DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					N AND TRANSMITTAL ID: 096L			
		T - TO BE COM	PLETED BY T	HE STATI	E SURVEY AGENCY	Facility ID: 00898		
1. MEDICARE/MEDICAID PROVIDER N (L1) 245149	0.	3. NAME AND ADI (L3) GOOD SAM			ASSADOR	4. TYPE OF ACTION: <u>7 (</u> L8)		
2.STATE VENDOR OR MEDICAID NO.		(L4) 8100 MEDIC			10571D OIX	1. Initial 2. Recertification		
(L2) 564214100		(L5) NEW HOPE,			(L6) 55427	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other		
 EFFECTIVE DATE CHANGE OF OWN (L9) 	VERSHIP	7. PROVIDER/SUF	PPLIER CATEGORY 05 HHA	7 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 03/22	/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICATION		10. THE FACILITY	IS CERTIFIED AS:					
From (a):		X A. In Compliar	nce With		And/Or Approved Waivers Of The	e Following Requirements:		
To (b):		Program Re Compliance			2. Technical Personnel	6. Scope of Services Limit		
					3. 24 Hour RN	7. Medical Director		
12.Total Facility Beds	77 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SNF)	—		
13 Total Certified Beds	77 (L17)	B. Not in Com	pliance with Program	L	5. Life Safety Code	9. Beds/Room		
			and/or Applied Waiv		* Code: A*	(L12)		
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
77								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PROVAL Date:		
Jessica Sellner, Ur	nit Superviso	or	03/22/2016	(L19)	Kate JohnsTon, Pro	ogram Specialist 04/05/2016 (L20)		
	PART II - TO	BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE OR SINGLE STAT			
19. DETERMINATION OF ELIGIBILITY		20. COM	PLIANCE WITH C	IVIL	21. 1. Statement of Financial Solvency (HCFA-2572)			
X 1. Facility is Eligible to Part	icipate	RIGH	ITS ACT:		 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible	Ĩ				5. Dom of the rice of e.			
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	NT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNING	DATE	ENDING DATE	Ξ	VOLUNTARY 00	INVOLUNTARY		
02/26/1968					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	nt 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS			03-Risk of Involuntary Termination	OTHER		
	A. Suspension	of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(107)			(L44)			00-Active		
(L27)	B. Rescind Sus	pension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
		00140						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DAT	ТЕ	Posted 04/06/2016 Co.			
	(1.22)	03/11/2016		<i>a</i>				
	(L32)			(L33)	DETERMINATION APPRO	VAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245149 April 5, 2016

Ms. Marie Barta, Administrator Good Samaritan Society - Ambassador 8100 Medicine Lake Road New Hope, Minnesota 55427

Dear Ms. Barta:

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 March 18, 2016 the above facility is certified for or recommended for:

77 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 77 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Good Samaritan Society - Ambassador April 5, 2016 Page 2

Sincerely,

J ate

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 5, 2016

Ms. Marie Barta, Administrator Good Samaritan Society - Ambassador 8100 Medicine Lake Road New Hope, Minnesota 55427

RE: Project Number S5149026

Dear Ms. Barta:

On February 25, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 11, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 22, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 22, 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 February 11, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 18, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 11, 2016, effective March 18, 2016 and therefore remedies outlined in our letter to you dated February 25, 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.

Good Samaritan Society - Ambassador April 5, 2016 Page 2

Sincerely,

K motor

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT		
IDENTIFICATION NUMBER	A. Building				
245149 _{Y1}	B. Wing	Y2	3/22/2016	Y3	
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY - AI	MBASSADOR	8100 MEDICINE LAKE ROAD			
		NEW HOPE, MN 55427			

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

ITE	м	DATI	e	ITEM			DATE	ITEM			DATE
Y4		Y5		Y4			Y5	Y4			Y5
ID Prefix	F0225	Correcti	ion	ID Prefix	F0226		Correction	ID Prefix	F0241		Correction
Reg. #	483.13(c)(1)(ii)-(iii - (4)), (c)(2) Comple	ted	Reg. #	483.13(c)	Completed	Reg. #	483.15(a)		Completed
LSC		03/16/20	16	LSC			03/16/2016	LSC			03/16/2016
ID Prefix	F0282	Correcti	ion	ID Prefix	F0309		Correction	ID Prefix	F0314		Correction
Reg. #	483.20(k)(3)(ii)	Comple	ted	Reg. #	483.25		Completed	Reg. #	483.25(c)		Completed
LSC		03/16/20	16	LSC			03/16/2016	LSC			03/16/2016
ID Prefix	F0315	Correct	ion	ID Prefix	F0323		Correction	ID Prefix	F0325		Correction
Reg. #	483.25(d)	Comple	ted	Reg. #	483.25(h)	Completed	Reg. #	483.25(i)		Completed
LSC		03/16/20	16	LSC			03/16/2016	LSC			03/16/2016
ID Prefix	F0412	Correcti	ion	ID Prefix	F0441		Correction	ID Prefix	F0456		Correction
Reg. #	483.55(b)	Comple	ted	Reg. #	483.65		Completed	Reg. #	483.70(c)(2)		Completed
LSC		03/16/20	16	LSC			03/16/2016	LSC			03/16/2016
ID Prefix		Correcti	ion	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Comple	ted	Reg. #			Completed	Reg. #			Completed
LSC				LSC				LSC			
REVIEWE STATE AG	/ /	REVIEWED BY (INITIALS) JS/K	(J	date 04/05/2	2016	SIGNATURE OF SU		9249		date 03/	22/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)		DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 2/11/2016			CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?						6 🗌 NO		

POST-CERTIFICATION REVISIT REPORT

			DATE OF REVISIT			
	A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	3/22/2016	Y3		
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE				
GOOD SAMARITAN SOCIETY - AI	MBASSADOR	8100 MEDICINE LAKE ROAD				
		NEW HOPE, MN 55427				

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

ITE	М	DATE	ITEM	DATE	ITEM		DATE
Y4		Y5	Y4	Y5	Y4		Y5
ID Prefix Reg. # LSC	NFPA 101 K0012	Correction Completed 03/18/2016	ID Prefix Reg. # NFPA 1 LSC K0050	01 Correction 01 03/18/2016	ID Prefix Reg. # LSC	NFPA 101 K0143	Correction Completed 03/18/2016
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
REVIEWE STATE AG REVIEWE CMS RO		REVIEWED BY (INITIALS) TL/KJ REVIEWED BY (INITIALS)	DATE 04/05/2016 DATE	TITLE	19251		DATE 03/22/2016 DATE
FOLLOWUP TO SURVEY COMPLETED ON 2/12/2016		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?					

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 02 - NEW ADDITION		DATE OF REVISIT		
	B. Wing	Y2	3/22/2016	Y3	
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY - AI	MBASSADOR	8100 MEDICINE LAKE ROAD			
		NEW HOPE, MN 55427			

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

ITE	М	DATE	ITEM	DATE	ITEM		DATE
Y4		Y5	Y4	Y5	Y4		Y5
ID Prefix Reg. # LSC	NFPA 101 K0012	Correction Completed 03/18/2016	ID Prefix Reg. # NFPA 1 LSC K0050	01 Correction 01 Completed 03/18/2016	Reg. #	NFPA 101 K0143	Correction Completed 03/18/2016
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. #		Correction Completed
REVIEWE STATE AG REVIEWE CMS RO		REVIEWED BY (INITIALS) TL/KJ REVIEWED BY (INITIALS)		SIGNATURE OF SURVEYOR TITLE ANY UNCORRECTED DEFICIENCIES		DATE MARY OF	22/2016
2/12/2016	6		UNCORRECT	TED DEFICIENCIES (CMS-2567) SENT	TO THE FACI	LITY? YES	NO NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	MEDICARE/MEDICAID CERTIFICA					DN AND TRANSMITTAL ID: 096L		
	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AGENCY	Facility ID: 00898		
1. MEDICARE/MEDICAID PROVIDER N (L1) 245149	Э.	3. NAME AND ADD (L3) GOOD SAM			SSADOR	4. TYPE OF ACTION: <u>2 (</u> L8)		
2.STATE VENDOR OR MEDICAID NO.		(L4) 8100 MEDIC	INE LAKE ROA	D		1. Initial 2. Recertification 3. Termination 4. CHOW		
(L2) 564214100		(L5) NEW HOPE,	MN		(L6) 55427	5. Validation 6. Complaint 7. On-Site Visit 9. Other		
 EFFECTIVE DATE CHANGE OF OWN (L9) 	IERSHIP	7. PROVIDER/SUB 01 Hospital	PPLIER CATEGOR	Y 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 02/11 /	2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:					
From (a):		A. In Complian	nce With		And/Or Approved Waivers Of The	e Following Requirements:		
To (b):		Program Re			2. Technical Personnel	6. Scope of Services Limit		
		Compliance	Based On:		3. 24 Hour RN	7. Medical Director		
12. Total Facility Beds	77 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SNF)	8. Patient Room Size		
-	77 (L13) 77 (L17)	V. D. M.C. C.	1' 'd D		5. Life Safety Code	9. Beds/Room		
13.Total Certified Beds	// (L1/)		pliance with Program and/or Applied Waiv		* Code: B *	(L12)		
14. LTC CERTIFIED BED BREAKDOWN		requirements	and of Applied Wall		15. FACILITY MEETS	(2.2)		
	10 (3) (5)	LOP				([15)		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
77 (L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PPROVAL Date:		
Mardelle Trettel	, HFE NE II		03/07/2016	(L19)	Kate JohnsTon, Pr			
	PART II - TO	BE COMPLETE	D BY HCFA RI		OFFICE OR SINGLE STAT	(L20) TE AGENCY		
19. DETERMINATION OF ELIGIBILITY		20. COM	IPLIANCE WITH C	IVIL	21. 1. Statement of Financ	ial Solvency (HCFA-2572)		
1. Facility is Eligible to Part	icipate	RIGH	ITS ACT:		 Ownership/Control Both of the Above : 	Interest Disclosure Stmt (HCFA-1513)		
2. Facility is not Eligible	(L21)							
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	ENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION 02/26/1968	BEGINNING	DATE	ENDING DATI	E	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	0 INVOLUNTARY 05-Fail to Meet Health/Safety		
(1.24)	(1.41)		(1.25)		02-Dissatisfaction W/ Reimburseme			
(L24)	(L41)		(L25)		03-Risk of Involuntary Termination	-		
25. LTC EXTENSION DATE:	27. ALTERNATIV				04-Other Reason for Withdrawal	OTHER 07 Provider Status Change		
	A. Suspension	of Admissions:	(1.44)			07-Provider Status Change 00-Active		
(L27)	B. Rescind Sus	pension Date:	(L44)			00-Active		
	D. Resenta Sus	pension Dute.	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
		00140						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	DETERMINATION (OF APPROVAL DA	ГЕ	Posted 03/11/2016 Co.			
	(L32)			(L33)	DETERMINATION APPRO	VAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 25, 2016

Ms. Marie Barta, Administrator Good Samaritan Society - Ambassador 8100 Medicine Lake Road New Hope, Minnesota 55427

RE: Project Number S5149026

Dear Ms. Barta:

On February 11, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the February 11, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5149028 that was found to be unsubstantiated.

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

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor Minnesota Department of Health St. Cloud B Survey Team Licensing & Certification Health Regulation Division Midtown Square 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7343 Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 22, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 22, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 11, 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 August 11, 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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

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, Supervisor Health Care Fire Inspections State Fire Marshal Division Email: tom.linhoff@state.mn.us Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

	-	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	MB NO.	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
		245149	B. WING		02/	11/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		B100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 000			
F 225 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of your validate that substar regulations has been your verification. A standard recertific and a complaint inv completed at the tir investigation of com substantiated during 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF ALLEGATIONS/IND The facility must not been found guilty of mistreating residen had a finding entered registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authorit The facility must entered the facility must entered of the facility must entered the facility must entered and report any know	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with cation survey was conducted restigation(s) was also ne of the standard survey. An nplaint H5149028 was not g this survey. (c)(2) - (4) PORT DIVIDUALS at employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a t an employee, which would or service as a nurse aide or the State nurse aide registry	F 225			3/16/16
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically Signed					03/04/2016

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.

