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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: E3N2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00356

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245550**
2.STATE VENDOR OR MEDICAID NO.
(L2) **304842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WARREN**
(L4) **410 SOUTH MCKINLEY STREET**
(L5) **WARREN, MN** (L6) **56762**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/15/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)
13.Total Certified Beds **45** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor — 09/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 09/19/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/10/2016
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5550

Good Samaritan Society - Warren is designated as a Special Focus Facility (SFF).

On August 15, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 25, 2016 the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 30, 2016. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of August 9, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 30, 2016, effective August 9, 2016 and therefore remedies outlined in our letter to you dated July 15, 2016, will not be imposed.

Refer to the CMS 2567b for both health and life safety code for the results of this visit.

Effective August 9, 2016, the facility is certtified for 45 skilled nuring facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245550

September 19, 2016

Ms. Michelle Garrey, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, Minnesota 56762

Dear Ms. Garrey:

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 August 9, 2016 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 Meath

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

An equal opportunity employer.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 8, 2016

Ms. Michelle Garrey, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, Minnesota 56762

RE: Project Number S5550027

Dear Ms. Garrey:

On July 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 30, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On August 15, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 25, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 30, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 9, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 30, 2016, effective August 9, 2016 and therefore remedies outlined in our letter to you dated July 15, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245550 Y1	A. Building B. Wing Y2	8/15/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0278	Correction	ID Prefix F0309	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.20(g) - (j)	Completed	Reg. # 483.25	Completed
LSC	08/09/2016	LSC	08/09/2016	LSC	08/09/2016
ID Prefix F0329	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.70(h)	Completed	Reg. #	Completed
LSC	08/09/2016	LSC	08/09/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	LB/mm	09/08/2016	28035	08/25/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/30/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245550	A. Building 02 - KITCHEN ADDTION B. Wing	8/25/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 08/09/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) TL/mm	DATE 09/08/2016	SIGNATURE OF SURVEYOR 36536	DATE 08/25/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 6/22/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: E3N2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00356

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245550**

2.STATE VENDOR OR MEDICAID NO.
(L2) **304842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WARREN**
(L4) **410 SOUTH MCKINLEY STREET**
(L5) **WARREN, MN** (L6) **56762**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/30/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)
13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Beth Nowling, HFE NEII 08/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/10/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5550

Good Samaritan Society - Warren is designated as a Special Focus Facility (SFF).

On Jun 30, 2016, a recerttification survey was completed and found that the facility was not in substantial compliance with Federal participation requirements. The survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level EThe facility has been given an opportunity to correct before remedies would be imposed. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

Refer to the CMS 2567 for both health and life safety code, along with the facility's plan of correction.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 15, 2016

Ms. Michelle Garrey, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, Minnesota 56762

RE: Project Number S5550027

Dear Ms. Garrey:

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 June 30, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140 Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 9, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 30, 2016 (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 December 30, 2016 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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F 000	INITIAL COMMENTS This is a Special Focus Facility (SFF) A standard survey survey was conducted on June 27, 28, 29 and 30, 2016 at Good Samaritan Society - Warren. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility to provide a dignified morning routine for 5 of 5 residents (R26, R23, R19, R22, R8) reviewed for dignity with personal cares. Findings include:	F 241	1. Residents 26, 23, 19, 22, and 8 morning cares are being completed after residents awaken for the day. 2. All residents who require assistance with morning ADLs would have the potential to be affected.	8/9/16

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

Electronically Signed | 07/25/2016

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.

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F 241	Continued From page 1 R26's quarterly Minimum Data Set (MDS) dated 3/22/16, identified R26 had severe cognitive impairment, and required extensive assistance with dressing. During observation on 6/29/16, at 8:29 a.m. nursing assistant (NA)-C and NA-A entered R26's room to assist R26 with morning care. R26 was in bed covered with the comforter and sheet, and her eyes were closed. NA-A removed the comforter and sheets, exposing R26 whom was already fully dressed in a floral design shirt and slacks. NA-C and NA-C assisted R26 to her wheelchair using a mechanical lift, then assisted her to the dining room for breakfast. When interviewed on 6/29/16, at 8:31 a.m. NA-A stated the night shift dresses, "X [a certain amount] amount of people" each day for the day shift, "So that we get things done on time." NA-A stated this had been happening for, "A very long time." NA-A stated the residents dressed by night shift were typically residents who require mechanical lifts to transfer and who, "Go right back to sleep after their cares." NA-A stated R26, R23, R19, R22, and R8 are typically residents who are dressed by the night shift and placed back into bed, "On a regular basis." Further, NA-A stated she had concerns with this being done, "I don't know if its the right thing to do." During interview on 6/29/16, at 9:09 a.m. family member (FM)-A stated her relative would not have dressed herself at home, then went back to bed as was being done in the nursing home, "She would have been against it." FM-A stated staff should be letting residents sleep until they are able to assist them with morning cares, "I think	F 241	3. The new process of night shift employees dressing residents and putting them back to bed was eliminated. A new process was developed to ensure that residents are not dressed prior to awakening for the day. All nursing staff were educated by the Interim DNS on 7/6/16 regarding the new process and immediate implementation of new process. 4. Observation audits will be completed by DNS or designee daily for 2 weeks, 4x/wk x 4 wks, then 2x/week x 4 weeks . All observation audits results will be reviewed by the QAPI committee for further recommendations. 5. August 9, 2016	

