
	and/or revise policie assessment and im following a fall. Edu the staff. The quali	es and procedu plementation of cation could be	res related to f interventions provided to				

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-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00356	B. WING	····	11/1	5/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WARREN	ITH MCKINLE N, MN 56762	Y STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
2 830	develop a system to the plan.	ge 48 o monitor the effectiveness of CORRECTION: Twenty-one	2 830				
21390	MN Rule 4658.0800 Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and content E. a resident he immunization progradefined in part 465 procedures of resid the prevention and F. the development of the products which affed disinfectants, antise incontinence products.	ealth program including an am, a tuberculosis program at 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of slicies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of ct infection control, such as eptics, gloves, and				12/26/16	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICAT	UPPLIER/CLIA ION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00356		B. WING		11/1	5/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN		H MCKINLE	Y STREET		
(VA) ID	CHMMA DV CTA	TEMENT OF DEFIC		MN 56762	PROVIDER'S PLAN OF CORRECTION	ON!	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LS	MUST BE PRECED	ED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 49		21390			
	This MN Requirements by: Based on observation review, the facility facilities isolation precaution the provision of direct resident (R26) observas in contact precipies.	on, interview and ailed to ensure swere implement resident concerved during pe	nd document contact ented during tact for 1 of 1		Corrected 12/26/16		
	Findings include:						
	R26's quarterly Min 8/10/16, indicated F impairment and req one staff for bed mo	R26 had mild co uired extensive	ognitive				
	On 11/7/16, at 3:00 isolation cart (plastiprotective equipment R26's room. The caindicated the individed contact precautions care of patients known serious illness easily contact or by indirect patient's environment (LPN)-A stated R26 methicillin-resistant (MRSA) at his suprecatheter inserted in site.	c container with nt) was observed art contained a dual in the room of the contact with it contact with it contact with it had been acted postaphylococcuapubic catheter	n personal ed outside of sign which n required used during ed to have a y direct patient items in the practical nurse sitive for s aureus r (urinary				
	On 11/8/16, at 1:50 call for assistance. (NA)-M entered R20 proceeded to empty	At 1:53 p.m. no	ursing assistant gloves and				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00356	B. WING		11/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN	H MCKINLE MN 56762	Y STREET		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	drainage bag. NA-I washed her hands. proceeded to make areas of the bed ind and pillows. When talked to R26 while his body then exited observed to wash his he left the room ar residents room (R5 R5 when the State wher. On 11/8/16, at 2:00 not washed her har room. She confirmed contact precautions she should have we exited the room. On 11/8/16, at 2:10 confirmed R26 had catheter cite and the considered contaminursing assistants whands after caring for the contaminurs of the contaminum of the contamination from room.	M removed her gloves and Without gloved hands, NA-M R26's bed touching multiple cluding the covers, bed rails completed the task, NA-M touching his wheelchair and d the room. NA-M was not her hands or use sanitizer as and walked into another). NA-M was about to touch Agency staff asked to speak to p.m. NA-M verified she had hads prior to leaving R26's hed R26 currently required ashed her hands when she p.m. registered nurse (RN)-B MRSA at the suprapubic he linens on his bed were hinated. She confirmed the her to be washing their hor R26. a.m. the director of hed R26 required contact her suprapubic catheter hands whould have hands whould have hands an attempt to minimize hands represented the hands whould have hands an attempt to minimize hands represented the hands represented the hands whould have hands represented the	21390			
	A policy related to in	nfection control/hand hygiene				

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00356			11/1	5/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN	H MCKINLE MN 56762	Y STREET		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21390	·	none was provided.	21390			
	SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or their designee, could develop and implement policies/procedures and staff training related to infection control practices. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			12/26/16
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by: Based on observati review, the facility fa seated at the same the same time as th meals observed for was observed seated	on, interview and document ailed to ensure residents dining table were served at neir tablemates during 2 of 3 1 of 1 resident (R41) who ed without being served and were		Corrected 12/26/16		
	Findings include:					