		AND HUMAN SERVICES	1		FORM MB NO.	03/07/2016 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245149	B. WING		02/*	11/2016
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	misappropriation of immediately to the to other officials in a through established State survey and ce The facility must haviolations are thoro prevent further pote investigation is in p The results of all into to the administrator representative and with State law (inclu- certification agency incident, and if the appropriate correct This REQUIREMEN by: Based on interview facility failed to ens mistreatment were reported to the state reported to the state reported to the adm (R20 and R65) who mistreatment. Findings include: R20's quarterly Min 12/22/15, indicated cognitive impairment	f unknown source and resident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency). ave evidence that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported to other officials in accordance uding to the State survey and the state survey and the alleged violation is verified ive action must be taken.	F 225	Preparation and execution of this response and plan of correction do constitute an admission or agreem the provider of the truth of the facts alleged or conclusions set forth in statement of deficiencies. The plar correction is prepared and/or exec solely because it is required by the provisions of federal and state law the purposes of any allegation that center is not in substantial complia with federal requirements of partici- this response and plan of correction constitutes the center is allegation compliance in accordance with set	ent by s the n of uted . For the ince ipation, on	

Facility ID: 00898

If continuation sheet Page 2 of 46

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	TIPLE	E CONSTRUCTION		0938-039 SURVEY
	PF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245149	B. WING			02/11/2016	
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		-	100 MEDICINE LAKE ROAD EW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 225	Continued From pa	ge 2	F 2	25			
	R20's care plan dated 4/9/15, indicated the resident had a ADL self care performance deficit				7305 of the State Operations Manu	ial.	
	related to cerebral	vascular accident (CVA).			F225		
	indicated "[R20] rec medical assistant/c	oncern report dated 1/4/16, quests that TMA/CNA (trained ertified nursing assistant) e in her room. Resident states			R65 alleged incident was reported agency on 2/9/16 and thoroughly investigated.	to state	
	that TMA/CNA "holl on 1/1/16 while care Resident reports th	ered" at her and swore at her es were being provided. at CNA [NA-E] provided HS id that during cares [NA-D]			R20 alleged incident was reported state agency on 2/11/16 and thorou investigated.		
	swore at her and "n [R20] reports that [I in her room with [N threatened her by s	nuttered" under her breath. NA-D] was "mean" to her while A-E] and states that she tating, "I'm taking care of you			Concern forms since 2-8-16 have be reviewed for other potential resider affected and reported and investigat appropriate.	l residents	
	[NA-D] fired and wa this." The Investig with [NA-D] and [NA reports that he prov and that [NA-D] was	nt reports that she wants ants something done abut ation indicated, "Interviews A-E] were conducted. [NA-E] <i>r</i> ided all HS cares for [R20] s told to stand by the wall and			Staff were re-educated on facility vulnerable adult policy and procedu include abuse definitions, reporting investigating responsibilities by 3/1	and	
	observe only. Both [NA-D and NA-E] report that no inappropriate words or tones were used by [NA-D] during the timeframe reported. [NA-E] reports that [R20] informed him on the day of question that she did not like [NA-D] and was going to "get her fired." The resolution indicated, "Care Plan includes 2 staff members in resident's room when providing cares. Resident has a				Random audits of concern forms w completed for identifying and repor potential abuse, neglect or maltrea by the director of social services da 1 week, weekly for 1 month, month months and quarterly thereafter.	ting of tment aily for	
	history of making fa and has difficulty ac care plan was being incident. Resident in her room again, r accommodated. [N	alse allegations against staff djusting to change. Resident's g followed at the time of the requests that [NA-D] not come request will be respected and IA-D] advised to have the tions to [R20] and switch with			Results of audits and investigations reported to the QAPI committee for further evaluation and recommends	or	

If continuation sheet Page 3 of 46

		AND HUMAN SERVICES				FORM	03/07/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245149	B. WING	i		02 / [.]	11/2016
NAME OF	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- AMBASSADOR			100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	was not reported the concern form was a 1/5/16, one day after During interview 2/- nurse (RN)-A stated her room per the re- resident was to haw RN-A stated R20 ha accusations of staff stated after they co- allegation did not ha needed to report it stated the facility do staff involved before decision as a team state agency, and s allegations need to the state agency. R65's quarterly MD indicated R65 was extensive assistant of daily living. R65's care plan dath had hearing and vis to allow him adequa repeat things as ne During interview on stated NA-F, "Picked bed when I asked to incident happened prior, but was unab R65 stated NA-F, "It the far side of the b resident to say, "Ow	allegation of mistreatment, it allegation of mistreatment, it is state agency, and the signed by the administrator on er the incident. 10/16, at 12:14 p.m. registered d NA-D does not enter R20's esidents request and the re two care givers in the room. ad a history of making false f mistreatment, and RN-A nfirmed with NA-E the appen, they did not feel they to the state agency. RN-A bes interview the residents or e they would make the to report the incident to the stated she was not aware that be reported immediately to S, completed 11/26/15, cognitively intact and required be of one to complete activities ted 02/09/16, identified R65 sual deficits and directed staff ate time to respond, and	F	225			

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		AND HUMAN SERVICES & MEDICAID SERVICES		FORM APPROVED MB NO. 0938-0391		
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245149	B. WING		02/	11/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG) BE	(X5) COMPLETION DATE
F 225 F 225 SS=D	and reported it to a A facility Suggestion 12/29/15, identified assistant had, "Pick the bed," and this h The form identified incident, which inclu- with resident who w further description of [R65] endorses feel Resident [R65] d deficits and severe interviewed five oth as R65 for potential no indication the all reported to the state staff interviewed as When interviewed as When interviewed as When interviewed as When interviewed to stated R65 had rep arms around R65's bed without waiting had been unable to member, however, the facility. SW station interviewed residen 483.13(c) DEVELO ABUSE/NEGLECT, The facility must de policies and proced mistreatment, negle	nurse. nurse. nor Concern form dated R65 had reported a nursing [[ed] him up and threw him on ad occurred, "Multiple times." a facility investigation into the uded, "SW [social worker] met ras unable to provide any of staff member Resident ling safe and denies being hurt oes have severe vision hearing difficult [sic]." SW er residents in the same unit abuse, however, there was egation of mistreatment was agency, nor were any other part of the investigation. on 2/9/16, at 12:20 p.m. SW orted a staff would wrap his chest and throw him on the for other staff to assist. R65 identify a specific staff R65 reported he felt safe at ted the allegation of abuse ncern form had not been e agency because the other ts all felt safe. P/IMPLMENT , ETC POLICIES velop and implement written	F 2	225		3/16/16

Facility ID: 00898

If continuation sheet Page 5 of 46

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/07/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245149	B. WING			02 / ⁻	11/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR			100 MEDICINE LAKE ROAD EW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From pa	ge 5	F 2	226			
	by: Based on interview facility failed to ensu- mistreatment were reported to the state reported to the adm facility abuse and n residents (R20 and staff mistreatment. Findings include: A facility Policy titled 9/13, indicated "Not immediately of any misappropriation of suspected abuse, a neglect, financial ex- seclusion. In case follow the chain of of (DNS, SW, etc) D "Immediately," in th as possible after dis ought not to exceed absence of a shorter requirement." The notify the designate and to interview sta witnesses to the ind R20's quarterly Min 12/22/15, indicated cognitive impairmer assistance with acti	thoroughly investigated, e agency, and immediately inistrator according to the eglect policy for 2 of 2 R65) who made allegations of d Abuse And Neglect revised tify the location administrator incidents of resident abuse, resident property, alleged or and injury of unknown origin, coloitation or involuntary absence of the administrator, command for notification occument this notification. is procedure means "as soon scovery of the incident, and d the end of the shift, in the er state time frame policy also directed staff to ad stated agency immediately, ff, residents, or other			F226 R65 alleged incident was reported t agency on 2/9/16 and thoroughly investigated. R20 alleged incident was reported t state agency on 2/11/16 and thorou investigated. Concern forms since 2-8-16 have b reviewed for other potential residen affected and reported and investiga appropriate. All allegations of mistreatment will be immedicately reported to the administrator and st agency and then a thorough investi- will be conducted Staff were re-educated on facility vulnerable adult policy and procedu- include abuse definitions, reporting investigating responsibilities by 3/16 Random audits of concern forms w completed for identifying and report potential abuse, neglect or maltreat by the director of social services da 1 week, weekly for 1 month, month months and quarterly thereafter. Results of audits and investigations reported to the QAPI committee for evaluation and recommendations.	to the ghly been ts tted as ate gation are that and 5/16 till be ting of trment illy for ly for 3 to the swill be	

Facility ID: 00898

If continuation sheet Page 6 of 46

		& MEDICAID SERVICES	I			0.0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		245149	B. WING _		02	2/11/2016
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 226	resident had a ADL related to cerebral A Suggestion Or Co indicated "[R20] rec medical assistant/c [NA-D] no longer bo	ge 6 self care performance deficit vascular accident (CVA). oncern report dated 1/4/16, quests that TMA/CNA (trained ertified nursing assistant) e in her room. Resident states ered" at her and swore at her	F 22	26		
	on 1/1/16 while car Resident reports th (bed time cares) ar swore at her and "r [R20] reports that [I in her room with [N threatened her by s tomorrow." Reside [NA-D] fired and wa this." The Investig with [NA-D] and [N/	es were being provided. at CNA [NA-E] provided HS ad that during cares [NA-D] nuttered" under her breath. NA-D] was "mean" to her while A-E] and states that she stating, "I'm taking care of you nt reports that she wants ants something done abut ation indicated, "Interviews A-E] were conducted. [NA-E]				
	and that [NA-D] wa observe only. Both no inappropriate we [NA-D] during the ti reports that [R20] ir question that she d going to "get her fir "Care Plan includes"	vided all HS cares for [R20] s told to stand by the wall and [NA-D and NA-E] report that ords or tones were used by meframe reported. [NA-E] nformed him on the day of id not like [NA-D] and was ed." The resolution indicated, s 2 staff members in resident's				
	history of making fa and has difficulty ac care plan was being incident. Resident in her room again, accommodated. [N nurse pass medica other team membe	ng cares. Resident has a alse allegations against staff djusting to change. Resident's g followed at the time of the requests that [NA-D] not come request will be respected and IA-D] advised to have the tions to [R20] and switch with rs for care needs. [NA-D] and the plan." Although the facility				

Facility ID: 00898

If continuation sheet Page 7 of 46

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	03/07/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245149	B. WING	i		02/	11/2016
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- AMBASSADOR			100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	 was not reported the concern form was as 1/5/16, one day after immediately accord. During interview 2/⁻ nurse (RN)-A stated her room per the represent was to haw RN-A stated R20 has accusations of staff stated after they coallegation did not have accusations of staff stated the facility do staff involved before decision as a team state agency, and sa allegations needed the state agency praccording to the facility investigated the state agency, n administrator immediately according. R65's quarterly MD indicated R65 was extensive assistance of daily living. R65's care plan dat had hearing and vis 	 be state agency, and the signed by the administrator on er the incident, and not ding to the facility policy. 10/16, at 12:14 p.m. registered d NA-D does not enter R20's esidents request and the ve two care givers in the room. ad a history of making false f mistreatment, and RN-A onfirmed with NA-E the appen, they did not feel they to the state agency. RN-A oes interview the residents or e they would make the to report the incident to the stated she was not aware that to be reported immediately to for to a full investigation cility policy. be an allegation of abuse the the incident, and did not notify or did they notify the ediately according to facility be completed 11/26/15, cognitively intact and required ce of one to complete activities ted 02/09/16, identified R65 sual deficits and directed staff ate time to respond, and 	F	226			

If continuation sheet Page 8 of 46

	-	AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245149	B. WING			02 / [.]	11/2016
NAME OF F	PROVIDER OR SUPPLIER		- -	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		-	100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	V	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	Х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 226	Continued From pa	ge 8	F 2	226			
	stated NA-F, "Picke bed when I asked to incident happened a prior, but was unab R65 stated NA-F, "I the far side of the b resident to say, "Ow sore spot on his hea and reported it to a						
	12/29/15, identified assistant had, "Pick the bed," and this h The form identified incident, which inclu- with resident who w further description of [R65] endorses fee Resident [R65] d deficits and severe interviewed five oth as R65 for potential no indication the all reported to the state facility policy, nor w as part of the invest When interviewed of stated R65 had rep arms around R65's bed without waiting had been unable to	n or Concern form dated R65 had reported a nursing ([ed] him up and threw him on ad occurred, "Multiple times." a facility investigation into the uded, "SW [social worker] met vas unable to provide any of staff member Resident ling safe and denies being hurt oes have severe vision hearing difficult [sic]." SW er residents in the same unit l abuse, however, there was egation of mistreatment was a agency according to the ere any other staff interviewed tigation.					
	the facility. SW sta	ted the allegation of abuse					

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		AND HUMAN SERVICES			FORM	03/07/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245149	B. WING		02/	11/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226 F 241 SS=D	facility policy becau residents all felt saf	e agency according to the set the other interviewed	F 2			3/16/16
00-2	The facility must pr manner and in an e enhances each res full recognition of h	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality. NT is not met as evidenced				
	Based on observat review, the facility f	tion, interview, and document ailed to promote dignity with 2 of 5 residents (R163 and 5 toileting.		F241 Incontinent product for R163 was disposed of immediately upon not by Licensed Nurse on 2/10/16.		
	R163's quarterly Mi 12/21/15, indicated	inimum Data Set (MDS) dated the resident was cognitively nsive assist with toileting, and ntinent of urine.		Bowel and Bladder Assessment completed 3/2/16 for R154. Carep reviewed and ammended to reflec current plan of care for toileting.	t R154	
	had bladder inconti	ated 10/08/15, indicated he nence and wore briefs.		All Residents careplans were revie and revised as needed to support individualized care provided in a d manner.		
	was sitting in his re incontinence brief v way sitting on the fl	2/10/16, at 6:51 a.m. R163 cliner chair, and a soiled, white vas observed from the hall oor behind his wheelchair.		Nursing staff will be re-educated 2 thru 3/11/16 on facility policy and procedure for resident dignity inclu proper disposal of incontinent pro	uding ducts	
	stated he was not a was on the floor ne	10/16, at 6:52 a.m. R163 aware the incontinence pad xt to him and stated, "I have not want them to see that."		and timely assistance with resider toileting needs Random audits for implementation		

Facility ID: 00898

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TATEMENT	OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245149	B. WING _		02	2/11/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
GOOD S	AMARITAN SOCIET	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 241	Continued From p	age 10	F 2	41		
	nurse (RN)-E state	(10/16, at 7:00 a.m. registered ed the pad should not be on the see, and RN-E then entered oved the pad.		toileting plan as carepla disposal of incontinent p done weekly for 1 month months, and quarterly th coordinated by the nurs Findings will be reported	broducts will be h, monthly for 3 hereafter as e manager. d to the QAPI	
	he was cognitively	IDS dated 11/12/15, indicated intact, needed extensive leting, and was frequently e.		committee for further ex recommendations.		
		lated 9/01/15, indicated he had ce and preferred a urinal or prief.				
	stated at times his minutes, and state into the bathroom. to tell them I peed me." R154 stated	(10/16, at 7:12 a.m. R154 call light was left on for over 30 d, "I am in bed wanting to go It's embarrassing when I have by pants again, please change he had incontinence episodes he had to wait so long for staff ally at night.				
	Report dated from	ler Documentation Survey 2/1/16, to 2/11/16, R154 was e five times at 7:00 p.m.				
	stated the facility of however, they wer print out to see ho being left on. RN-4 audit on 1/28/16, h	(11/16, at 10:58 a.m. RN-A loes random call light audits, e not able to do a computerized w long R154's call light was A was able to provide one call lowever, only the morning ed, and the facility was unable ning audits.				