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F 241	Continued From page 2 that would be better." When interviewed on 6/29/16, at 9:45 a.m. licensed practical nurse (LPN)-A stated she was not aware the night shift had been dressing residents. LPN-A stated residents should be allowed to sleep in bed undisturbed until staff can assist them with morning cares, "When its time for breakfast." During interview on 6/29/16, 12:44 p.m. the director of nursing (DON) stated the night shift gets, "A few" residents dressed and puts them back to bed, "Due to only three nurse aides on the floor." The night shift starts getting residents dressed around 4:30 a.m. in the morning, and it had been the process in the facility for, "A long time," and they felt the residents were accepting of this because, "Their not resistive to the care." Further, the DON stated she had some concerns with this process, adding residents shouldn't be forced to get dressed, "Until its time to get up for the day." A facility policy on dignity was requested, but none was provided.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278		8/9/16

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F 278	Continued From page 3 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to accurately complete the Minimum Data Set (MDS) to reflect a stage 2 pressure ulcer(partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough) for 1 of 2 residents (R2) reviewed for pressure ulcers and to identify falls for 1 of 2 residents (R23) reviewed for falls Findings include: R2's quarterly Minimum Data Set (MDS) dated 4/6/16, identified R2 was at risk of developing pressure ulcers, and had no unhealed pressure ulcers at stage 1 or higher. R2's care plan revised on 4/16/16, identified R2	F 278	F278 1. The User Defined Assessment (UDA) for skin will be completed for R2 by 8/9/16. R23's care plan will be updated to reflect falls by August 9, 2016. 2. The charts of residents with skin conditions or falls in the past 3 months will be reviewed for accuracy and the care plans updated to ensure the data for the MDS is accurate by 8/9/16.. 3. Individuals who complete the MDS will be educated by the DNS or designee by August 9, 2016 on the importance of completing observation assessments and review of clinical record prior to the coding of the MDS to ensure accuracy. 4. Audits will be conducted on MDS	

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F 278	Continued From page 4 was at risk for development of pressure ulcers related to immobility. Interventions included frequent repositioning and pressure reducing mattress on the bed and cushion in chair. Review of R2's Wound Data Collection dated, 4/1/16 described R2's wound on coccyx with partial tissue thickness loss, wound bed was red tone and 100% granulation (refers to tissue that is pink or beefy red with a shiny, moist , granular appearance). Wound measurement was 1.0 cm x 0.2 cm x 0 cm, no drainage. Mepiplex dressing in place, to be changed every 3 days. Skin observation dated 4/4/16, indicated R2 had an open area to the coccyx, with a Mepilex dressing in place. (no measurements included on assessment). R2 also had a reddened area to the left buttock. R2 required staff assistance for repositioning and was incontinent of both bowel and bladder. On 6/29/16, at 8:37 a.m. interim MDS coordinator confirmed R2 was at risk for pressure ulcers, and verified R2 had an open area on the coccyx at the time the quarterly MDS was completed on 4/6/16, and should have been coded as a stage 2 pressure ulcer. On 6/30/16, at 8:28 a.m. DON-A confirmed R2's quarterly MDS was incorrectly coded. DON-A verified R2's sore on the coccyx was clearly identified on the skin assessment dated 4/1/16 as a stage 2 pressure ulcer. Further, the DON-A stated the MDS coordinator should have consulted the Resident Assessment Instrument (RAI) prior to completing R2's MDS.	F 278	sections related to falls and skin to ensure accuracy for those residents who have been identified as having a fall or skin condition and have had an MDS completed in the past month. Audits will be completed monthly x3. Audit results will be reported to the QAPI committee for further recommendations. 5. August 9, 2015	

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F 278	Continued From page 5	F 278		

R23's quarterly Minimum Data Set (MDS) dated 6/17/16, identified R23 had not fallen since the prior assessment dated 3/15/16.

R23's care plan dated 6/21/16, identified R23 was at risk for falls and had a history of falls. R23's falls on 5/2/16 and 5/10/16 were not identified on R23's care plan.

On 6/28/2016, at 3:18 p.m. nursing assistant (NA-B) stated R23 was at risk for falls, had a history of falls and had fallen recently.

On 6/28/16, at 3:24 p.m. NA-D stated R23 was at risk for falls and R23 had fallen recently.

Review of facility Falls Tools revealed R23 had fallen on 5/2/16, and 5/10/16.

On 6/30/16, at 12:27 p.m. DON-A confirmed R23 had fallen on 5/2/16, and 5/10/16. DON-A confirmed according to reference dates and the Resident Assessment Instrument 3.0 (RAI) manual R23's falls should have been identified on the MDS completed 6/17/16. DON-A stated R23's 6/17/16 MDS was coded incorrectly for falls, and R23's falls since the prior assessment

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F 278	Continued From page 6 should have been identified. The facility's MDS 3.0/RAI policy revised 4/16, indicated each team member would review the electronic medical record (EMR) to determine if there was accurate documentation to support coding for the payment items on the MDS.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess and monitor healing skin wounds for 2 of 2 residents (R8 and R23) who had active wounds in the facility. In addition, the facility failed to follow a physician's order for a wound dressing to heal and prevent the further development of wounds for 1 of 1 residents (R23) with non pressure skin concerns. Findings include: Review of R8's quarterly Minimum Data Set (MDS) dated 6/1/16, identified R8 had severe cognitive impairment and had diagnoses which included unspecified open wound of the lower back and pelvis (sacrum) without penetration into	F 309	F309 1. R8 and R23 will have skin observation User Defined Assessments (UDAs) completed by August 9, 2016., The care plan will be updated to reflect the findings and the physician will be notified if new orders are needed. Any new orders will be followed. 2. Residents who have a Braden of 18 or less have the potential to be affected. Residents with a Braden of 18 or less will be reviewed to assure that weekly skin observations are completed, care plans are updated to reflect the findings of the UDAs and physician orders are for wound care are followed. 3. Facility□s contracted wound	8/9/16