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-	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		00356		B. WING		11/	15/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN		TH MCKINLE , MN 56762	Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE ' MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 52		21805			
	R41's quarterly Min 10/14/16, indicated nutritional deficienc severely impaired v one staff for eating cueing.	R41 was diagno y, had intact cog ision, and require	sed with nition, had ed assist of				
	R14's care plan dathad a performance blindness. The planup with meal tray, a encourage intake. Table to feed self buitems were and who	deficit related ea directed staff to assist with meals The plan indicate t needed to be to	ating due to provide set and to d R41 was old what food				
	On 11/9/16, at 7:35 (NA)-J was observed room via her wheeld dining room table. Of the dining room table. Of the dining room. -At 7:38 a.m. dietar water and grape juity -At 7:43 a.m. R41 water while a tabler was eating the meature -At 7:59 a.m. licens was observed to promedications. R41 to LPN-B returned to 19-At 8:17 a.m. R41's breakfast and left the observed to bring or room and serve the not been served he -At 8:27 a.m. NA-J dining room and observed to bring or dining room and observed to dining room and dining room and dining room and observed to dining room and d	ed to assist R41 in chair and position of the table of the table of the table of the table of table of table of table. Nursing their residents into the table of tabl	to the dining ned her at her at her at her , NA-J left rved R41 hking her erved and e (LPN)-B er ons and art. inished her staff were to the dining ts. R41 had enter the				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICAT	SUPPLIER/CLIA ION NUMBER:	` ′	E CONSTRUCTION		E SURVEY PLETED
		00356		B. WING		11/	15/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN		H MCKINLE , MN 56762	Y STREET		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21805	NA-J obtained a brotoast for R41. NA-J to the toast and addexited the dining romom table a total of served or assisted. On 11/9/16, at 11:43 the dining room and residents have been dining room and seprovided mealsAt 11:53 a.m. R41' lunch meal and begreat 12:03 a.m. NA-H meal and sat down dining table a total of served or assisted tablemate had been on 11/9/16, at 8:54 time, she had to was meals and did not keep to the toast of	eakfast meal of applied peanuded sugar to thom. R41 sat at f 52 minutes which her breakf as a.m. NA-J as dipositioned at nobserved arriated at other tast to her. R4 of 20 minutes which her lunch in served. a.m. R41 state at long periods anow why it too	t butter and jelly e cereal then the dining ithout being ast meal. sisted R41 to her table. Other ving to the ables and as served her with her lunched sat at her without being meal after her ed most of the of time for her k so long. R41	21805			
	stated she knew the to help, but thought would not have to w On 11/9/16, at 9:07 not served her brea	staff could tak vait so long all t a.m. NA-J veri	e turns so she the time.				
	dining room after as stated, R41 should eat. On 11/09/2016, at 1 stated R41 should and she expected as	ssisting other renot have to wa 2:19 p.m. dieta	esidents. NA-J it that long to ary supervisor ng to be served				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00356	B. WING		11/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN	H MCKINLE MN 56762	Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21805	Continued From pa	ge 54	21805			
	to be served before going to another table. The supervisor stated R41 should not have to wait that long for her meal.					
	nursing (DON) verfi served her meal tim have to wait over 45 the 20 minute wait a unacceptable. The was for staff to ensi	8:36 p.m. the director of ied R41 should have been nely and stated R41 should not 5 minutes to be served, even at lunch time was absolutely DON stated her expectation ure all residents were served have to wait to be served				
	directed staff to pro enhanced resident aspects and to serv	nity policy dated 2/2013, vide care in a manner that dignity regarding dietary re all residents at the table at esidents could their meals eat				
	The director of nurs implement policies dining expereience.	THOD FOR CORRECTION: sing (DON) or designee could and procedures dignified. The quality assessment and ee could perform random mpliance.				
	TIME PERIOD FOR days.	R CORRECTION: Twenty (21)				
21980	MN St. Statute 626 Maltreatment of Vul	.557 Subd. 3 Reporting - Inerable Adults	21980			12/26/16
	Subd. 3. Timing o	f report. (a) A mandated				