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		AND HUMAN SERVICES & MEDICAID SERVICES		F	TED: 03/07/2016 ORM APPROVED NO. 0938-0391
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION (X3	B) DATE SURVEY COMPLETED
		245149	B. WING _		02/11/2016
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD SA	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 241 F 282 SS=D	promote care for re environment that m resident's dignity an his or her individual indicated "Refrainin to residents such as bags uncovered, re residents request for 483.20(k)(3)(ii) SEF PERSONS/PER CA The services provide must be provided b accordance with ea care. This REQUIREMEN by: Based on observat review, the facility fa interventions were for residents (R34) rev	icated, "The facility will sidents in a manner and in an aintains or enhances each ad respect in full recognition of lity." The policy further ng from practices demeaning s keeping urinary catheter fusing to comply with a or toileting." RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility y qualified persons in the resident's written plan of NT is not met as evidenced tion, interview, and document ailed to ensure care plan followed by staff for 1 of 3 iewed for accidents and for 1	F 24	F282 R34 had care plan reviewed on 2/18/1 for current fall interventions including f	all
	of 3 residents (R37) pressure ulcers. Findings include:) reviewed for toileting and		mats, low bed and call light within read all interventions were in place. R37 was reassessed for toileting plan	
	R34's admission Mi 1/13/16, indicated F	inimum Data Set (MDS) dated R34 had moderate cognitive		2/18/16 and care plan was revised to reflect change in tolieting plan.	
	failure. The MDS i extensive assist of dressing, bed mobil	ncer, anemia, and heart indicated the resident needed two with transfers, toileting, lity, was incontinent of bowel		Care plan interventions for R34 and R are appropriately implemented by care staff.	9
		ad no falls in the last month. red 1/14/16, indicated the		All residents care plans were reviewed and revised as needed to reflect individualized current plan of care.	Ŀ

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		AND HUMAN SERVICES				FORM	03/07/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245149	B. WING			02 / ⁻	1/2016
	PROVIDER OR SUPPLIER	- AMBASSADOR		8	TREET ADDRESS, CITY, STATE, ZIP CODE 100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	resident had metas mass, was at risk for mobility, had a histor mat, concave mattr care plan directed call light with in her During observation observed laying in H observed in the low mat on the floor. During observation observed laying in H the low position, ho folded up against t tank. During interview 2/S nurse (RN)-I stated floor and the bed sh all times. RN-I enter the fall mat on the f During observation observed laying in H low position with fall the residents call lig floor out of R34's re (DON) was informe R34's reach, and sh and gave her the cal During interview 2/- stated she didn't kn the low position, an NA who was workin the NA stated she t	tic breast cancer with brain or falls related to impaired bry of falls, had low bed, floor ress, and a body pillow. The staff to ensure R34 had her reach. 2/9/15, at 8:21 a.m. R34 was her bed. R34's bed was not position, nor was there a floor 2/9/15, at 9:32 a.m. R34 was bed dressed. The bed was in wever, the floor mat was he wall behind the oxygen 9/16, at 11:39 a.m. registered the fall mat should be on the hould be in the low position at ered R34's room and placed floor next to resident. 2/10/16, at 8:01 a.m. R34 was bed and the bed was in the Il mat on the floor. However, ght was observed laying on the each. Director of nursing ed of the call light being out of he entered the residents room	F 2	82	Nursing staff will be re-educated 2/ thru 3/11/16 on facility policy and procedure for following resident s individualized care planned interver Random audits on care provided fo residents individualized plan of care be done weekly for 1 month, month months, and quarterly thereafter as coordinated by the nurse manager. Results of audits will be reviewed a analyzed by nurse manager with ch implemented as needed. Findings of reported to the QAPI committee for evaluation and recommendations.	ntions. Ilowing e will ily for 3 f nd nanges will be	

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DA	<u>). 0938-039</u> TE SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CO	MPLETED
		245149	B. WING		02/11/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 282	interventions in placincluding having the resident will use R37's admission M 1/7/16, identified R3 impairment, was free bladder and bowel, development of preextensive assistance personal hygiene, a staff for transfers a R37's care plan data bowel and bladder weakness and impairment bladder weakness and impairment bladder weakness and impairment (and as need check/change ever while asleep. The assist R37 with turr every two hours with During continuous 7:23 a.m. to 10:17 toileting, checked/ or repositioned for two stated R37 was to I toileted every two hours in bed was not indicing positioning, toileting to the toileted every two hours in bed was not indicing positioning, toileted every two hours in bed was not indicing positioning, toileted every two hours in bed was not indicing positioning, toileted every two hours in bed was not indicing positioning, toileted every two hours in bed was not indicing positioning, toileted every two hours is to be to be a state of the toileted every two hours is the toileted every two hours to the toilet	have all the assessed ce according to the care plan, e call light available because e it to call for staff assistance. inimum Data Set (MDS) dated 37 had no cognitive equently incontinent of both was at risk for the essure ulcers, required ce from staff for toilet use and and was totally dependent on	F 2	82		

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATI	E SURVEY PLETED
		245149	B. WING _		02 /*	11/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 309 SS=D	ask R37 if she wou offload her bottom, utilize the bedpan. planned intervention toileting were not for observations. A facility Care Plan indicated, "Residen the necessary care highest practicable the comprehensive will have an individu care that will include timetables directed maintaining the res nursing physical, fu psychosocial and e use of departmenta Assessment Instrum physician's orders, concerns identified 483.25 PROVIDE C HIGHEST WELL B Each resident must provide the necessa or maintain the high mental, and psycho accordance with the and plan of care. This REQUIREMEN by: Based on observat	Id like to be repositioned to have her brief changed, and RN-A stated R37's care ns for repositioning and illowed during the above Policy dated September 2013, ts will receive and be provided and services to maintain the well-being in accordance with assessment. Each resident ualized comprehensive plan of e measurable goals and toward achieving and ident's optimal medical, nctional, spiritual, emotional, ducational needs. Through Il assessments, the Resident ment and review of the any problems, needs and will be addressed." CARE/SERVICES FOR	F 28			3/16/16

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STATEMEN	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		045140	B. WING	۵		
	PROVIDER OR SUPPLIER	245149		STREET ADDRESS, CITY, STATE, ZIP COD		11/2016
	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 309	were in place to rel (R154) with pain. Findings include: R154's quarterly Mi 11/12/15, indicated was on a scheduled (as needed) pain m occasional to mode R154's care plan da chronic pain/discon gout, and neuropat medications. The of staff to, "Report to activity attendance activities related to c/o (complaints of) health care provide unsuccessful or if of significant change for of pain." A Care Area Assess 5/25/15, indicated ff worsening right hip indicated the pain a R154 Pain Data Co indicated R154 had was frequent on all The form indicated 6 (on a scale from pain) and had voca expressions of pain	inimum Data Set (MDS) dated he was cognitively intact and d pain regimen, received prn hedications, and had	F 30	9 R165 had pain data tool comp 2/15/16. Orders were received medication, Gabapentin on 2/ Orders for OT and PT were re 2/15/16 to evaluate and treat f pain, knee pain, e-stim and TE Pain assessment completed of Careplan was reviewed and re new interventions for pain main All residents at risk for pain were reassessed for pain and effect pain management intervention Changes to pain managemen were received and implement needed. Care plans were revier revised as needed with chang management interventions Licensed Nurses were re-edur 2/17/16 - 3/11/16 on facility po procedures for pain managem including effectiveness of pain management interventions. Random Audits of residents to effectiveness of pain intervent done weekly for 1 month, mor months and quarterly thereaft directed by Nurse Managers v implemented as needed. Find reported to the QAPI committe evaluation and recommendati	d for new 15/16. ceived on or hand ENS unit. on 2/22/16. evised with nagement ere ctiveness of ns. t program ed as ewed and es in pain cated licy and nent o review ions will be othly for 3 er as with changes dings will be ee for further	

If continuation sheet Page 16 of 46

		AND HUMAN SERVICES				FORM	03/07/2016 APPROVED 0938-0391
		. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245149	B. WING			02/	11/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		-	100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	had no changes in on a scheduled pair Resident/Family Ec c/o increased pain Goal is tolerable pain eeded." A Pain Data Collect R154 had pain in hi extremity, rated his body movements o day-to-day activities interest pursuits, ar The Pain Data Colle not received PRN p "Current Treatment pain". R154's current phys 2016, indicated he (hydrochloride) 5 m analgesic used for tablet three times a indicated the start of 8/14/15. R154 also HCL 5 mg every for do not exceed six ta of 6/26/15. R154 al 325 mg two tablets needed for headach 5/31/15. R154's medication dated 2/1/16, to 2/1 R154 did not receiv medications.	ge 16 r limit his day to day activities, appetite/eating ability, and was n medication regimen. Under lucation indicated, "Resident (nothing new) over a few days. in. PRN's to be offered as tion dated 2/7/16, indicated is entire back and right lower pain at a 5, made protective r postures due to pain, limited s because of pain, decreased nd had irritability and anger. ection also indicated he had bain medication and the, plan addresses resident's sician orders dated February received Oxycodone HCL illigrams (mg) (a narcotic moderate to severe pain) one day for pain. The orders date of the medication was o had an order for Oxycodone ur hours as needed for pain; ablets per day with a start date lso had an order for Tylenol by mouth every 4 hours as he pain with a start date of administration record (MAR) 0/16, at 2:31 p.m. indicated re any of his PRN pain	F 3	309			

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		AND HUMAN SERVICES			FORM	03/07/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245149	B. WING		02/11/2016	
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR	-	100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	indicated R154 had physician had incre used for gout) and a used for gout), and morephine (a pain in however, his morph to sedation and need effects of opioid). A HealthPartners S indicated R154 use his "Mobility limited pain." A Park Nicollet Sen Visit Note dated 2/3 Park Nicollet team, syndrome and had years and was rece day as well as prn. current pain regime During interview on he felt his leg pain in his pain medication the nurses he want however, "I get no a say they will contac heard back and I as The nurse practioner rarely. I haven't hav the pain, she doesr pain. They are doir stated his pain was During a follow up i p.m. R154 stated h but it didn't help, so	I gout in his knee and the ased allopurinol (a medication added cholchicine (medication he had been receiving medication for severe pain), hine tablets were stopped due eding narcan (reverses the Gubsequent visit dated 1/4/16, d a scooter for mobility and by chronic right lower ext ior Services Nursing Home B/16, indicated he was new to and R154 had chronic pain been on narcotics for several siving oxycodone three times a There was no indication if the en was effective. 2/8/16, 6:43 p.m. R154 stated was getting worse, he wanted s increased, and he had told ed more pain medication, answer and they [the nurses] t the nurse practioner. I never sk again and never hear back. er comes and see's me but d a chance to talk to her about o't come and ask me about my ng nothing for me." R154	F 309			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DA	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
			NG					
		245149	B. WING _			/11/2016		
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - AMBASSADOR				STREET ADDRESS, CITY, STATE, ZIP C 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427	ODE	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP	SHOULD BE	(X5) COMPLETIC DATE		
F 309	level of 5. During interview 2/ ² assistant (NA)-B sta and he has a lot of back, and because to transfer or ambu stay in bed because During observation was observed to tra NA-C situated a cha the bed and placed in front of R154 with briefly repositioned an audible sigh and noted. NA-C asked today?Where?" F my legs." Once all "Take your time" se first attempt to stan on his legs and fee quickly returned to wheelchair. He wa heavily, and then b transfer, and again heavily with his mon closed, as he took a bed. With contact of wheelchair and place The NA repeated se do you want me to declined for the aid seated on the bed,	d that he is very rarely at a 10/16, at 1:01 p.m. nursing ated she worked with R154 pain in his right leg and his of the pain R154 would refuse late, and at times would just e of the pain. 2/10/16, at 2:27 p.m. NA-C ansfer R154 in his room. air at a 45 degree angle from a four wheeled walker (4WW) h the brakes applied. R154 himself in his wheelchair and I vocalization of "Ah" were						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES								APPROVED		
CENTERS FOR MEDICARE & MEDICAID SERVICES								MB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED				
		245149	B. WING	i			02 / ⁻	1/2016		
NAME OF	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE					
GOOD	SAMARITAN SOCIETY	- AMBASSADOR			8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427					
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX i	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE		(X5) COMPLETION DATE		
F 309	Continued From pa	ge 19	F	309)					
	the following: -On 2/3/16, 4:26 p.I Physician Note Tex NP (nurse practione (Transcutaneous E which is predominal pain conditions) uni- knee if that was pos- Awaiting return call -A physician order w days after the reque- evaluate right knee tens unit. -On 2/4/16, at 3:00 resident but he refu- -On 2/5/16, at 8:58 -On 2/9/16, at 10:00 dinner. He wheeled wheelchair. -On 2/10/16, at 3:24 with Physician Note- residents c/o pain in continues to c/o "sh denied that it is rad requested PRN pai Continue to monitor - On 2/10/16, at 10:35 buring interview on	 was received 2/11/16, eight est for physical therapy to pain and appropriateness of p.m. staff approached to walk used due to pain. p.m. resident refused to walk. p.m. patient did not walk to d himself out in his electric 4 p.m. Communication/Visit e Text: NP updated on hilateral hands. Resident harp pain" in his hands. He iating from anywhere. He has n pills this shift, with little relief. r and update NP. i01 p.m. resident refused tay." Pain 								