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F 309	Continued From page 7 retroperitoneum, Alzheimer's disease and adult failure to thrive. The MDS identified R8 required total assistance with all activities of daily living (ADL's.) The MDS revealed R8 had received nutrition/hydration interventions for skin problems and had a dressing. The MDS did not identify R8 had a skin condition at the time of the assessment. Review of R8's care plan revised 4/19/16, identified R8 had a sacral opening, required frequent repositioning, weekly skin observations by a licensed nurse and nutritional interventions to promote skin integrity. Review of R8's Care Area Assessment dated 12/16/15, identified R8 required total assistance from staff for ADL's and was at risk for pressure ulcers and required staff assistance to maintain skin integrity. Review of a positioning assessment and evaluation form dated 6/1/16, identified R8 was at high risk for pressure skin breakdown, was totally dependent on staff for mobility and turning in bed, was incontinent of bowel and bladder and was wheelchair bound and needed a total lift. The positioning assessment identified R8 had a pressure reduction cushion for wheelchair and mattress for the bed. Review of a skin observation form dated 5/10/16, identified R8 had reddened areas on the coccyx and was repositioned by staff every 3-4 hours, skin checks were to be completed with am and hs (before bed) cares and licensed staff were to complete weekly skin assessments. Review of facility form titled, fax communication	F 309	consulant will provide education to all licensed nursing staff regarding proper identification of skin conditions, correct measurement of wounds, and appropriate dressings for various conditions by 8/9/16. Nursing Assistants will be educated on proper skin care and what to report by 8/9/16. DNS or designee will educate licensed staff on expectations of how and when to complete skin UDAs and updating of care plans. Education will be completed by August 9, 2016. 4. Audits will be completed once per week x4, twice per month x2 by the DNS or designee to assure UDAs are completed timely and accurately, wound measurements are complete and correct, care plan reflects current skin conditions, and that dressings are applied as ordered by the physician. Auditresults will be reported to the QAPI committee for further recommendations. 5. August 9, 2016	

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F 309	Continued From page 8	F 309		

to physician form, dated 6/1/16, revealed R8's primary physician was notified of several bleeding open areas to R8's sacrum and the surrounding skin was fragile. An order for a Mepilex (an adhesive dressing applied to open wounds to aid in healing) dressing was requested and ordered by R8's MD.

Review of R8's signed physician orders dated 6/15/16, revealed an order dated 6/2/16, of Mepilex to sacral area for protection and drainage every 72 hours for small open areas to sacral area.

Review of R8's electronic medical record lacked physician progress notes pertaining to R8's several sacral wounds.

Review of R8's June 2016, treatment administration record (TAR) revealed R8 received a Mepilex dressing change every 72 hours.

Review of R8's electronic progress notes from 5/1/16, to 6/21/16, revealed the following:

-6/2/16, revealed R8 had several open areas on the sacrum and MD had "okayed" a Mepilex dressing for protection and drainage.

-6/8/16, revealed a nutritional status note in which R8 was added to the nutritional risk list due to several open areas on the sacrum, R8 had a history of pressure ulcers and would receive a wound healing supplement.

-6/9/16, revealed a care conference note in which R8's several open areas and nutrition risk were discussed.

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-6/21/16, revealed a nutritional status note in which R8 was added to the nutrition risk list due to skin breakdown.

Review of R8's medical record lacked a comprehensive skin assessment (description, measurements, tissue type, drainage type,) or observation of R8's several sacral open areas.

R8's progress notes and TAR lacked documentation of monitoring the healing of the wounds, any ongoing measurements, or characteristics of the wound.

On 6/28/16, at 3:41 p.m. nursing assistant (NA)-B assisted R8 to turn to her left side and removed R8's incontinent brief. R8's had a bright red, raised butterfly shaped area, with no open skin or drainage noted on her sacrum.

On 6/28/16, at 3:49 p.m. NA-B stated R8 needed total assistance with all cares and required assistance with repositioning every 3 hours. NA-B stated R8's sacral area started to breakdown a few weeks ago and the area was new. NA-B stated R8 was receiving a dressing change to her sacrum every few days.

On 6/29/16, at 8:07 a.m. NA- A stated she had noticed R8's sacral wound when it had started a few weeks ago. NA-A stated the wound started with several open areas which had bled and a larger reddened area. NA-A stated the nurses had began putting a dressing on R8's sacrum a few week ago. NA-A stated she thought the area had improved.

On 6/29/16, at 9:19 a.m. during an observation of R8's sacral wound with registered nurse (RN)-A

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and licensed practical nurse (LPN)-A, R8 was assisted to roll onto her left side in bed and LPN-A removed R8's incontinent brief. Upon removal of the brief R8's sacrum was covered with a large heart shaped Mepilex dressing. RN-A removed the dressing on R8's sacrum which revealed a closed chaffed, reddened area which covered R8's entire sacrum. RN-A did not measure the red raised area due to the area not being open.

On 6/29/16, at 9:21 a.m. RN-A stated R8's sacrum had developed several open areas within the reddened area a few weeks ago but was not pressure related. RN-A stated she was not aware of any measurements being done on R8's wound and stated the usual practice would not be to measure non-pressure wounds. RN-A stated the wound should be monitored for healing weekly and a weekly comprehensive assessment should be conducted to ensure healing. RN-A confirmed she had no completed any skin assessments on R8's sacral wound. RN-A stated she was unaware of what the etiology of the wound was and was not aware of the progression of healing.