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PRINTED: 01/18/2017

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21980 Continued From page 55 reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult PROVIDER'S PLAN OF CORRECTION (X5 (EACH CORRECTIVE ACTION SHOULD BE COMP DATE OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21980 21980 21980				RESS, CITY, S H MCKINLE	STATE, ZIP CODE Y STREET	
reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult	(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	L	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility, or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or	TAG	Continued From page 55 reporter who has reason to believe that a vulnerable adult is being or has been maltre or who has knowledge that a vulnerable adu has sustained a physical injury which is not reasonably explained shall immediately repoinformation to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mand reporter is not required to report suspected maltreatment of the individual that occurred to admission, unless: (1) the individual was admitted to the facility another facility and the reporter has reason believe the vulnerable adult was maltreated previous facility; or (2) the reporter knows or has reason to be that the individual is a vulnerable adult as defin section 626.5572, subdivision 21, clause (b) A person not required to report under the provisions of this section may voluntarily repase described above. (c) Nothing in this section requires a report known or suspected maltreatment, if the repknows or has reason to know that a report hence to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforce agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (c), occurred must make a report under this subdivision. If the reporter or a facility, at an time believes that an investigation by a lead agency will determine or should determine the reported error was not neglect according the criteria under section 626.5572, subdivision 626.5572, subdivision expected of 626.5572, subdivision expected error was not neglect according the criteria under section 626.5572, subdivision	eated, dult ort the nuse ndated I prior I from to I in the pelieve efined (4). the eport of porter has a ement as a lause s ny dut that g to sion			DATE

6899

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00356	B. WING		11/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN	TH MCKINLE	_		
(VA) ID	CHMMA DV CTA	TEMENT OF DEFICIENCIES	N, MN 56762	PROVIDER'S PLAN OF CORRECTI	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 56	21980			
	directly to the lead a how the event meet 626.5572, subdivisi (5). The lead agen	e to the common entry point or agency information explaining ts the criteria under section on 17, paragraph (c), clause ncy shall consider this naking an initial disposition of bdivision 9c.				
	by: Based on interview facility failed to immagency (SA), and/oincidents of potential significant injuries a for possible mistreat of 1 resident (R23 with serious injury a origin. In addition, the report to the SA incident (R12)			Corrected 12/26/16		
	Findings include:					
		ses of unknown origin and had lls with significant injury which o the SA.				
	9/2/16, indicated R2 impairment, was rai required extensive a	inimum Data Set (MDS) dated 23 had severe cognitive rely or never understood, assistance with activities of had a history of falls with				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00356	B. WING		11/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN	H MCKINLE	Y STREET		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	MN 56762	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21980	Continued From pa	ge 57	21980			
	fractures, and received anti-anxiety and diuretic medications which could increase fall risk.					
	R23 was admitted to following surgical rediagnoses which inhemorrhage and he the musculoskeleta	eport dated 11/9/16, indicated to the facility in August 2016, epair of a fractured femur and cluded interoperable ematoma (bleed or bruise) of all structure, Alzheimer's nemia, pain, osteoarthritis, eakness.				