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		AND HUMAN SERVICES				FORM	03/07/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245149	B. WING			02/	11/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR			100 MEDICINE LAKE ROAD EW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	having increased particular and had been medication. During interview on registered nurse (R manager for R154's was having pain. F switched to a new of practioner and physi- to additional pain m nurses. In addition aware a request for she would call the N During interview on stated she worked th had a pain rating of resident has had in During interview on p.m. NA-C stated F morning and afterna- his pain medication three weeks R154's Although R154 repo- refusing to ambulat the pain, the facility if any further interve- to decrease the ress A facility policy titleo Assistance policy is indicated the purpo- assistance in pain r residents will receiv consultations on as	ain and he asked for a PRN in asking more for his pain 2/10/16, at 2:30 p.m. RN)-A stated she was the sunit and was not aware R154 RN-A stated he had recently doctor and his previous nurse sician were not very receptive hedication requests from the RN-A stated she was not r a tens unit was made and NP and re-request the order. 2/11/16, at 9:31 a.m. RN-F the day shift and R154 usually f 7/10, and recently the creased complaints of pain. 2/11/16, at approximelty 1:50 R154 complained of pain in the oons and had been requesting nore often, and felt in the last s pain has been increasing. 0 orted increased pain, was te, and was observed to be in r did not reassess to determine entions could be implemented sidents pain. d Pain Management-Resident asued September 2012, use was to provide resident management and, "All	F 3	09			

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE		
ND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:		IG	СОМ	PLETED	
		245149	B. WING _		02/	11/2016	
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE	
F 309 F 314 SS=D	the physician and ir interventions that m well as pharmacolo will review response and work closely wi the individualized pa	pain levels and develop with neterdisciplinary team hay be non-pharmacological as gical. The registered nurse to medication interventions th the physician to assist in ain measurement plan." ENT/SVCS TO	F 30			3/16/16	
	resident, the facility who enters the facil does not develop p individual's clinical they were unavoida pressure sores rece	prehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that uble; and a resident having eives necessary treatment and a healing, prevent infection and from developing.					
	by: Based on observat review, the facility far repositioning were of prevent pressure ull reviewed who was ulcer development. Findings include: R37's admission M 1/7/16, identified R3 impairment, was free bladder and bowel, development of pre	inimum Data Set (MDS) dated 37 had no cognitive equently incontinent of both		F314 Turning/repositioning plan for R37 reviewed and careplan reflects cur plan of care. Reviewed with staff to ensure care planned intervention is implemented. R37 was reassessed toileting plan on 2/18/16 and care was revised to reflect current toliet plan. Residents at risk for pressure ulce have careplan reviewed, and revis needed and implemented to preve breakdown.	rrent o s d for plan ing rs will ed if		

Facility ID: 00898

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TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
	245149	B. WING			11/0010
NAME OF PROVIDER OR SUPPLIER	243143	D. mild	STREET ADDRESS, CITY, STATE, ZIP CC		11/2016
GOOD SAMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
 staff for transfers a R37's Care Area A 1/12/16, indicated fracture, was weak non-weight bearing The CAA identified from skin breakdow use of an incontine R37's Positioning A 1/3/16, identified R with repositioning a repositioning every R37's care plan da bowel and bladder weakness and imp directed to offer an hours (and as need check/change ever while asleep. The assist R37 with tur every two hours wi R37's Braden Scal Risk dated 2/6/16, identifying R37 was development of pressisted with to knew of at least on wait through the su incontinence product 	and was totally dependent on and bed mobility. ssessment (CAA) dated R37 had a prosthetic knee a, de-conditioned, and g on her right, lower extremity. a goal for R37 to remain free wn related to incontinence and ence brief. Assessment & Evaluation dated 37 required total assistance and directed staff to offer a two hours. ted 2/2/16, identified R37 had incontinence related to aired mobility, and staff were id assist with toileting every two ded) while awake, and to ry two hours (and as needed) care plan also directed staff to ning and repositioning at least th use of a mechanical lift. e for Predicting Pressure Sore indicated a score of 16/18, s at mild risk for the essure ulcers. e interview on 2/8/16, at 7:36 er (FM)-A stated R37 did not bileting timely, and stated she ue instance where R37 had to upper meal for her soiled	F 3	14 All nursing staff will be re-edi 2/16/16 thru 3/11/16 on indiv toileting programs, incontine turning and repositioning foll- individualized plan of care. Random audits on turning an repositioning toileting and ind care will be done weekly for monthly for 3 months, and qu thereafter as coordinated by Manager. Results of audits will be revie analyzed by nurse manager changes implemented as ne Findings will be reported to th committee for further evaluat recommendations	idualized nce care, and owing nd continence 1 month, uarterly the Nurse ewed and team with eded. he QAPI	

If continuation sheet Page 23 of 46

		& MEDICAID SERVICES				0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
		245149	B. WING _		02/11/2016		
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
F 314	7:23 a.m. to 10:17 a toileting, checked/o repositioned for two Observations includ At 7:23 a.m., R37 v assistant (NA)-G w At 7:30 a.m., NA-G incontinence produ her wheelchair usin staff to transfer. At 7:45 a.m., NA-G room for the breakf At 9:00 a.m., R37 v room after breakfas (across from the dii watched television At 9:20 a.m., R37 r wheelchair in the da "See how late they had not yet receive nor had she been a and R37 visibly and At 9:40 a.m. R37 as staff member on he (RN)-G was asked RN-G, "Well I'd like RN-G assisted R37 her the call light, ar not offer toileting, c repositioning to R37 At 9:57 a.m., NA-G offered to assist he NA-G got another s transferring R37 int At 10:07 a.m., NA-G (LPN)-G used a me bed and proceeded	a.m., R37 was not offered changed, or turned/ o hours and 37 minutes. ded the following: vas lying in bed and nursing as present in the room. checked/ changed R37's ct before assisting R37 to sit in ig a mechanical lift and two brought R37 to the dining fast meal. vas moved from the dining st, to an alcove/ day room area ning room), where the resident with two of her peers. emained seated in her ay room area and R37 stated, get?" The resident stated she d her morning medications, assisted with her exercises, d audibly sighed several times. sked the surveyor to find a er behalf and registered nurse to assist R37. R37 stated to a to get back to my room." T to her resident room, handed and exited the room. RN-G did hecking/ changing or turning/ 7. entered R37's room and r into bed. R37 accepted and staff member to assist with	F 3 ⁻				

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		AND HUMAN SERVICES	-			FORM	D: 03/07/2016 MAPPROVED D: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRI			TE SURVEY MPLETED
		245149	B. WING _			02	2/11/2016
NAME OF F	PROVIDER OR SUPPLIER	•	·		DRESS, CITY, STATE, ZIP CO		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR			CINE LAKE ROAD E, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORF ACH CORRECTIVE ACTION S SS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314	herself during this of At 10:17 a.m., NA-C checked/ changed, every two hours. Progress Notes fro were reviewed and refusing or declinin repositioning and c incontinence produ During a continuou 8:23 a.m. to 11:29 a toileting, checked/or repositioned for thr Observations inclue At 8:23 a.m., R37 v table, awaiting her At 9:06 a.m., R37 s the day room area. brought her to her r medication and the room. RN-H did no change, or reposition At 10:09 a.m., NA-/ if she wanted to lay down, however, NA check/ change her offload R37. No er was provided to pre At 10:31 a.m., an a attend an exercise and remained seator room. At 10:46 a.m., NA-/	mall void of urine. ved to offload or reposition observation. G stated R37 was to be and turned/ repositioned m 12/31/15, through 2/10/16, lacked evidence of R37 g cares, including turning/ hecking/ changing her ct. s observation on 2/11/16, from a.m., R37 was not offered changed, or turned/ ee hours and five minutes. ded the following: vas seated at the dining room breakfast meal. self-propelled her wheelchair to RN-H approached her, room, administered eye drop n returned R37 to the day ot offer to toilet or check/ on R37. A approached R37 and asked r down. R37 declined to lay A did not offer to reposition or necuragement or education event skin breakdown. ctivities staff invited R37 to group. R37 declined this offer ed in her wheelchair in the day A was interviewed and stated	F 3	4			
	offload R37. No er was provided to pre At 10:31 a.m., an a attend an exercise and remained seate room. At 10:46 a.m., NA-/ R37 was to be chee	acouragement or education event skin breakdown. ctivities staff invited R37 to group. R37 declined this offer ed in her wheelchair in the day					

If continuation sheet Page 25 of 46

		AND HUMAN SERVICES				FORM	: 03/07/2016 APPROVED . 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		E SURVEY IPLETED
		245149	B. WING			02/	11/2016
NAME OF PF	ROVIDER OR SUPPLIER		•	;	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD SA	MARITAN SOCIETY	- AMBASSADOR			8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	last checked/ chang at 8:00 a.m. NA-A R37 earlier and ask down, but the resid NA-A stated she int refusal to be check repositioned. NA-A approach R37 ever wanted to lay down lay down staff would NA-A then proceed residents, and R37 toilet and/or checke repositioned. At 11:05 a.m., the s staff would expect to changing and turnir which time NA-A ap she could take her incontinence brief. brought the residen RN-H to assist. NA transferring R37 to changed her incont and five minutes be offloading. R37's b slightly pink, but bla confirmed. At 11:29 a.m., NA-A brief she had a sma small void of urine i During interview on stated R37 was to b every two hours an RN-H stated she fe down did constitute	ge 25 to bed. NA-A stated R37 was ged and turned/ repositioned stated she had approached ked her if she wanted to lay ent declined to lay down. erpreted R37's response as a ed/ changed and/ or a stated she attempted to y two hours and ask if she , and if the resident agreed to d check and change her. ed with assisting other had still not been offered to ed/ changed or turned/ surveyor asked NA-A when to offer toileting, checking/ ng/ repositioning to R37, at oproached R37 and asked if to her room to check her R37 accepted and NA-A at to her room, and asked A-A and RN-H proceeded with her bed and checked and inence brief, with three hours etween changes and ottom was observed as anchable, which RN-H A stated when changing R37's all bowel movement and a in her incontinence brief. 2/11/16, at 2:25 p.m. RN-H be repositioned and toileted d was usually incontinent. It NA-A's offer for R37 to lay an offer for turning/ bileting or checking/ changing,	F	314			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· /	E SURVEY IPLETED	
	or connection	IDENTIFICATION NOMBER.	A. BUILDING	à	CON	IFLETED	
		245149	B. WING		02/	11/2016	
	PROVIDER OR SUPPLIER	- AMBASSADOR	STREET ADDRESS, CITY, STATE, ZIP CODE 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 314 F 315 SS=D	considered a refusa repositioning. During interview on stated R37 was to b toileted every two h in bed was not indic repositioning, toileti R37's declining to la refusals for these c staff should have sy have liked to be rep bottom, have her bu bedpan. RN-A stat interventions for rep not followed during The facility's policy Pressure Ulcer Pre Requirements date who are unable to r independently should directed by the care 483.25(d) NO CATH RESTORE BLADD Based on the reside	decline to lay down, that was al for toileting and 2/11/16, at 3:01 p.m. RN-A be turned/ repositioned and yours, and offering to lay down cative of an offer for turning/ ing or checking/ changing; and ay down did not equate ares. RN-A stated the facility pecifically asked if she would positioned to offload her rief changed, and utilize the ed R37's care planned positioning and toileting were the above observations. titled Skin Assessment, vention, and Documentation d 12/15, directed, "Residents reposition themselves and be repositioned as often as a plan approaches."	F 314			3/16/16	
	indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servi	s the facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder					

Facility ID: 00898

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		AND HUMAN SERVICES			FORM	03/07/2016 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED	
		245149	B. WING _		02/	11/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 315	Continued From pa	ge 27	F 3 ⁻	15			
	by: Based on observat review, the facility f in accordance with maintain as much u 1 of 3 residents (R3 incontinence. Findings include: R37's admission M 1/7/16, identified R3 frequently incontine was not on a toiletin extensive assistance personal hygiene, a staff for transfers a R37's Care Area As 1/12/16, indicated F fracture, was non-w lower extremity, and assistance from two identified R37 requited toileting, had function increased risk for u infection due to a p had increased urinat use of diuretic med R37's care plan dat bowel and bladder weakness and impa- directed staff to, "O "every two hours (a	essessment (CAA) dated R37 had a prosthetic knee weight bearing on her right, d required a total lift with o staff to transfer. The CAA ired maximum assistance with onal incontinence, was at an rinary incontinence and revious UTI, and may have ary frequency secondary to her ications. ted 2/2/16, identified R37 had incontinence related to aired mobility. The care plan ffer and assist with toileting ind as needed) while awake, ge every two hours (and as		F315 R37 Bladder assessement completed on 2/18/16 and was reviewed and revised current toileting needs of c offer changing every 2 hou communicated to staff. Sta current plan of care. All residents with toileting p careplan reviewed and rev to reflect individualized toile All nursing staff will be re-e 2/16/16 thru 3/11/16 on toil incontinence care and follo individualized plan of care. Random audits on toileting incontinence care will be de 1 month, monthly for 3 mon quarterly thereafter as coor Nurse Manager. Results of audits will be rev analyzed by nurse manage changes implemented as r Findings will be reported to committee for further evalu- recommendations	toileting plan to reflect R37 hecking and rs. Changes ff are following orograms had vised if needed eting needs. educated eting programs, wing and one weekly for nths, and rdinated by the viewed and er team with needed. o the QAPI		