On 6/29/16, at 12:37 p.m. the interim director of nursing (DON)-A stated she had some concerns about routine wound monitoring and assessments when she had come to the facility 3 weeks ago. DON-A confirmed there was no comprehensive assessment completed on R8's sacral wound or routine monitoring for healing. DON-A stated she expected wounds, both pressure and non-pressure related to be comprehensively assessed and routinely monitored for healing.

Review of a facility procedure titled, Skin

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F 309	Continued From page 11 assessment, Pressure ulcer Prevention and Documentation requirements, revised 4/16, revealed a purpose of the facility to ensure residents were systematically assessed with regards to skin breakdown and to accurately document observations and assessments.. R23's quarterly MDS dated 6/17/16, identified R23 had diagnoses which included diabetes, non-pressure chronic ulcer of buttock limited to breakdown of skin, and non-pressure chronic ulcer skin sites limited to breakdown of skin. The MDS identified R23 had moderate cognitive impairment, and required extensive assistance with all activities of daily living (ADL's). Further, the MDS identified R23 was frequently incontinent of bowel and bladder, was at risk for pressure ulcers, did not have any ulcers, wounds or skin problems, had a pressure reducing device for bed and chair, dressings and ointments. R23's Care Area assessment dated 12/30/15, identified R23 was incontinent of urine, at risk for urinary tract infection and skin breakdown, and had the potential to develop pressure ulcers, did not have current a pressure ulcer. R23's care plan dated 6/21/16, identified R23	F 309		

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had rash to abdominal fold and groin, required repositioning scheduled routinely, washcloths or gauze between tummy folds, had the potential for pressure ulcer development related to limited mobility and Braden score, and staff were to notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or daily care.
R23's care plan did not identify active or history of wounds, wound dressing or treatments to R23's skin.

Review of R23's Wound RN Assessment forms from 4/12/16 to 5/3/16 revealed the following:
-4/12/16, R23's identified a wound to her coccyx that had partial thickness loss. Staff were to continue with current plan of care and no measurements were done or new interventions started.
-5/3/16, R23 had an open area to her coccyx. The wound was not measured. Staff were to no continue with current care plan of care, and no new interventions were added.
No further wound assessment forms for R23 were found in the clinical record.

Review of R23's progress notes from 4/16 to 6/26/16 revealed the following:
-4/11/16, R23 had 2 areas of concern noted to her buttocks. The area to her left buttock was scabbed over and measured 1 cm x 0.5 cm. The area to her right buttock was slightly open and measured 2 cm x 1.2 cm. The current orders were to apply barrier cream and staff were directed to continue with the current plan of care.
-5/29/2016, R23 was to continue with barrier cream to her coccyx, and have new wound dressing applied every morning to her open areas on her coccyx. R23's wound to her left buttock

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had opened and had a moist wound bed. R23's wound was cleansed, and a foam dressing was applied for protection from further breakdown.

-5/30/2016, R23 had an open area to her left inner buttock which measured 1.3 cm X 1.3 cm. The wound bed was moist and consisted of 25% slough and 75% light pink tissue. There was a scant amount of yellow drainage to the previous dressing. R23's open area was cleansed with wound wash, patted dry and a new foam dressing was applied.

-6/5/16, R23 had an open area to her left inner buttock which measured 1.7 cm X 2.5 cm with no measurable depth. The wound bed was moist and there was a scant amount of yellow drainage on the previous dressing. R23's open area was cleansed with wound wash, patted dry and and a new dressing applied.
R23's current (which month)Treatment Administration Record (TAR) identified:
-Mepilex dressing to sacral area, change every 72 hours and as needed when soiled for skin protection, started on 6/8/16.
-Continue with barrier cream to coccyx, but apply wound dressing to change daily in the morning for open areas to coccyx, started 4/2/16.

On 6/28/16, at 3:07 p.m. R23 was observed lying on her back in bed with eyes closed, and nursing assistant (NA-B) and NA-D entered R23's room. NA-B and NA-D proceeded to assist R23 with perineal care and the incontinent product change. R23's brief was observed to be wet with urine, and both the incontinent product and wound dressing were soiled with stool. The soiled wound dressing and dirty incontinent product was removed and a fresh incontinent product was

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applied. A fresh wound dressing was not applied, and the wound was not covered. NA-B and NA-A proceeded to transfer R23 to her wheelchair and NA-A propelled R23 in her wheelchair to the day room to watch TV.

At that time, NA-D stated R23 always had sores on her bottom. NA-B stated R23's bottom was really bad 4 days ago and had been open. NA-A stated R23 had a pinpoint area open area at this time with a little bit of drainage. NA-B stated R23's bottom was always kind of sore and she had recurring open areas to her buttocks. NA-B & NA-A stated the nurse takes care of R23's wound dressings.

On 6/28/16, at 3:18 p.m. NA-B stated R23 was routinely assisted with toileting and repositioning to keep R23's skin clean and dry. NA-B stated R23 was confused all of the time and was totally dependent on staff for cares.

On 6/28/16, 3:24 p.m. NA-D stated she felt R23 was at risk for skin breakdown if they didn't reposition her often. NA-D confirmed R23 was confused and needed help with cares. NA-D stated R23's bottom frequently opened and closed, got better and then worse.

On 6/29/16, at 7:48 a.m. R23 was observed on her back in bed with eyes closed, and NA-A and NA-C entered R23's room. NA-A and NA-C proceeded to assist R23 with perineal care and incontinent product change. R23 did not have a wound dressing in place or in her brief. R23's brief was wet with urine and stool. R23's coccyx area was red on both sides, and had a scabbed area on her left coccyx area. NA-A applied a fresh incontinent brief, transferred R23 into the

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wheelchair and assisted her into the day room area next to the TV. A fresh wound dressing was not observed to be placed on R23's buttocks wound.