	9/2/16, identified R2 cognitive impairmed R23 had a function motion, pain and arwithout significant pand non-verbal. The had vision problems during tradue to recent hip frafurther identified R2 to diuretic medication.	ssessment (CAA) dated 23 had Alzheimer's disease, nt and anxiety. CAA indicated nal limitation in range of n inability to perform ADLs ohysical assistance, was deaf e CAA further identified R23 s, restricted mobility, balance unsitions, and difficulty sitting acture and surgery. The CAA 23 had urinary urgency related on use and received ution (sedative) which k for falls.				
	revealed on 10/10/- was noted to have lupper back (in the sidentify the size/col- bruises were identification. The facility dunknown origin to the an investigation on	noted in R23's medical record 16, at 6:07 p.m. indicated R23 bruises on lower legs and spine area). The report did not oring of the bruises. The fied as being of an unknown lid not report the bruises of the SA. The facility completed 10/14/16, in which they ises to the lower legs may				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00356	B. WING		11/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN	TH MCKINLE , MN 56762	Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 58	21980			
		wheelchair legs, however, the to the spine was not				
	confirmed the bruis were of an unknow	30 a.m. the administrator es identified on 10/10/16, n origin and they were not nor were they investigated to e of the bruising.				
	indicated R23 was 100-hallway floor at by nursing and assivia a mechanical lifther right shoulder a her forehead. R23 opreviously administ 7:28 a.m. that morremergency department from the Eindicated R23 had a pathology noted. The continue to monitor frontal hematoma for the street of the street results of the street results of the street results with the street results of	e (PN) dated 10/30/16, found on her buttocks on the ta:30 a.m. R23 was assessed isted back into the wheelchair ta. R23 was noted to be holding and had a large hematoma to denied pain and had been ered Tylenol with codeine at hing. R23 was sent to nent (ED) for evaluation. R23 ED at 11:39 a.m. The note a Cat Scan with no acute the ED recommended staff R23's neurological status and or skin breakdown and for R23 e clinic on 10/31/16.				
	the nurse was infor dining room floor, ly heavy bloody nose assessed and R23 assisted into a dinir lift. R23's nose conremoved from the cat 6:30 p.m. indicat	/30/16, indicated at 5:15 p.m. med R23 was found on the ving on her right side with a from both nostrils. R23 was denied pain. R23 was no room chair via a mechanical tinued to bleed so R23 was dining area. A follow up noted ed the above fall occurred at a seated in the dining room				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
	00356	B. WING		11/1	5/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
GOOD SAMARITAN SOCIETY -	WARREN	TH MCKINLE , MN 56762	Y STREET		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
through the nose, the her room and in to be was given to "settle in nurse entered R23's amounts of blood on clotted with blood. R2 87/54. The on call ph was taken to the ED. -A follow up noted at was admitted to the head injury and poss. The bleeding had cerfluids. The hospital w R23 and hopefully shithe next day. R23's PN dated 11/7/R23 was found on the to the sink. No injuries assisted into the wheat Although no injuries of medical record lack of investigation as to the determine if neglect of the Review of the facility lacked documentation otified of R23's unwinjury. On 11/09/16, at 1:34 (DON) stated she did sustained on 10/30/1 reported to the SA or	Ito "head bob" and bleed erefore she was assisted to ed. An antianxiety medication ner." Once settled into bed, a room, and observed large R23's pillow and her nose 23's blood pressure was nysician was notified and R23 hospital for observation of sible urinary tract infection. ased and R23 was receiving yould continue to monitor ne would return to the facilty were sustained. R23 was elchair via a mechanical lift. were sustained, R23's documentation of an e root cause of the fall and to of care had occurred. Tyulnerable adult (VA) reports on in which the SA had been witnessed falls with significant p.m. the director of nursing dn't know if R23's injuries				