If continuation sheet Page 28 of 46

ICAID SERVICES VIDER/SUPPLIER/CLIA TIFICATION NUMBER: 245149 SSADOR		OI IPLE CONSTRUCTION NG	(X3) DATE S COMPLE	URVEY
TIFICATION NUMBER:	A. BUILDIN			
I	B. WING _			
SADOR			02/11/	/2016
SADOR		STREET ADDRESS, CITY, STATE, ZIP CODE		
		8100 MEDICINE LAKE ROAD		
		,	1	(ME)
PRECEDED BY FULL FYING INFORMATION)	D PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE C	(X5) COMPLETION DATE
n	F 31	15		
w on 2/8/16, at 7:36 stated staff did not ely, and she knew of R37 had to wait her soiled changed. ation on 2/10/16, from 7 was not offered ed for two hours and ncluded the following: in her bed and as present in the d/ changed R37's e she was assisted to a mechanical lift and R37 to the dining l. ed from the dining m area (across from e watched television I seated in her area and stated, "See ated she had not yet cations, nor had she cises, and was surveyor to find a and Registered nurse R37's request for RN-G, "Well I'd like to G assisted R37 to her the call light and not offer toileting				
	PF DEFICIENCIES PRECEDED BY FULL FYING INFORMATION) w on 2/8/16, at 7:36 stated staff did not ely, and she knew of R37 had to wait ther soiled changed. ation on 2/10/16, from 7 was not offered ed for two hours and ncluded the following: in her bed and as present in the d/ changed R37's e she was assisted to a mechanical lift and R37 to the dining l. ed from the dining m area (across from e watched television seated in her area and stated, "See ated she had not yet cations, nor had she cises, and was surveyor to find a and Registered nurse R37's request for RN-G, "Well I'd like to G assisted R37 to her the call light and not offer toileting	PF DEFICIENCIES ID PRECEDED BY FULL PREFIX FYING INFORMATION) PREFIX F 31 w on 2/8/16, at 7:36 stated staff did not ely, and she knew of R37 had to wait her soiled changed. ation on 2/10/16, from 7 was not offered ed for two hours and ncluded the following: in her bed and as present in the d/ changed R37's e she was assisted to a mechanical lift and R37 to the dining l. ed from the dining marea (across from e watched television seated in her area and stated, "See ated she had not yet cations, nor had she cises, and was surveyor to find a and Registered nurse R37's request for RN-G, "Well I'd like to G assisted R37 to her the call light and	SSADOR Status (Construction) PEPECIENCIES PRECEDED BY FULL -YING INFORMATION) ID PRECENT (Construction) PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY) v on 2/8/16, at 7:36 stated staff did not ely, and she knew of R37 had to wait ther soiled changed. F 315 ation on 2/10/16, from 7 was not offered ed for two hours and necluded the following: in her bed and as present in the d/ changed R37's e she was assisted to a mechanical lift and R37 to the dining marea (across from e watched television R37 had to wait seated in her area and stated, "See ted she had not yet vaitons, nor had she cises, and was surveyor to find a and Registered nurse R37's request for RN-G, "Well I'd like to G assisted R37 to her the call light and not offer toileting	SSADOR 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427 IF DEFICIENCIES PRECEDED BY FULL TAG ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C V on 2/8/16, at 7:36 stated staff did not ely, and she knew of R37 had to wait ther solied changed. F 315 F ation on 2/10/16, from 7 was not offered def for two hours and nocluded the following: in her bed and as present in the d/ changed R37's e she was assisted to a mechanical lift and R37 to the dining l. ed from the dining m area (across from e watched television R37 to the dining l. ed from the dining m area (across from e watched television seated in her area and stated, "See tated she and not yet vations, nor had she cises, and was See surveyor to find a and Registered nurse R37's request for NN-G, "Well I'd like to G assisted R37 to her the call light and not offer toilelting

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		& MEDICAID SERVICES				0.0938-039		
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED		
		245149	B. WING		02/11/2016			
NAME OF	PROVIDER OR SUPPLIER	• •		STREET ADDRESS, CITY, STATE, ZIP CC	DE			
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE		
F 315	At 9:57 a.m., NA-G offered to assist he NA-G sought anoth the transfer. At 10:05 a.m., while of the room to find stated staff did not commode or bedpa did not believe she commode because non-weight bearing At 10:07 a.m., NA-((LPN)-G used a me bed, and NA-G the R37's incontinence minutes between c use of a toilet or be At 10:17 a.m., NA-(checked/ changed use a bedpan or to incontinent, and NA incontinence brief of Progress Notes fro were reviewed and refusing or declinin of a bedpan and ch incontinence produ During a continuou 8:23 a.m. to 11:29 a toileting or checked five minutes. Obse following: At 8:23 a.m., R37 w table waiting for bre At 9:06 a.m., R37 s	entered R37's room and or into bed. R37 accepted and her staff person to assist with e NA-G had again stepped out another staff person, R37 offer her use of the toilet, an for toileting, and stated she could use the toilet or of her leg injury and status. G and licensed practical nurse echanical lift to transfer R37 to n proceeded with changing brief, with two hours and 37 hanges. R37 was not offered adpan. G stated R37 was to be every two hours and did not ilet because she was always A-G confirmed R37's contained a small void of urine. m 12/31/15, through 2/10/16, lacked evidence of R37 g cares, including toileting/ use necking/ changing her ct. s observation on 2/11/16, from a.m., R37 was not offered d/ changed for three hours and ervations included the was seated at the dining room	F 3	15				

If continuation sheet Page 30 of 46

STATEMENT	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED
		245149	B. WING		0	2/11/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		2/11/2010
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE	(X5) COMPLETIC DATE
F 315	eye drop medicatio the day room. RN- check/ change R37 At 10:09 a.m., NA- if she wanted to lay offer, however, NA check/ change R37 At 10:31 a.m., an a attend an exercise and remained seat room. At 10:46 a.m., NA- R37 was to be che hours, using a med bed. NA-A stated I changed at 8:00 a. approached R37 e wanted to lay dowr NA-A stated she in refusal to be check would approach R3 she wanted to lay o check and change use a toilet or com mechanical sling lif did not use a bedp proceeded with ass had still not been o changed. At 11:05 a.m., the s R37 would be offer approached R37 a to her room to check accepted and NA-A before seeking a si the transfer. NA-A the room to assist	A approached R37 and asked down. R37 declined this -A did not offer to toilet or 7. A approached R37 and asked down. R37 declined this -A did not offer to toilet or 7. activities staff invited R37 to group, which R37 declined ed in her wheelchair in the day A was interviewed and stated cked/ changed every two chanical lift to transfer her into R37 was last checked/ m. and stated she had arlier and asked her if she b, but the resident declined. terpreted R37's response as a ed/ changed, and typically she 87 every two hours and ask if down, which is when she would R37. NA-A stated R37 did not mode because she required a t for transfers, and stated R37 an either. NA-A then sisting other residents and R37 ffered to toilet or be checked/ surveyor asked NA-A when ed toileting again, and NA-A nd asked if she could take her ck her incontinence brief. R37 A brought her to her room econd staff person to help with returned and RN-H entered with transferring R37 to bed nging her incontinence brief,	F 3	315		

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		AND HUMAN SERVICES				FORM	: 03/07/2016 APPROVED . 0938-0391	
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED	
		245149	B. WING _			02/	11/2016	
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 315	bowel movement a incontinence brief. observed offering F this observation, N bedpan and R37 de During interview or stated R37 was to and was usually ind she and NA-A did of the above noted ob RN-H stated that sl lay down did consti checking/ changing offer equated a refu During interview or confirmed R37 was bedpan every two f offered a bedpan d bowel in her incont offer to lay down in offer for toileting or R37's declining to I refusal for toileting. have specifically as have her brief char staff were not follow interventions for toi The facility's Bowel Evaluation and Ret directed staff to enso or bladder incontine treatment and serv	A stated R37 had a small ind a small void of urine in her Though staff were not R37 the use of a bedpan during A-A stated she did offer the eclined. 1 2/11/16, at 2:25 p.m. RN-H be toileted every two hours continent. RN-H stated that offer a bedpan to R37 during oservation, but R37 declined. he felt NA-A's offer for R37 to tute an offer for toileting or g, and R37's decline to this usal. 1 2/11/16, at 3:01 p.m. RN-A s to be offered the use of a nours, and should have been espite identification of urine or inence brief. RN-A stated an bed was not indicative of an checking/ changing, and ay down did not equate a . RN-A stated staff should sked if she would have liked to nged and use the bedpan, and wing R37's care planned	F 31	15				

If continuation sheet Page 32 of 46

		AND HUMAN SERVICES			FO	RM APF	/07/2016 PROVED 38-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SUI COMPLET		
		245149	B. WING	i		02/11/2016		
NAME OF I	PROVIDER OR SUPPLIER	L			TREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COI	(X5) MPLETION DATE	
F 323 SS=D	SS=D HAZARDS/SUPERVISION/DEVICES		F:	323		3/1	6/16	
	environment remain as is possible; and	sure that the resident ns as free of accident hazards each resident receives on and assistance devices to						
	by: Based on observat review the facility fa assess and implem risk of falls for 1 of accidents hazards. Findings include: R34's admission M 1/13/16, indicated F impairment, had ca failure. The MDS i extensive assist of dressing, bed mobi and bladder, and ha R34's Care Area As 1/13/16, indicated t with transfers, rece difficulty maintaining balance during tran falls would be addre goal of preventing f R34's care plan dat	NT is not met as evidenced tion, interview, and document ailed to comprehensively tent interventions to reduce the 3 residents (R34) reviewed for inimum Data Set (MDS) dated R34 had moderate cognitive ncer, anemia, and heart indicated the resident needed two with transfers, toileting, lity, was incontinent of bowel ad no falls in the last month. Seessment (CAA) dated he resident was not steady ived an antidepressant, had g balance, and had impaired sitions. The CAA indicated essed in the care plan with a alls.			F323 R34 was assessed for a need of a call light clip. Call light clip was attached to call light cord on 2/10/16. Falls assessment was completed for R34 3/1/16. Care plan reviewed and revised with additional fall interventions. Residents at risk for falls had assessments and care plans reviewed f ensure all care planned interventions we appropriate and in place. Revisions we completed if needed. Nursing Staff were re-educated 2/16/16 through 3/11/16 on fall prevention, management, assessing and care planning with fall interventions and ensuring all careplanned interventions and ensuring all careplanned interventions and visual observations of careplanned fall interventions will be completed weekly f 1 month, monthly for 3 months, and	o ere re		

Facility ID: 00898

SUMMARY STA (EACH DEFICIENC) REGULATORY OR L ntinued From pa ss, was at risk fo	IDENTIFICATION NUMBER: 245149 - AMBASSADOR TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	B. WING	SSS STREET ADDRESS, CITY, STATE, ZIP CODE 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427 PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	02/-	(X5) COMPLETIO
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ntinued From pa ss, was at risk fo	- AMBASSADOR TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427 PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL	ON D BE	(X5)
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ntinued From pa ss, was at risk fo	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427 PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL	D BE	
SUMMARY STA (EACH DEFICIENC) REGULATORY OR L ntinued From pa ss, was at risk fo	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	NEW HOPE, MN 55427 PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL	D BE	
(EACH DEFICIENC) REGULATORY OR L ntinued From pa	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	
ss, was at risk fo	ae 33		DEFICIENCY)		DATE
t, concave mattr e plan directed l light with in her Incident Report icated, "Writer w swer a light, whe p. Resident [R3 e on the floor by icated she receivents, and an air ow d a low bed and divided to residen Incident Report icated, "Resident or in resident's room mach at foot of the ce and time. She report indicated roose and the ce sed area on the l ad. The report a opers on and a fluor near her bed.	or falls related to impaired bry of falls, had low bed, floor ress, and a body pillow. The staff to ensure R34 had her reach. dated 1/20/16, at 3:49 a.m. vas walking down the hall to en I heard a resident yelling for 4] was found lying on her left her bed." The report ved a skin tear on her left erlay mattress was removed concave mattress was t. dated 1/25/16, at 2:30 a.m. tt [R34] noted to be lying on boom, she was lying on her bed. Resident is confused to the states: "I slipped out of bed." d she had facial bruising on enter of her forehead, and a lower part of the back of her llso indicated she had gripper oor mat was placed on the 02/9/15, at 8:21 a.m. R34 was her bed. R34's bed was not	F 323	quarterly thereafter as coordinate DNS. Results of audits and investigation reported to the QAPI committee to further evaluation and recomment	ns will be for	
ic swip. e ic station in the second	ated, "Writer we ver a light, whe Resident [R3 on the floor by ated she receir , and an air ov a low bed and ided to residen ncident Report ated, "Residen in resident's ro- lach at foot of l e and time. She report indicate to area on the d area on the d. The report a ers on and a fl near her bed. In observation erved laying in l over a laying in l	ncident Report dated 1/25/16, at 2:30 a.m. ated, "Resident [R34] noted to be lying on in resident's room, she was lying on her each at foot of bed. Resident is confused to be and time. She states: "I slipped out of bed." report indicated she had facial bruising on nose and the center of her forehead, and a ed area on the lower part of the back of her d. The report also indicated she had gripper ers on and a floor mat was placed on the near her bed. mg observation 02/9/15, at 8:21 a.m. R34 was erved laying in her bed. R34's bed was not erved in the low position, nor was there a floor	ated, "Writer was walking down the hall to ver a light, when I heard a resident yelling for Resident [R34] was found lying on her left on the floor by her bed." The report ated she received a skin tear on her left , and an air overlay mattress was removed a low bed and concave mattress was ided to resident. ncident Report dated 1/25/16, at 2:30 a.m. ated, "Resident [R34] noted to be lying on in resident's room, she was lying on her vach at foot of bed. Resident is confused to e and time. She states: "I slipped out of bed." report indicated she had facial bruising on nose and the center of her forehead, and a ed area on the lower part of the back of her the report also indicated she had gripper ers on and a floor mat was placed on the near her bed. Ing observation 02/9/15, at 8:21 a.m. R34 was erved laying in her bed. R34's bed was not erved in the low position, nor was there a floor on the floor. Ing observation 02/9/15, at 9:32 a.m. R34 was erved laying in bed dressed. The bed was in pow position, however, the floor mat was	ated, "Writer was walking down the hall to ver a light, when I heard a resident yelling for Resident [R34] was found lying on her left on the floor by her bed." The report ated she received a skin tear on her left , and an air overlay mattress was removed a low bed and concave mattress was ided to resident. ncident Report dated 1/25/16, at 2:30 a.m. ated, "Resident [R34] noted to be lying on in resident's room, she was lying on her iach at foot of bed. Resident is confused to e and time. She states: "I slipped out of bed." report indicated she had facial bruising on nose and the center of her forehead, and a id area on the lower part of the back of her I. The report also indicated she had gripper ers on and a floor mat was placed on the near her bed. ng observation 02/9/15, at 8:21 a.m. R34 was inved laying in her bed. R34's bed was not inved in the low position, nor was there a floor on the floor.	ated, "Writer was walking down the hall to ver a light, when I heard a resident yelling for Resident [R34] was found lying on her left on the floor by her bed." The report ated she received a skin tear on her left , and an air overlay mattress was removed a low bed and concave mattress was ided to resident. ncident Report dated 1/25/16, at 2:30 a.m. ated, "Resident [R34] noted to be lying on in resident's room, she was lying on her each at foot of bed. Resident is confused to e and time. She states: "I slipped out of bed." report indicated she had facial bruising on nose and the center of her forehead, and a d area on the lower part of the back of her I. The report also indicated she had gripper ers on and a floor mat was placed on the near her bed. ng observation 02/9/15, at 8:21 a.m. R34 was inved laying in her bed. R34's bed was not inved in the low position, nor was there a floor on the floor.