At that time, NA-A confirmed R23 did not have a wound dressing in place and had not been applied to her bottom with cares. NA-A stated they assisted R23 with repositioning,toileting and used powder and creams on R23's bottom. NA-A confirmed R23 required assistance with all cares, was confused and was dependent on staff for cares.

On 6/29/16, at 9:41 a.m. after visualizing R23's buttock area, registered nurse (RN-A) confirmed R23's current wound to her buttocks and confirmed a wound dressing was not in place or in her brief. RN-A stated R23's wound was not pressure related, and R23's wound and surrounding skin was completely blanchable. She stated she understood the current orders gave them the option to apply either a wound dressing or cream on R23's bottom. She stated she felt the dressing was for when R23's bottom was more open. She stated R23 has had concerns with her bottom for about 6 months, and was at risk for skin breakdown.

On 6/29/16, at 11:27 a.m. RN-A confirmed 2 separate orders for R23's wound dressing, and confirmed the current order for R23's wound dressing to be replaced every 72 hours in the p.m. or when soiled. She stated she was confused, as there were multiple orders for R23's wound dressing and treatments. She stated she understood the orders meant they had the option to use either the wound dressing or the barrier cream order. She indicated that after review of

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F 309	Continued From page 16 R23's current wound orders, she felt the Mepilex should be used consistently. RN-A confirmed R23 had not had a wound dressing on her bottom since it was removed at 3:07 p.m. on 6/28/16. On 6/29/16, at 1:09 p.m. DON-A stated she was aware R23 had skin breakdown and had been on her list for more than 2 weeks, to have an assessment completed. She indicated she felt the facility had problems identifying wounds, staff did not properly chart, or chart routinely on skin breakdown. DON-A stated, " Its a whole broken process." DON-A stated she would expect the RN to assess and collect data on wounds daily, and comprehensively assess healing progress and measurements for each area every week. She stated she would expect a comprehensive assessment to be completed after each new concern was identified and the Dr. be notified, and this had not been done. She stated she was aware R23's Dr's orders needed to be clarified, and that was also on her to do list. She stated she expected Dr's orders to be clarified if there was questions and followed as ordered. Review of a facility procedure titled, Skin assessment, Pressure ulcer Prevention and Documentation requirements, revised 4/16, revealed a purpose of the facility to ensure residents were systematically assessed with regards to skin breakdown and to accurately document observations and assessments. Review of the physician/practitioner orders policy dated 7/2015 identified to provide individualized care to each resident by obtaining appropriate, accurate and timely physician/practitioner orders.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		8/9/16

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F 329	Continued From page 17 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have appropriate medical justification and identify target behaviors for continued use of anti-psychotic medication for 1 of 5 residents (R9) reviewed for unnecessary medication use. Findings include: R9's quarterly Minimum Data Set (MDS) dated 6/10/16, identified R9 had diagnoses which	F 329	F329 1. R9's anti-psychotic has been discontinued. 2. All residents receiving anti-psychotic medications have the potential to be affected. All current residents receiving an anti-psychotic will be reviewed by 8/9/16 to ensure that the facility anti-psychotic management process is active. 3. All licensed nurses will be educated on the need to identify the target behavior,	

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F 329	Continued From page 18 included dementia, anxiety and depression, and psychotic disorder. The MDS identified R9 had with moderate cognitive impairment, had no behaviors, wandering or rejection of care and received a anti-psychotic medication and anti-anxiety medication on a daily basis. R9's physician orders signed 5/20/16, identified orders which included the following psychotropic medications: - "Lexapro [anti-anxiety medication] Tablet 5 mg [milligrams] ... 1 tablet by mouth in the morning for anxiety ...", started on 11/11/15 and; - "RisperDAL [anti-psychotic medication] Tablet ... Give 0.125 mg by mouth one time a day related to UNSPECIFIED PSYCHOSIS NOT DUE TO A SUBSTANCE..." started on 12/30/15. Further, this order identified, "On hold from 03/25/2016 03:05 [3:05 a.m.] to 04/08/2016 03:03 [3:03 a.m.]." R9's Consultant Pharmacist Medication Review dated 12/9/15, identified recommendations from the consulting pharmacist (CP) which included, "Risperdal recently started and reduced. Please clarify target behaviors? [i.e. (in example) hallucinations, delusions, aggressive behavior, etc (etcetera).] ... Did also have treatment for UTI [urinary tract infection], question if could possibly DC [discontinue] now?" R9's physician responded on 12/30/15 with, "[decrease] Risperdal 0.125 mg PO [by mouth] QHS [every hour of sleep]." The MD did not provide any target behaviors for the use of R9's anti-psychotic medication as requested by the consulting pharmacist. An additional Consultant Pharmacist Medication Review dated 3/8/16, identified recommendations	F 329	to assess and document behavior prior to the initiation of anti-psychotic medication. Education will also include the expectation to review the physician's orders upon hospital returns to assure that any "re-start all prior medications" orders when there is an anti-psychotic, that there is physician justification to restart the anti-psychotic. Education will be provided by the DNS or designee on July 27, 2016. 4. The order listing report on PCC will be run weekly x4 and monthly x2 to identify residents using a psychopharmacological medication. Based on this report, audits will be conducted on care plans and physician orders to assure target behaviors are identified and the presence of physician justification. Auditresults will be reported to the QAPI committee for further recommendations. 5. August 9, 2016	

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from the consulting pharmacist which included, "Resident seems to be doing OK with recent Risperdal decrease, consider a trial hold?" R9's physician responded on 3/23/16, with, "Hold Risperdal." There was no established period for which to hold the medication, or reasons to re-start the medication identified on the provided response from the physician.