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00356	B. WING		11/	15/2016
NAME OF	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN	SOUTH MCKINLE RREN, MN 56762	Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21980	a right frontal hemal hospitalized after the The DON stated she R23 was hospitalized that R23 had sustained a hematoma. She stated shematoma is thought R23 had a R23's hematoma she	atoma, nose bleed, and waste second fall on 10/30/16. e didn't previously know were and was unaware until a red a right frontal scalp ated no one had told her Rematoma as she had just bump on her head. She strould have been reported as a pents should have been immediately. The DON and interviewed. Both confirmation on 10/30/16, were not away as injuries actually were, at ents should have been immediately. The DON are at they were both notified at message after both R23' and addition, the administrate ompleted a root cause 3's fall on 11/7/16, because they be a team effort that a she could have stigation but didn't. She strough and stated because a not hold their morning. Due to lack of investigation 3's care plan was	ated to ned of are and and sor see tated of			
	approximately 12:30 therapist (OT) confi	nitoring visit on 11/11/16, a 0 p.m. the occupational rmed R23's cognition was paired safety awareness a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						DATE SURVEY COMPLETED	
		00356		B. WING		11/	15/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN		TH MCKINLE , MN 56762	Y STREET		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21980	Continued From particle of the cued of the	y measure reca e OT stated R2 to licensed pra R23 onto the to e OT stated R2 ne call light to a eded and would shut if off hers 45 p.m. LPN-B nto the toilet a	23's fall in the ctical nurse ilet and leaving 23 does not allert staff to usually turn on elf, shortly confirmed she and had left her	21980			
	Monday 11/7/16, or also confirmed R23 light to request assion the scene for bo LPN-B stated the fareport major injuries wasn't followed. Sh care plan was follow 10/30/16, and state R23's major injuries	a previous Mos did not always stance when on 34 a.m. LPN-B th of R23's fall acility policy dires if a resident's e stated she dowed for both R2 d that's why she	stated she was on 10/30/16. ected them to care plan etermined R23's 23's falls on				
	On 11/15/16, at 10: administrator were they had completed 11/7/16, and had dherself to the bathroadminstrator stated injuries were not refalls were investigated followed, there was and R23 had been However, both the	interviewed ag I R23's fall invertermined R23 com after bread R23's falls wit ported to the Sted, the care place on evidence oseen by a physikall inverted.	ain. both stated estigation from had taken kfast. The h serious A because the an was f maltreatment, sician.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00356	B. WING		11/1	5/2016	
GOOD SAMARITAN SOCIETY - WARREN 410 SOUTI			DRESS, CITY, S TH MCKINLE , MN 56762	STATE, ZIP CODE Y STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
21980	stated they were not directed staff to do falls with injury occur. The Minnesota Rep Vulnerable Adults of facility had knowled sustained a physical reasonably explained report the incident to indicated if the facility are resulting in make a report to the suspected violation neglect, or abuse in origin to be reported administrator and the R12's report of missing to the SA timely. Review of the VA resincluded a report day reported she was mone ten dollar bills (for purse. R12 reported a suggestion or contact the staff of the suggestion or contact the staff of the suggestion or contact the staff of the suggestion or contact the suggestion of the suggestion or contact the suggestion or contact the suggestion of the suggestion or contact the suggestion or contact the suggestion or contact the suggestion or contact the suggestion of the suggestion or contact the suggestion or contact the suggestion or contact the suggestion of the suggestion or contact the suggestion or contact the suggestion of the suggestion of the suggestion or contact the suggestion of the suggestion of the suggestion of the suggestion or contact the suggestion of the sugges	orting of Maltreatment of ated, 9/15 indicated if the lege that a vulnerable adult had al injury which was not ed, the facility was required to o the SA. The policy further ity had reason to believe an harm or injury occurred must e SA. Ind Neglect policy dated aff to report alleged or s involving any mistreatment, including injuries of unknown d immediately to the facility	21980	DEFICIENCY)			
	8/15/16. On 11/10/16 at 12:	30 the administrator confirmed					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00356		B. WING		11/1	5/2016
NAME OF	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN	410 SOUTH WARREN, I	H MCKINLE MN 56762	Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21980	R12 had reported the 8/14/16, and the SA day, Monday, 8/15/1 the facility was to remisappropriation of immediately. The Abuse Definition identified misappropriation of administrator and SA Background Checks. On 11/8/16, at 10:20 confirmed licensed been contracted an 5/2/16, through 11/2 LPN-A had worked	ne concern on Sunday was not notified until 16. The administrator eport concerns of resident property to the oriation of resident pro the staff to report resident property to the A immediately.	the next stated ne SA 3, operty as ne or -A had y from or stated roviding	21980	DEFICIENCY)		
	the facility had not of check on LPN-A. Background Investi- dated 8/15, indicate	3 a.m. administrator conducted a back ground gations - Minnesota part the facility would fold dures for obtaining ents.	olicy low				
	administrator or des revise the policies a and investigating, e	HOD OF CORRECTI signee could review and and procedures for rep ducate the staff on wh amediately report to the	nd / or porting nat is				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
00356		00356	B. WING		11/1	5/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WARREN	H MCKINLE , MN 56762	Y STREET			
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21980	Continued From pa	ge 64	21980				
	administrator and the state agency. The administrator of designee could develop a system to monitor the effectiveness of the plan.						
	TIME PERIOD OF (21) Days.	CORRECTION: Twenty-one					
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults		22000			12/26/16	
	facility, except hom personal care atten establish and enfor prevention plan. The assessment of the environment, and it factors which may early and a statement of to minimize the risk comply with any rule promulgated by the (b) Each facility, agency and person providers, shall dever prevention plan for residing there or reacting there or reacting there or reacting the plan shall contains assessment of: (1) abuse by other individual reactions and specific measures trisk of abuse to that	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan licensing agency. Including a home health care all care attendant services elop an individual abuse each vulnerable adult ceiving services from them. In an individualized the person's susceptibility to viduals, including other (2) the person's risk of abusing cults; and (3) statements of the cobe taken to minimize the coses of this paragraph, the					