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/07/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •				E SURVEY PLETED
		245149	B. WING			02 / ⁻	11/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR			3100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	nurse (RN)-I stated floor and the bed sh all times. RN-I enter the fall mat on the f During observation observed laying in b low position with fall the residents call lig floor out of R34's re (DON) was informe R34's reach, and sh and gave her the ca During interview 2/1 stated she didn't kn the low position, an NA who was workin the NA stated she t he had left the bed fall risk and should interventions in place light available beca call for staff assista A facility Fall Preven issued July 2015, in Approach-requires and taking steps to again. In a fall prev approach will incluce determine the caus analysis), identifying (interventions) to pr again."	 /9/16, at 11:39 a.m. registered the fall mat should be on the nould be in the low position at ered R34's room and placed loor next to resident. 2/10/16, at 8:01 a.m. R34 was bed and the bed was in the l mat on the floor. However, ght was observed laying on the each. Director of nursing ed of the call light being out of the call light being out of the entered the residents room all light. 10/16, at 12:31 p.m. RN-A now why R34's bed was not in d stated she had talked to the the g with R34 on 02/9/16, and hought during a physician visit up. RN-A stated R34 was a have all the assessed be, including having the call use the resident will use it to 		323			3/16/16
F 325 SS=D	483.25(i) MAINTAIN UNLESS UNAVOID		F (525			3/16/16

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM /	03/07/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	()	E SURVEY PLETED
		245149	B. WING	i		02/1	1/2016
NAME OF I	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR			100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	Continued From pa	ge 35	F	325			
	resident - (1) Maintains accept status, such as bod unless the resident demonstrates that the (2) Receives a thermonutritional problem.	cility must ensure that a stable parameters of nutritional by weight and protein levels, s clinical condition his is not possible; and apeutic diet when there is a					
	review the facility fareassess nutritional loss for 1 of 4 resid nutritional needs an Findings include: R72's quarterly Min 12/08/15, indicated impairment, felt deg dementia and heart with eating, and had R72's care plan dat resident had obesit exceeding needs, li high calorie foods a plan goal was for th weight of 278 lbs (p 2-4 lbs a month. Th had an amputee of	ion, interview, and document iled to comprehensively needs for a significant weight ents (R72) reviewed for id weight loss. imum Data Set (MDS) dated the resident had no cognitive pressed and tired, had failure, needed set up help d no swallowing problems. ed 2/14/14, indicated the y related to energy intakes mited mobility, and choosing it meals/snacks. The care he resident to maintain a bounds); or a gradual loss of the care plan indicated R72 her lower extremity, reflux disease, (a chronic			 F325 R72 was reassessed for nutritional to by Dietitian on 2/17/16. Recommendincreased assistance with feeding a meals and order for nutritional supp was received on 2/19/16. R72 was at to Nutrition Risk List and will continuible monitored monthly and as needed Care plan updated to reflect current dietary plan of care. All residents in facility were reviewed significant weight loss on 2/15/16. Residents with significant weight loss were reassessed by the dietitian. Nursing staff re-educated 2/16/16 th 3/11/16 on policy and procedure for weight monitoring and notifications to Dietitian with changes in weights. Dietitian weight care weights. 	ded t lement added ue to ed. d for ss nrough to	

Facility ID: 00898

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			OMB NO.	APPROVEI 0938-039
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245149	B. WING _			11/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIOI DATE
F 325	acid coming up from failure. A Dietary Profile da received a regular of supplements, and h A Mini-Nutritional As indicated she had m and had weight loss lbs). A Nutrition Risk Not resident was at nutri was sporadic and h last 14 days. The m facility would continne preferences, offer se would continue to m weight. R72's physician or the resident received fluid) 20 milligrams On 2/9/16, at 5:47 p a hamburger on a b R72 ate 50% of her wheelchair which has of her wheelchair in weighed 51.8 lbs. On 2/10/16, at 12:2 eating shrimp scam she ate 75% of her A facility Percentag 1/13/16, to 2/10/16, meals. R72's Vital Results weights: 12/2/15 - 260 lbs	n the stomach) and heart ted 12/07/15, indicated R72 diet, did not receive had an amputation. ssessment dated 12/07/15, to decrease in her food intake is greater than 3 kilograms (6.6 te dated 1/4/16, indicated rition risk, and her oral intake had 11 meal refusals with in the note further indicated the use to assess for food substitutions for meals, and nonitor her oral intake and ders dated 2/11/16, indicated ed Lasix (diuretic to remove (mg) twice a day for edema. b.m. R72 was observed eating bun, salad, and apple crisp. r meal. R72 was sitting in her ad a sticker taped to the back indicating the foot pedals 2 p.m. R72 was observed hpi and a baked potato, and meal. e Of Meal Eaten form dated indicated R72 refused 19 identified the following	F 32	Procedures for Monitor Impaired Nutrition, Nutrition 2/15/16. Dietitian will m vitals weekly to help ide fluctuations and reside Nutrition risk monitorin Random audits to ensu assessment for signific interventions are in pla weekly for one month, months and quarterly t of audits will be review DNS with changes imp needed. Findings will b QAPI committee for fur recommendations.	ritional Risk and onal Risk on nonitor weights and entify weight nts that require g. ure appropriate cant weight loss ce will be done monthly for 3 hereafter. Results ed by Dietitian and blemented as be reported to the	

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		AND HUMAN SERVICES				FORM	03/07/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245149	B. WING			02/	11/2016
	PROVIDER OR SUPPLIER	- AMBASSADOR		8	TREET ADDRESS, CITY, STATE, ZIP CODE 100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 325	1/20/16 - 286 lbs 1/27/16 - 285 lbs 2/03/16 - 263 lbs (22 lbs, no documer 2/11/16 - 245 lbs (2 no documentation a Although R72's wei 5.8 % weight loss f was no indication th determine why ther changes. During interview on registered nurse (R Lasix, however, aft stated it looked as inconsistency with wouldn't loose 20 lb she would have sta follow-up interview was weighed and th RN-A stated she fe be from R72 not ha however, RN-A wei which weighed 4.4 During interview 2// dietician (RD) state and felt the weights 280's were inaccura the weight from 12/ accurate for R72. working with staff to accurate weights, reweigh the resider lbs. RD stated R72 indicated it could be	285 to 263 lbs weight loss of htation as to why). 63- 245 weight loss of 18 lbs, as to why). ghts fluctuated and R72 had a rom 12/02/15, to 2/11/16, there he facility reassessed R72 to e were significant weight 2/10/16, at 12:22 p.m. N)-A stated R72 was on er reviewing the weights she f there was some the weights because, "You bs in one week," and stated ff reweigh the resident. In a at 2:22 p.m. RN-A stated R72 he weight was 242.6 lbs. It the weight fluctuation could ving her prosthetic leg on, ghed R72's prosthetic leg	F 3	225			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:096L11

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						. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245149	B. WING		02	/11/2016
NAME OF F	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 325	Continued From pa	ge 38	F 3	25		
	stated R72 should I had further interver	in her room more often. RD have been reassessed and ntions put into place when the as initially noted, from January				
	(DON) stated R72 I bed more often and confused. The DO weights on paper so however, the weight	11/6, director of nursing had been refusing to get out of d seemed to be more N stated the nuses used to do o they could see a weight loss, its are now entered taff are not able to see the				
F 412 SS=D	revised 2/16, indica with notify the dieta by sending an alert gain or loss, 3 pour one month, 7.5 per percent in six mont indicated the direct designee will review more often to identi weight loss or gain refers to a gradual weight loss or gain	E/EMERGENCY DENTAL	F 4	12		3/16/16
	an outside resource §483.75(h) of this p covered under the s dental services to n resident; must, if ne	must provide or obtain from e, in accordance with part, routine (to the extent State plan); and emergency neet the needs of each ecessary, assist the resident in hts; and by arranging for				

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		AND HUMAN SERVICES				FORM	03/07/2016 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245149	B. WING	i		02/	11/2016
NAME OF	PROVIDER OR SUPPLIER	<u> </u>			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		-	100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 412	transportation to an must promptly refer damaged dentures This REQUIREMEN by: Based on observat review the facility fa appointments were (R15) reviewed for Findings include: R15's significant ch (MDS) dated 1/6/16 moderate cognitive extensive assistance daily living. R15's care plan dat provide resident wit dressing and groom performed oral care During interview on stated he had missi side of his mouth al evaluation by the de teeth and discomfo jaw. R15 stated he be a follow up appor heard nothing regat with the dentist. During observation was observed eatin problems chewing.	A from the dentist's office; and residents with lost or to a dentist. NT is not met as evidenced tion, interview, and document ailed to ensure dental follow up completed for 1 of 3 residents dental services. A ange Minimum Data Set 6, indicated the resident had impairment and need for the 2/10/16, directed staff to the assistance to complete ning, and the resident	F	412	F412 Resident #15 agreed to a follow up appointment scheduled for 3/4/16 a outpatient Dental office. Center will review the medical recor the long term care residents for the months to identify any other residen had dental appointment follow-up recommendations. Any affected res will have their dental recommendati followed-up on as needed. Health Information Management Department and Licensed Nurses w re-educated on the process of revie recommendations from the dental s and ensuring the recommendations followed-up on including scheduling related transportation, if needed. Center will complete audits of denta monthly for the next three months a quarterly thereafter. The results will reviewed, shared and followed-up w QAPI Committee for further recommendations.	t an rds on past 6 hts who sidents ons vill be wing service are the al visits und be	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/07/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245149	B. WING			02/	11/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- AMBASSADOR			100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 412	the upper right side and again stated he supposed to follow dentist], and I have Review of the Apple note dated 9/10/15, that date for a recal indicated, "Diagnos High;rampant decay #12 and 13 had but non-restorable, Rec Several no [sic] cay Treatment recomm fillings and extraction prophylaxis treatment Review of R15's me resident had no furt appointments, nor w appointments, nor w appointments schee During interview on registered nurse (R dental recommenda because when a fol appointments is con "Noted," on the form indicated there had communication with since R15's visit of A review of the polic Services and Asses 2012, indicated the	of his mouth with chewing, a had broken teeth and, "I was up a long time ago [with the n't heard anything." Tree Coon Rapids progress indicated (R15) was seen on I exam. The progress note sis/Assessment: Caries risk: y . See oral exam form. Tooth ccal cusps have fractured off; commend extractions " ities noted since last exam." endations were made for ons, in addition to follow up for ent every three months. edical records indicated the her follow up dental were there any follow up dental duled. 2/11/16, at 1:55 p.m. N)-A stated it appeared the ations were not processed low up of recommendation of mpleted, the nurse will write, n. A review of R15's record been no follow up or a Apple Tree dental services 9/10/15. cy titled Dental/Oral Health asments, issued September	F 4	112			
F 441	-	I CONTROL, PREVENT	F 4	141			3/16/16

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
_							
		245149	B. WING			02/1	11/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		-	100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	~	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
F 441	Continued From no	urao 41					
SS=D		.ge 41	F 4	.41			
33=D	SFREAD, LINENS						
		tablish and maintain an					
		ogram designed to provide a					
		comfortable environment and development and transmission					
	of disease and infe						
	(a) Infection Contro	tablish an Infection Control					
	Program under whi						
	(1) Investigates, cor	ntrols, and prevents infections					
	in the facility;						
		rocedures, such as isolation, o an individual resident; and					
		ord of incidents and corrective					
	actions related to in						
	(b) Preventing Spre						
		ion Control Program					
		esident needs isolation to of infection, the facility must					
	isolate the resident.						
	(2) The facility must	t prohibit employees with a					
		ease or infected skin lesions					
	from direct contact	with residents or their food, if					
		t require staff to wash their					
		rect resident contact for which					
	hand washing is inc						
	professional practic	æ.					
	(c) Linens						
	Personnel must har	ndle, store, process and					
		as to prevent the spread of					
	infection.						