R9's Medication Records dated 4/1/16 to 6/30/16, identified R9 had been given the ordered Risperdal 0.125 mg dosing on a daily basis since 4/7/16.

Review of R9's progress notes from 4/5/16 to 6/25/16, identified the following:

-On 4/17/16, Resident is currently taking Lexapro 5 mg and Risperdal 0.125 mg which was restarted on 4/7/16 after being on hold since 3/25/16. Resident has not exhibited any exit seeking or hallucinations.

-On 6/25/16, resident currently taking Lexapro 5 mg and Risperdal 0.125 mg daily. Resident has not exhibited any exit seeking or hallucinations.

No further documentation of behaviors for R9 were found in the clinical record. In addition, R9's progress notes lacked documentation on the reason why Risperdal had been re-started after being held from 3/25/16 to 4/8/16 nor the reason why R9 remained on the antipsychotic medication.

R9's physician progress note dated 5/20/16, identified R9 had dementia and, "Continue current medications and cares as per last order sheet." The physician did not identify R9 to be

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exhibiting any behaviors or any reasoning why R9 remained on the antipsychotic medication.

R9's care plan dated 6/15/16, identified R9 had behavior symptoms related to anxiety, and listed a goal for R9 to have no reports of hallucinations. The care plan directed staff to reminisce with R9 about her family, and offer to play music. However, the care plan did not identify any use of Risperdal, or list any target behaviors for the continued use of the medication.

During interview on 6/30/16, at 9:25 a.m. nursing assistant (NA)-B stated R9 was rarely confused, and typically was pleasant to speak with. NA-B stated she had never noticed any hallucinations or aggressive behaviors from R9, "She's very kind."

When interviewed on 6/30/16, at 9:42 a.m. NA-C stated R9 was a, "Pleasant lady" and only became confused if she had developed a UTI. NA-C stated she had never observed any hallucinations or aggressive behaviors from R9 in the past several months. Further, NA-C stated she was unaware of any target behaviors staff were to be monitoring for with R9's use of the anti-psychotic medication.

During interview on 6/30/16, at 10:30 a.m. registered nurse (RN)-A stated R9 was currently receiving the daily dose of Risperdal. RN-A stated R9 used to have behaviors of calling out for her mother, however it had not occurred for the past several months, adding R9 had never been physically or verbally aggressive with staff or other residents to her knowledge. RN-A stated she was unaware of any target behaviors to monitor for R9's anti-psychotic medication use,

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F 329	Continued From page 21 but staff were expected to chart behaviors in the progress notes if they occurred. RN-A reviewed R9's progress notes and stated there were no documented behaviors for R9 in the past six months. Further, RN-A stated she was unaware why R9's Risperdal had been re-started since there were no documented behaviors, "I couldn't give you that information." When interviewed on 6/20/16, at 11:57 a.m. the director of nursing (DON) stated she had reviewed R9's medical record and was unable to identify why R9's Risperdal was restarted, or any target behaviors for the medication, "I can't find anything." The DON was unaware why R9 had been identified as having exit seeking behaviors, and could not explain why R9 continued to receive antipsychotic medication without demonstrating any behaviors warranting such medication. Further, the DON stated she expected staff to document the reasoning for these decisions in order to make sure they were supported. A facility Psychopharmacological Medications and Sedative/Hypnotics policy dated 8/14, identified a purpose which included, "To eliminate unnecessary psychopharmacological medications and sedative/hypnotics." The policy directed staff to conduct a comprehensive assessment to ensure, "Resident who have not used anti-psychotic drugs are not given these drugs unless anti-psychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record."	F 329		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465		8/9/16

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F 465	Continued From page 22 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide maintenance services and ongoing repairs in a safe and sanitary manner in 10 of 10 resident rooms(rm) (rm201, rm208, rm212, rm213, rm214, rm401, rm403, rm 405, rm414, rm608) reviewed for environmental concerns. In addition, the facility failed to ensure furniture was kept in a safe manner to prevent potential injury for 1 of 1 residents (R17) observed to have a broken book shelf in his room. Findings include: Room 201-2, smelled of urine, non-skid strips in room were jagged and lipped, and the toilet grout was brown and stained. Room 208-1, smelled or urine, The bedroom floor had food stains and food debris/crumbs along the side of the bed, the wall next to the bed was dirty and scraped, the bathroom wall had brown stains which ran down the length of the wall underneath the soap dispenser, and paint was chipped in the bathroom around the toilet. Room 212-1, had dirty, damaged non-skid strips in front of the bed. Room 213-1, had green lime scale on the pipe all	F 465	F465 1. Rm 201 will have odor controlled, non-skid strips repaired and toilet re-grouted by 8/9/16. Rm 208 will have odor controlled, food stains and debris cleaned from floor, wall by bed cleaned and repaired, brown stains removed from under the soap dispenser, and chipped paint repaired by 8/9/16. Rm 212 will have non-skid strips replaced. Rm 213 will have pipe cleaned or replaced by 8/9/16. Rm 214 will have the bathroom faucet repaired and bathroom paint cleaned and repaired by 8/9/16. Rm 401 will have wall repaied and non-slip strips replaced by 8/9/16. Rm 403 will have grout replaced by 8/9/16. Rm 405 will have grout replaced by 8/9/16. Rm 414 will have odor controlled by 8/9/16. Floor was swept the day of observation. Rm 608 will have caulking cleaned or replaced by 8/9/16. R17's bookcase was removed for resident's safety. 2. All Resident Rooms have the potential to be affected by this practice and will be	