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PRINTED: 01/18/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00356 11/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **410 SOUTH MCKINLEY STREET GOOD SAMARITAN SOCIETY - WARREN WARREN, MN 56762** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 22000 Continued From page 65 22000

Corrected

12/26/16

(c) If the facility, except home health agencies and personal care attendant services providers. knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.

This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse policy as directed related to the immediate reporting to the

State agency of injures of unknown origin for 1 of 1 resident (R23) identified with bruising of unknown origin; failed to immediately report and thoroughly investigate falls with significant injury for possible mistreatment and neglect of care for 1 of 1 resident who sustained significant injures during unwitnessed falls. The facility failed to report missing money to the State agency for 1 of 1 resident (R12) who had reported missing money and failed to conduct background checks for 1 of 5 agency staff members licensed practical nurse (LPN)-A) who lacked a criminal

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00356		B. WING		11/1	5/2016
NAME OF	PROVIDER OR SUPPLIER			DRESS, CITY, S TH MCKINLE	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN		MN 56762	TOTALLI		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 66		22000			
	background check.						
	Findings include:						
	The Abuse and Neg directed the staff to violations involving abuse including injureport immediately the State Agency (S	report alleged any mistreatm uries of unkno to the facility a	d or suspected nent, neglect, or wn origin to be				
	The Abuse Definition identified misappropriation of administrator and S	priation of resi the staff to re resident prop	ident property as port erty to the				
	Background Investi dated 8/15, indicate state specific proce back ground check	ed the facility vedures for obta	vould follow				
	Findings include:						
	R23 sustained bruis two unwitnessed fa were not reported to	lls with signific					
	During record revie dated 10/10/16, at onoted to have bruis back in the spine at the size of the bruis	6:07 p.m. indic es on lower le rea (the report	cated R23 was gs and upper t did not indicate				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00356		B. WING		11/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
I GOOD SAMARITAN SOCIETY - WARREN			H MCKINLE MN 56762	Y STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 67	22000			
	facility completed a which they determine legs may have been however, the origin not identified. The bruises of unknown The administrator s	of an unknown origin. The in investigation on 10/14/16, in need the bruises to the lower in from the wheelchair legs, for the bruise to the spine was facility did not report the in origin to the State Agency. Signed the report on 10/14/16.				
	confirmed the bruis were of an unknow reported to the SA	es identified on 10/10/16, n origin and they were not timely nor were they ermine if abuse had occurred.				
	Progress Note (PN R23 was found sea with a large hemato The fall was unwitn	w for R23, an entry in the dated 10/30/16, at 8:30 a.m. ted on the floor in the hallway smoa on her right forehead. essed. R23 was sent to the or an evaluation which included				
	on the floor of the d sustained a bloody blood pressure dro	6, at 5:17 p.m. R23 was found lining room. R23 had nose. At 6:18 p.m. R23's oped to 87/54, she was then ospital to rule out head injury				
	R23 was found on to the sink. No injur assisted into the wh Although no injuries	7/16, at 2:26 p.m. indicated the floor in her bathroom, next ies were sustained. R23 was neelchair via a mechanical lift. If were sustained, R23's documentation of an				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00356	B. WING		11/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WARREN	H MCKINLE MN 56762	Y STREET		
(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 SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 68	22000			
		he root cause of the fall and to t of care had occurred.				
	which the SA had b significant injury or	eports lacked documentation in een notified of R23's falls with an investigation to determine awitnessed fall to determine if occurred.				
	On 11/10/16, at 1:05 p.m. the administrator confirmed R23 had sustained significant injury from unwitnessed falls. The incidents had not been reported to the SA immediately as directed by the policy.					
	R12's report of missing money was not reported to the SA timely.					
	included a report da reported she was m one ten dollar bill, fi one dollar bills (for purse. R12 reporte a suggestion or cor	eports from 6/2016 - 11/2016, ated 8/14/16, in which R12 had hissing one twenty dollar bill, ive five dollar bills and three a total of \$58.00) from her ed the concern to the facility via his form dated 8/14/16. The rt the concern to the SA until				
	R12 had reported the 8/14/16, and the SA day, Monday, 8/15/the facility was to re	30 the administrator confirmed ne concern on Sunday, A was not notified until the next 16. The administrator stated eport concerns of resident property to the SA				

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PRINTED: 01/18/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00356 11/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **410 SOUTH MCKINLEY STREET GOOD SAMARITAN SOCIETY - WARREN WARREN, MN 56762** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 22000 Continued From page 69 22000 Background Checks: The facility failed to ensure background checks had been completed on 1 of 5 agency staff. licensed practical nurse (LPN)-A. On 11/8/16, at 10:28 a.m. the administrator confirmed licensed practical nurse (LPN)-A had been contracted and worked at the facility from 5/2/16, through 11/2/16. The administrator stated LPN-A had worked on the nursing units providing direct resident care and as the minimum data set (MDS) coordinator. On 11/9/16, at 11:13 a.m. administrator confirmed the facility had not conducted a back ground check on LPN-A. SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the need to immediately report and investigate suspected abuse/neglect to the designated state agency/common entry point according to the facility's policy. The director of nurses' could monitor incident reports for implementation of this requirement.

Minnesota Department of Health STATE FORM

(21) days.

TIME PERIOD FOR CORRECTION: Twenty One