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F 465	Continued From page 23 the way from the sink to the toilet. Room 214-1, had a bathroom faucet which was not working, made a loud noise when faucet turned on to run water and water did not come out, bathroom wall was dirty and had chipped paint and cement brick was dirty. Room 401-1, had holes and marks on the bedroom wall, and non-skid strips in front of toilet and sink were dirty. Room 403-1, the grout around the toilet and bathroom tile were dirty and damaged. Room 405-1, the grout around the toilet and bathroom tile were dirty and damaged. Room 414-1, smelled of urine, and had dust accumulated on the floor next to floor boards in the room. Room 608-1, had brown, stained, dirty caulking around the base of the toilet. On 6/28/16, at 08:33 a.m. R1 stated her bathroom sink was still not working. R1 stated the pipes sure did make a lot of noise and had been like that for awhile. She stated she used to have a wrench and would hit the pipe to get the air out of it, and stated she can't find her wrench now. On 6/28/16, at 08:45 a.m. family member (FM-A) stated she had noticed R26's room was not clean. She stated sometimes the floor collected dust bunnies in the corners, and stated she had gotten a broom before and swept it. FM-A stated she didn't expect R26's room to be spotless, but stated she felt the room should be cleaned and	F 465	inspected for a safe/functional/sanitary/comfortable environment. 3. The environmental Services director will educate the housekeeping and maintenance staff to immediately report and respond to conditions requiring extra cleaning and repair. The current system for reporting and responding to environmental concerns will be reviewed by the environmental services director for efficiency and updated as needed. The environmental services director will develop a process for routine monitoring of resident room conditions. These interventions will be completed by 8/9/16. 4. Audits of resident room conditions will be completed weekly x4 and twice per month x2 by the environmental services director or designee. The results will be reported to the QAPI committee for review and recommendations. 5. The above will be accomplished by 8/9/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 24	F 465		

dusted. FM-A stated she has had to ask to have R26's bedding washed before because R26 had a catheter that spilled or something. She stated sometimes she can "really smell urine, and she had to tell them that a few times."

On 6/30/16, at 10:35 a.m. Director of Environmental Services (DES) stated he was responsible for all of housekeeping, maintenance and laundry for the facility. He stated he was unaware of any cleaning or repair needs in any resident rooms except for R17. He stated if the repair needs were not written down on the maintenance clipboard he would have no way of knowing about them. DES stated he didn't know if there was a policy and procedure for odor control and stated he did not have an odor control process. He stated the carpet in the facility was vacuumed only, and not cleaned. He stated the floors should have been deep cleaned but wasn't getting done because he had lost a couple housekeepers. He stated he did not have a schedule for stripping or waxing the floors, and wasn't sure who was responsible for that. DES stated nursing assistants (NAs) had some responsibility for cleaning the resident rooms but stated he wasn't sure of what was on their task lists. DES stated he wasn't sure what he was supposed to do as far as painting. He stated he felt all resident rooms need to be repainted, and wasn't sure if he could do that. He stated they cleaned, swept and mopped the resident rooms as best they could. He stated the non-skid strips were hard to clean and remove from the floor. He confirmed the non-skid strips were damaged, dirty and were uncleanable due to rips and tears. He stated the urine odor in resident rooms was from damaged tile and caulking in the bathrooms, and broken tiles in the resident rooms. DES

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F 465	Continued From page 25	F 465		

stated they should deep clean 1-2 resident rooms each week, but admitted it had not been done because they were short staffed. He stated he expected all staff to write cleaning or repair needs for resident rooms on the maintenance clipboard so he was aware.

R17's annual Minimum Data Set (MDS) dated 6/10/16, identified R17 had severe cognitive impairment.

During observation on 6/27/16, at 7:21 p.m. R17 was seated in his room in his wheelchair looking out the window. Along the wall in R17's room was a two shelf bookcase full of encyclopedias, including multiple columns of them being stacked up on top of the shelf. The bottom of the shelf unit was broken with exposed support dowels visible. This caused the entire shelf, and the stacked encyclopedias, to lean significantly to the right side.

During subsequent observations on 6/28/16, at 9:14 a.m. and 6/29/16, at 7:02 a.m. R17's bookcase remained in disrepair, continued to have multiple columns of stacked encyclopedias on top and was observed to lean significantly to the right side.

When interviewed on 6/29/16, at 7:46 a.m. nursing assistant (NA)-C stated R17 spends a majority of his day in his room. NA-C stated R17's bookshelf appeared to be, "Breaking" and had been that way for, "The past few months." NA-C stated she thought facility maintenance staff was aware of the broken bookcase, however was unsure what was being done to fix it.

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	245550	A. BUILDING _____ B. WING _____	06/30/2016

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F 465	Continued From page 26 During interview on 6/29/16, at 1:25 p.m. NA-A stated R17's bookcase looked, "Ready to tip over." NA-A stated it had been in disrepair for, "Over a year" and appeared dangerous because the columns of stacked encyclopedias could fall on someone if the shelf completely broke. NA-A stated staff should be reporting broken furniture to the environmental service staff so it could be addressed, and R17's broken bookcase should have been addressed, "A long time ago." When interviewed on 6/29/16, at 1:43 p.m. DES stated nursing staff were responsible to identify concerns for repair on a maintenance clipboard which had not been done for R17's broken bookshelf. DES stated the books were, "Way too heavy" for the shelf and it needed to be addressed as, "It's going to eventually fall on somebody." A facility General Repair Requests policy dated 12/9/91, identified, "Any staff member finding or needing something taken care of ... will record it on the Fix-It sheet," and repairs would be, "Completed by the maintenance person."	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **01** B. WING _____	**06/22/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET** **WARREN, MN 56762**

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Good Samaritan Society Warren 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/25/2016

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **01** B. WING _____	**06/22/2016**

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GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET** **WARREN, MN 56762**

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K 000	Continued From page 1	K 000		

Or by e-mail to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

The Facility was inspected as 2 buildings:
Good Samaritan Society Warren (Marshal Manor) was built in 1968 as a 1-story building without a basement and was determined to be Type II (111) construction. In 1973 a 1-story addition was constructed to the east of the original building and was determined to be Type II (000) construction. In 2010 a kitchen addition was constructed to the north of the original building's dining room. It is 1-story, no basement and Type II(000) construction. In 2013 a connecting link was constructed to the east connecting the new hospital with the facility. This addition is i-1story , no basement and Type II(000) construction. The building is divided into 6 smoke zones with 1/2 hour fire rated barriers. An apartment building is attached to the southwest wing that is separated with a 2-hour fire barrier.

The facility is completely protected with an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING 01 B. WING _____	06/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 2 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 52 beds and had a census of 31 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		8/9/16

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	245550	A. BUILDING 01 B. WING	06/22/2016

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K 018	Continued From page 3 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the latching ability of 1 resident room door according to NFPA 101 LSC (00) section 19.3.6.3.2. This deficient practice could affect the safety of 12 of the 31 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 9:45 am to 1:45 pm on 06/22/2016 observations and staff interview revealed resident room 408 did not latch properly. This deficient condition was verified by the Interim Facility Administrator and the Maintenance Supervisor.	K 018	K018 1. The door to resident room 408 will be adjusted to ensure proper latching. All resident rooms will be tested to ensure proper latching, and any rooms identified as not latching properly will be adjusted. 2. The above will be accomplished by 8/9/16. 3. The Environmental Services Director, or designee, will be responsible for the correction and monitoring to prevent reoccurrence.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in 1 of the hazardous rooms in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 5 of the 31 residents and an	K 029	K029 1. A positive latch will be installed on the therapy storage closet in the 100 hall. All storage closets of similar types were inspected during the tour and are equipped with a positive latching	8/9/16

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K 029	Continued From page 4 undetermined amount of staff and visitors. Findings include: On the facility tour between 9:45 am to 1:45 pm on 06/22/2016 observations and staff interview revealed the storage room doors in wing 100 near the therapy room did not positively latch. . This deficient condition was verified by the Interim Facility Administrator and the Maintenance Supervisor.	K 029	mechanism. 2. The above will be accomplished by 8/9/16. 3. The Environmental Services Director, or designee, will be responsible for the correction and monitoring to prevent reoccurrence.	
K 074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 o Newly introduced upholstered furniture and mattresses means purchased since March, 2003. This STANDARD is not met as evidenced by: Based on observations and staff interview the	K 074	K074	8/9/16

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K 074	Continued From page 5 facility failed to maintain the requirements for Furnishing, Bedding, and Decorations for use in health care occupancies in accordance with provisions of NFPA Life Safety Code 101 (2000 edition) section 19.7.5.1 & 10.3.1. This deficient practice could affect the exiting of 13 of 31 residents and an undetermined amount of staff and visitors. In the event of a fire in this space, smoke and fire could spread into the corridor making it untenable. Findings Include: On the facility tour between 9:45 am to 1:45 pm on 06/22/2016 observations and staff interview revealed the drapes in resident room 205 were supplied by the resident and were not treated with a fire retardant. This deficient practice was verified by the Interim Facility Administrator and the Maintenance Supervisor.	K 074	1. The drapes in resident room 205 will be treated with a fire retardant and labelled with the date of treatment. 2. The above will be accomplished by 8/9/16. 3. The Environmental Services Director, or designee, will be responsible for the correction and monitoring to prevent reoccurrence.	

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	245550	A. BUILDING **02 - KITCHEN ADDTION** B. WING _____	**06/22/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET WARREN, MN 56762**

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K 000	INITIAL COMMENTS FIRE SAFETY 02 Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Good Samaritan Society Warren 02 Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/25/2016

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K 000	Continued From page 1	K 000		

Or by e-mail to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

The Facility was inspected as 2 buildings:
Good Samaritan Society Warren (Marshal Manor) was built in 1968 as a 1-story building without a basement and was determined to be Type II (111) construction. In 1973 a 1-story addition was constructed to the east of the original building and was determined to be Type II (000) construction. In 2010 a kitchen addition was constructed to the north of the original building's dining room. It is 1-story, no basement and Type II(000) construction. In 2013 a connecting link was constructed to the east connecting the new hospital with the facility. This addition is i-1story , no basement and Type II(000) construction. The building is divided into 6 smoke zones with 1/2 hour fire rated barriers. An apartment building is attached to the southwest wing that is separated with a 2-hour fire barrier.

The facility is completely protected with an

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 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 52 beds and had a census of 31 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to provide 1 of several exit discharge walking surfaces in accordance with NFPA 101 Life Safety Code (00) edition, Section 7.1.6.2. During an evacuation this deficient practice could affect all dining room occupants, and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:45 am to 1:45 pm on 06/22/2016 observations and staff interview revealed the concrete landing on the exterior of	K 038	K038 1. A ramp will be installed over the 2 ½ inch gap between the concrete slab on the exterior of the dining room emergency exit and the building. 2. This will be accomplished by 8/9/16. 3. The Environmental Services Director, or designee, will be responsible for the correction and monitoring to prevent reoccurrence.	8/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **02 - KITCHEN ADDTION** B. WING _____	**06/22/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET WARREN, 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 3 the dining room emergency exit separated from the building, leaving a 2 1/2 inch gap between the slab and the building. This deficient condition was verified by the Interim Facility Administrator and the Maintenance Supervisor	K 038		