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ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY
ID PLAN C	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG	COM	IPLETED
		245149	B. WING _		02/	11/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 441	Continued From pa	ge 42	F 44	41		
		NT is not met as evidenced				
		tion, interview, and document		F441		
	review the facility failed to ensure proper disinfecting procedure of the glucometer after blood glucose monitoring for 2 of 3 residents (R42 and R90) who utilized the facility community glucometer on the Sunny Ridges unit.		R20, R42, and R90 were each p with a glucometer for individual of 2/12/16. Staff caring for them ins on individual use and cleaning a disinfecting procedures.	ise on structed		
	Findings include:			All residents with ordered blood	alucose	
	2/10/16 at 8:23 a.m who pierced R42's placed a large drop of the glucometer to After disposing of the strip, the glucometer	for a blood glucose testing on a. by registered nurse (RN)-B finger using a lancet and of blood on the collection strip o measure the glucose level. he lancet and blood collection er was then wiped down with		checks were provided a glucome individual use. New system was developed to provide a glucome individual use for all residents re blood glucose checks. Glucome be disinfected per facility Policy Procedure.	eter for er for quiring ers will	
	the tote. At 8:30 a.l blood glucose on R used for R42. Upor testing, the glucom	and placed on a paper tissue in m., RN-B proceeded to test 90 with the same glucometer a completion of blood glucose eter, was cleaned with alcohol in a clean paper tissue in the powed to air dry.		Licensed Nurses will be trained system of each resident having assigned glucometer for individu Staff re-educated on Policy and of cleaning glucometers 2/17/16	an al use. procedure -3/11/16.	
	RN-B stated that th with alcohol wipes b of Sunny Ridges us On 2/11/16, register R42, R90, and R20	on 2/10/16 at 8:35 a.m., e glucometer is wiped down between residents. Residents se a community glucose meter. red nurse (RN)-C identified all had orders for routine itoring on Sunny Ridges unit.		Audits of individual glucometer uproper cleaning and storage will completed weekly for 1 month, r for 3 months, and quarterly there coordinated by the Infection Pre Nurse. Results of audits will be reviewe analyzed by Nurse Manager tea changes implemented as neede	be nonthly eafter as ventionist d and m with	
	residents have their term care units. The	a.m., RN-D stated that the r own glucometer on the short e long term care units, be wiped with sani cloth plus		Infection Preventionist Nurse wil findings to the QAPI committee evaluation and recommendation	report or further	

Facility ID: 00898

If continuation sheet Page 43 of 46

		AND HUMAN SERVICES & MEDICAID SERVICES		FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION (X3) D	ATE SURVEY OMPLETED
		245149	B. WING _	0	2/11/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441 F 456 SS=F	wipes before and at the surfaces for rem minutes. RN-D sta wipe glucometer with The facility policy of Disinfecting, and Cl 2012, was reviewed to disinfectant the mone of two ways, eit dilute 1 ml of house achieve a 1;10 dilut paper towel to wipe attention to the time The other option that germicidal disposate Society's preferred meter should be lef it is dry. 483.70(c)(2) ESSEI OPERATING CONIT The facility must mat mechanical, electric equipment in safe control by: Based on observate review the facility fat the walk-in cooler to temperatures were	ther use, taking time to assure hained visibly wet for 3 ated "It is not our procedure to th alcohol wipes." Blood Glucose Monitoring, eaning, issued September d and indicates the process neter may be completed in ther with a process of using a e bleach in 9 ml of water to ion, using a lint-free cloth or down the meter, paying the meter must remain wet. at may be used is the use of a ble wipe supplied by the vendor. After disinfecting, the t a few minutes to ensure that NTIAL EQUIPMENT, SAFE DITION aintain all essential cal, and patient care operating condition. NT is not met as evidenced ion, interview, and document iled to ensure timely repair of	F 44		d

Event ID:096L11

Facility ID: 00898

If continuation sheet Page 44 of 46

	<u> SFOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES	(Y2) MILLI TU	PLE CONSTRUCTION). 0938-039 TE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		G	· /	MPLETED
		245149	B. WING		02	/11/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	Ε	
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 456	On 2/8/16, at 1:12 p facility's kitchen wa dietary manager (C walk-in cooler was and was not sealed no longer automatic pressed shut after informed the mainte issue. On 2/11/16, at 1:23 conducted with CD again observed to b sealed shut. CDM maintenance of the approximately two facility had experien maintenance perso departments respo requests may have result. CDM was u documentation rega repair, and stated h request but just spo department. During entered and exited press the door shut to rest slightly open noticed and presse During interview on environmental serv he had started work approximately three was not aware of th not sealing. He sta maintenance log with	b.m. an initial tour of the s conducted with certified 2DM), and the door of the observed resting slightly open I shut. CDM stated the door cally sealed and had to be each entry, and he had already enance department of this p.m. a follow-up tour was M and the walk-in cooler was be resting slightly open/ not stated again he had informed e door/seal needing repair weeks prior, however, the nced a turn-over of onnel and he suspected the nse time to maintenance been somewhat delayed as a unable to provide any arding the request for the nee did not document the oke to the maintence g this follow-up tour, cook-A the walk-in cooler, but failed to t behind him, leaving the door ned/ unsealed, until CDM d the door closed. 0 2/11/16, at 4:13 p.m. the ices director (ESD) reported	F 45	6 reviewed in the QAPI Commit further evaluation and follow-u		

If continuation sheet Page 45 of 46

		AND HUMAN SERVICES			FORM	03/07/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245149	B. WING _		02/	11/2016
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 456	facility's process. E preventative mainted back logged, he wa maintenance/ repai had known about the repaired it immedia The facility's Food S directed the CDM we refrigerator temperation	SD stated though some of the enance tasks were slightly as on schedule with r requests, and stated if he he issue, he would have tely. Storage policy dated 2/16, vas responsible for monitoring atures. The policy added, to be brought to the attention	F 45			

Facility ID: 00898

If continuation sheet Page 46 of 46

		AND HUMAN SERVICES		~	F5149025	FORM	03/08/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - MAIN BUILDING 01		E SURVEY IPLETED
		245149	B. WING			02/	12/2016
	PROVIDER OR SUPPLIER	- AMBASSADOR		810	REET ADDRESS, CITY, STATE, ZIP CODE 00 MEDICINE LAKE ROAD EW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	ΓS	K 0	00			
	FIRE SAFETY			i.			
	ALLEGATION OF O DEPARTMENTS A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	MPLIANCE WITH THE AS BEEN ATTAINED IN					
	A Life Safety Code Minnesota Departm Fire Marshal Divisio the time of this surv Ambassador was for compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F				FDOC		

CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR

By email to:

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

(X6) DATE 03/04/2016

Electronically Signed

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

FV

TITLE

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		IG 01 - MAIN BUILDING 01		MPLETED
		245149	B. WING		02	/12/2016
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CC		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
K 000	Continued From pa	age 1	K 00	00		
	Marian.Whitney@s Angela.Kappenma	state.mn.us				
 		RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:				
	1. A description of to correct the defic	what has been, or will be, done iency.				
	2. The actual, or pr	oposed, completion date.				
	responsible for cor	er title of the person rection and monitoring to ence of the deficiency.				
	building with a part constructed at 3 dii building was constru- determined to be o 1996, an addition w determined to be o 2010, an addition w determined to be o There is a 2-hour fi addition and the re	ociety Ambassador is a 1-story ial basement. The building was fferent times. The original ructed in 1963 and was f Type II(000) construction. In was constructed and was f Type II(000) construction. In was constructed and was f Type V (111) construction. ire wall between the 2010 st of the building. Therefore, yed as two buildings with two used.				
	throughout. The fact with smoke detection open to the corrido automatic fire depart	omatic fire sprinkler protected cility has a fire alarm system on in the corridors and spaces rs that is monitored for artment notification. The facility 7 beds and had a census of 68 by.		<		

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Event ID: 096L21

Facility ID: 00898

If continuation sheet Page 2 of 5

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULTIPL	E CONSTRUCTION	(X3) DATE	E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		01 - MAIN BUILDING 01		PLETED
		245149	B. WING		02/	12/2016
NAME OF F	ROVIDER OR SUPPLIER	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETIO DATE
	NFPA 101 LIFE SA	FETY CODE STANDARD	K 012			3/18/16
SS=F	of the following: 19.1.6.2, 19.1.6.3, This STANDARD is Based on observat building does not m proper separation of This deficient pract residents. Findings include: During a tour of the 1:30 PM on Februa revealed that the 2- fiberglass insulation the large penetration the 1997 building a	on type and height meets one 19.1.6.4, 19.3.5.1 s not met as evidenced by: tion and staff interview, this beet the requirements for of multiple construction types. ice could affect all 68 facility between 9:30 AM and ry 12, 2016, observation hour fire separation had n and no fire caulking around ons through the wall between nd the 2010 building.		Preparation and execution of this response and plan of correction do constitute an admission or agreem the provider of the truth of the facts alleged or conclusions set forth in statement of deficiencies. The plan correction is prepared and/or exect solely because it is required by the provisions of federal and state law the purposes of any allegation that center is not in substantial complia with federal requirements of partic this response and plan of correction constitutes the center is allegation compliance in accordance with set 7305 of the State Operations Manual	nent by s the n of cuted e v. For t the ance ipation, on n of ction	
	administrator at the	ice was verified by the time of the inspection.		K 012 Center will remove fiberglass insul from two- hour fire separation wall will install mineral wool and seal be with appropriate fire rated caulk. Environmental Services Director is responsible for correction and mor to prevent a reaccurance of the de	l, and arrier s nitoring	0/10/10
K 050 SS=C	Fire drills include th signal and simulatic conditions. Fire drill	FETY CODE STANDARD e transmission of a fire alarm on of emergency fire s are held at unexpected g conditions, at least quarterly	K 050	9		3/18/16

Facility ID: 00898

If continuation sheet Page 3 of 5

TATEMENT	OF DEFICIENCIES OF CORRECTION	KANNERS EXAMPLIES AND A CONTRACT AND A CONTRACT AND A CONTRACT A CONTRACTACTACTICACIÓN A CONTRACTACTACTICACIÓN A CONTRACTACTACTICACIÓN A CONTRACTACTACTICACIÓN A CONTRACTACTACTICACIÓN A CONTRACTACTACTICACIÓN A CONTRACTACTICACIÓN A CONTRACTACTACTACTICACIÓN A CONTRACTACTICACIÓN A CONTRACTACTACTACTICACIÓN A CONTRACTACTACTACTACTACTACTACTACTACTACTACTACTA				E SURVEY PLETED
		245149	B. WING		02/1	2/2016
	PROVIDER OR SUPPLIER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
K 050 K 143 SS=E	persons who are q Where drills are co 6:00 AM a coded a instead of audible 18.7.1.2, 19.7.1.2 This STANDARD Based on docume interview, the facili documentation that once per shift per of varying times and on NFPA 101, Section practice could affer Findings include: On facility tour betw February 12, 2016 documentation for that a fire drill was evening shift during This deficient pract Director of Environ discovery. NFPA 101 LIFE SA Transferring of liquito another shall be specifically designation as follows: (a) separated from wherein patients	assigned only to competent ualified to exercise leadership. onducted between 9:00 PM and announcement may be used alarms. is not met as evidenced by: entation review and staff ty could not provide t fire drills were conducted quarter for all staff under conditions as required by 2000 of 19.7.1.2. This deficient ct all 68 residents. ween 9:30 AM and 1:30 PM on , the review of the fire drill the past 12 months revealed not documented for the g the second quarter. tice was confirmed by the mental Services at the time of AFETY CODE STANDARD id oxygen from one container accomplished at a location ated for the transferring that is any portion of a facility ned, or treated by a separation	K 050	K050 Missing fire drill was second quarter time of drill was not noted am/pm. U to correct second quarter Drill. Goir forward, Environmental Services Dir will document fire drills using militan and once per shift per quarter for all under varying times and conditions.	nable ig ector / time staff	3/18/16

		AND HUMAN SERVICES			FORM	APPROVED
		& MEDICAID SERVICES			1	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - Main Building 01		E SURVEY PLETED
		245149	B. WING		02/1	2/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		8100 MEDICINE LAKE ROAD		
				NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
K 143	sprinklered, and ha and (c) in an area that is that transferring is of the immediate area accordance with NF Association. 8-6.2.5.2 (NFPA 99) This STANDARD is Based on observat building does not m proper arrangemen transferring of liquid another per NFPA 9 practice could affect Findings include: During a tour of the 1:30 PM on Februa revealed that the op building had vinyl flo	s ceramic or concrete flooring; s posted with signs indicating occurring, and that smoking in is not permitted in PA 99 and Compressed Gas s not met as evidenced by: ion and staff interview, this eet the requirements for the t of room intended for the d oxygen from one container to 99 8-6.2.5.2. This deficient it all 44 residents. facility between 9:30 AM and ry 12, 2016, observation cygen transfilling room in 1963	K 143		ces on and	
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 096L21	F	Facility ID: 00898 If contin	uation shee	et Page 5 of 5

		AND HUMAN SERVICES			F5149025	FORM	: 03/08/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · · / · · ·		LE CONSTRUCTION 6 02 - NEW ADDITION	(X3) DA1	E SURVEY
		245149	B. WING			02	/12/2016
NAME OF I	PROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR			8100 MEDICINE LAKE ROAD		
				1	NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	ĸ	000			
	FIRE SAFETY						
	ALLEGATION OF C DEPARTMENTS AC SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Divisio the time of this surv Ambassador was for compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	Survey was conducted by the pent of Public Safety, State on on February 12, 2016. At rey, Good Samaritan Society bund not in substantial e requirements for participation id at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), ealth Care.					
	DEFICIENCIES (K- Healthcare Fire Insp State Fire Marshal I 445 Minnesota St., St. Paul, MN 55101	R THE FIRE SAFETY TAGS) TO: Dections Division Suite 145			EPOC		
	By email to:						
	′ DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE 03/04/2016

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.

TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	CONSTRUCTION 2 - NEW ADDITION	(X3) DATE SURVEY COMPLETED	
		245149	B. WING		02/12/2016	
NAME OF	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	1	112/2010
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		00 MEDICINE LAKE ROAD W HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
K 000	Continued From pa Marian.Whitney@s Angela.Kappenmai	tate.mn.us	K 000			
		RRECTION FOR EACH TINCLUDE ALL OF THE DRMATION:				
	1. A description of v to correct the defici	what has been, or will be, done ency.				
	2. The actual, or pr	oposed, completion date.				
		r title of the person rection and monitoring to ence of the deficiency.				
	building with a parti constructed at 3 dif building was constr	ociety Ambassador is a 1-story al basement. The building was ferent times. The original ucted in 1963 and was				
	1996, an addition w determined to be or 2010, an addition w determined to be or There is a 2-hour fi	f Type II(000) construction. In vas constructed and was f Type II(000) construction. In vas constructed and was f Type V (111) construction. re wall between the 2010		E.		
-		st of the building. Therefore, ved as two buildings with two used.				
	throughout. The fac with smoke detection open to the corridor automatic fire depa	omatic fire sprinkler protected cility has a fire alarm system on in the corridors and spaces rs that is monitored for rtment notification. The facility 5 beds and had a census of 82 y.				
	The requirement at NOT MET as evide	42 CFR, Subpart 483.70(a) is				

		AND HUMAN SERVICES		1004 M	FORM	03/08/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (2 02 - NEW ADDITION		E SURVEY PLETED
		245149	B. WING		02/1	2/2016
NAME OF F	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 012 SS=F				3/18/16		
	Based on observation building does not me proper separation of	s not met as evidenced by: tion and staff interview, this neet the requirements for of multiple construction types. ice could affect all 68		Preparation and execution of this response and plan of correction does constitute an admission or agreemen the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of	nt by e	
	1:30 PM on Februa revealed that the 2- fiberglass insulation the large penetration the 1997 building a	e facility between 9:30 AM and ary 12, 2016, observation -hour fire separation had n and no fire caulking around ons through the wall between nd the 2010 building. r fire separation cannot be		statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation this response and plan of correction constitutes the center □s allegation of compliance in accordance with section 7305 of the State Operations Manual.		
		ice was verified by the a time of the inspection.		K 012 Center will remove fiberglass insulat from two hour fire separation wall, an install mineral wool and seal barrier appropriate fire rated caulk. Environmental Services Director is responsible for correction and monit to prevent a reaccurance of the defic	nd will with oring	
K 050 SS=C	Fire drills include th signal and simulation conditions. Fire dril times under varying on each shift. The and is aware that d	FETY CODE STANDARD ne transmission of a fire alarm on of emergency fire Is are held at unexpected g conditions, at least quarterly staff is familiar with procedures rills are part of established ility for planning and	K 050			3/18/16

Facility ID: 00898

If continuation sheet Page 3 of 5

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	1	0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		02 - NEW ADDITION		PLETED
		245149	B. WING		02/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 050	Continued From pa	age 3	K 050			
	conducting drills is persons who are q Where drills are co 6:00 AM a coded a instead of audible 18.7.1.2, 19.7.1.2 This STANDARD Based on docume interview, the facili documentation that once per shift per varying times and	assigned only to competent ualified to exercise leadership. onducted between 9:00 PM and announcement may be used alarms. is not met as evidenced by: entation review and staff ty could not provide t fire drills were conducted quarter for all staff under conditions as required by 2000 a 18.7.1.2. This deficient		K050 Missing fire drill was second quarter time of drill was not noted am/pm. to correct second quarter Drill. Go forward, Environmental Services D will document fire drills using milita and once per shift per quarter for a under varying times and conditions	Unable ing irector ry time Ill staff	
K 143 SS=E	On facility tour bety February 12, 2016 documentation for that a fire drill was evening shift durin This deficient prac Director of Environ discovery. NFPA 101 LIFE SA Transferring of liqu to another shall be specifically design as follows: (a) separated from wherein patients a	ween 9:30 AM and 1:30 PM on , the review of the fire drill the past 12 months revealed not documented for the g the second quarter. tice was confirmed by the mental Services at the time of AFETY CODE STANDARD hid oxygen from one container accomplished at a location ated for the transferring that is any portion of a facility re housed, examined, or ation of a fire barrier of 1-hour ruction; and	K 143			3/18/16

Event ID: 096L21

Facility ID: 00898

If continuation sheet Page 4 of 5

8

	OF DEFICIENCIES	KANNERS EXAMPLIES KANNERS KANNERS KANNERS KANNERS		PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
		245149	B. WING		0.2/	12/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		12/2010
				8100 MEDICINE LAKE ROAD	000	
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		NEW HOPE, MN 55427		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIO
K 143	Continued From pa	age 4	K 14	3		
	sprinklered, and ha and	as ceramic or concrete flooring;				
	that transferring is the immediate area accordance with N Association. 8-6.2.5.2 (NFPA 98 This STANDARD Based on observa building does not n proper arrangemen transferring of liqui another per NFPA practice could affer Findings include: During a tour of the 1:30 PM on Februa revealed that the o building had vinyl f	is not met as evidenced by: ition and staff interview, this neet the requirements for the nt of room intended for the d oxygen from one container to 99 8-6.2.5.2. This deficient ct all 24 residents. e facility between 9:30 AM and ary 12, 2016, observation xygen transfilling room in 2010		K143 Vinyl tile in the oxygen trans be removed. Environmenta Director is responsible for c monitoring to prevent reocc deficiency	I Services orrection and	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

February 25, 2016

Ms. Marie Barta, Administrators Good Samaritan Society - Ambassador 8100 Medicine Lake Road New Hope, Minnesota 55427

Re: Enclosed State Supervised Living Facility Licensing Orders - Project Number S5149026

Dear Ms. Barta:

The above facility was surveyed on February 8, 2016 through February 11, 2016 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Supervised Living Facilities.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is the Time Period For Correction.

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

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

Good Samaritan Society - Ambassador February 25, 2016 Page 2

When all orders are corrected, the first page of the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Jessica Sellner, Unit Supervisor at (320)223-7343. A written plan for correction of licensing orders is not required.

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

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

Feel free to contact me with any questions related to this letter.

Sincerely,

ato Comston

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility Licensing and Certification File

	OF DEFICIENCIES				
AND PLAN OF	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:		(X3) DATE SURVEY COMPLETED
		00898	B. WING		02/11/2016
NAME OF PRO	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
GOOD SAM	IARITAN SOCIETY - AM	IBASSADOR	DICINE LAKE RO PE, MN 55427	AD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 000	Initial Comments		2 000		
	*****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
f f r v t t c c r r r r r r r r r r	144A.10, this correction pursuant to a survey. found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart Determination of whet corrected requires cor requirements of the ru number and MN Rule When a rule contains comply with any of the lack of compliance. L re-inspection with any	ther a violation has been mpliance with all ule provided at the tag number indicated below. several items, failure to e items will be considered .ack of compliance upon y item of multi-part rule will			
t		ent of a fine even if the item ng the initial inspection was			
t c t	that may result from n orders provided that a	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a for non-compliance.			
r t i c c	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic sure orders consistent with ment of Health 14-01, available at te.mn.us/divs/fpc/profinfo/inf icensing orders are			

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

(X6) DATE

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
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GOOD SA	MARITAN SOCIETY - AN	IBASSADOR	DICINE LAKE ROA PE, MN 55427	D		
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2 000	Continued From page	e 1	2 000			
	you electronically. All is necessary for State enter the word "corre text. You must then in State licensure proce completion date, the corrected prior to elec Minnesota Departme On February 8-11 20 Department's staff, vit the following correction Please indicate in you correction that you ha and identify the date Minnesota Departme the State Licensing C federal software. Tag	16, surveyors of this isited the above provider and on orders are issued. ur electronic plan of ave reviewed these orders, when they will be completed. nt of Health is documenting Correction Orders using				
	column entitled "ID F statute/rule out of cor "Summary Statement and replaces the "To correction order. This findings which are in after the statement, " evidence by." Followi are the Suggested M Time period for Correct PLEASE DISREGAR FOURTH COLUMN V "PROVIDER'S PLAN	D THE HEADING OF THE WHICH STATES, OF CORRECTION." THIS RAL DEFICIENCIES ONLY.				

	OF DEFICIENCIES OF CORRECTION	h (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
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NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR	DICINE LAKE ROA DPE, MN 55427	D		
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2 000	Continued From page	e 2	2 000			
	PLAN OF CORRECT MINNESOTA STATE A complaint investiga	tion (s) H5149028 was also of the standard survey and				
2 565	MN Rule 4658.0405 S Plan of Care; Use	Subp. 3 Comprehensive	2 565			
	-	nprehensive plan of care personnel involved in the				
	by: Based on observatior review, the facility fail interventions were fol residents (R34) review	It is not met as evidenced n, interview, and document led to ensure care plan llowed by staff for 1 of 3 wed for accidents and for 1 eviewed for toileting and				
	Findings include:					
	1/13/16, indicated R3 impairment, had can failure. The MDS ind extensive assist of tw dressing, bed mobility	imum Data Set (MDS) dated 44 had moderate cognitive cer, anemia, and heart dicated the resident needed 70 with transfers, toileting, y, was incontinent of bowel I no falls in the last month.				
	R34's care plan dated	d 1/14/16, indicated the				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00898	B. WING		02/11/2016	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AM	MBASSADOR	DICINE LAKE ROA DPE, MN 55427	D		
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2 565	Continued From page	e 3	2 565			
	 2 565 Continued From page 3 resident had metastic breast cancer with brain mass, was at risk for falls related to impaired mobility, had a history of falls, had low bed, floor mat, concave mattress, and a body pillow. The care plan directed staff to ensure R34 had her call light with in her reach. During observation 2/9/15, at 8:21 a.m. R34 was observed laying in her bed. R34's bed was not observed in the low position, nor was there a floor mat on the floor. During observation 2/9/15, at 9:32 a.m. R34 was observed laying in bed dressed. The bed was in the low position, however, the floor mat was folded up against the wall behind the oxygen tank. 					
	nurse (RN)-I stated the floor and the bed sho	16, at 11:39 a.m. registered he fall mat should be on the buld be in the low position at ed R34's room and placed for next to resident.				
	observed laying in be low position with fall i the residents call ligh floor out of R34's rea (DON) was informed	/10/16, at 8:01 a.m. R34 was ed and the bed was in the mat on the floor. However, it was observed laying on the ch. Director of nursing of the call light being out of e entered the residents room light.				
	stated she didn't know the low position, and NA who was working the NA stated she the	0/16, at 12:31 p.m. RN-A w why R34's bed was not in stated she had talked to the with R34 on 02/9/16, and pught during a physician visit p. RN-A stated R34 was a ave all the assessed				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	MBASSADOR	DICINE LAKE ROAI DPE, MN 55427	D		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN	OF CORRECTION	(X5)
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2 565	Continued From page	e 4	2 565			
	including having the	e according to the care plan, call light available because t to call for staff assistance.				
	R37's admission MDS dated 1/7/16, identified R37 had no cognitive impairment, was frequently incontinent of both bladder and bowel, was at risk for the development of pressure ulcers, required extensive assistance from staff for toilet use and personal hygiene, and was totally dependent on staff for transfers and bed mobility.					
	bowel and bladder in weakness and impair directed to offer and a hours (and as needer check/change every while asleep. The ca assist R37 with turnir	d 2/2/16, identified R37 had continence related to red mobility, and staff were assist with toileting every two d) while awake, and to two hours (and as needed) are plan also directed staff to ng and repositioning at least use of a mechanical lift.				
	7:23 a.m. to 10:17 a. toileting, checked/ ch	oservation on 2/10/16, from m., R37 was not offered anged, or turned/ nours and 37 minutes.				
	8:23 a.m. to 11:29 a.i toileting, checked/ ch	observation on 2/11/16, from m., R37 was not offered anged, or turned/ e hours and five minutes.				
	stated R37 was to be toileted every two ho in bed was not indica repositioning, toileting RN-A stated the facili	2/11/16, at 3:01 p.m. RN-A e turned/ repositioned and urs, and offering to lay down tive of an offer for turning/ g or checking/ changing. ity staff should specifically like to be repositioned to				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
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AME OF PF	ROVIDER OR SUPPLIER		F ADDRESS, CITY, STATE, ZIP CODE				
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2 565	Continued From page	e 5	2 565				
	utilize the bedpan. RN-A stated R37's care planned interventions for repositioning and toileting were not followed during the above observations.						
	indicated, "Residents the necessary care a highest practicable w the comprehensive a will have an individual care that will include timetables directed to maintaining the residen nursing physical, fund psychosocial and edu use of departmental a Assessment Instrume	ent's optimal medical, ctional, spiritual, emotional, ucational needs. Through assessments, the Resident ent and review of the ny problems, needs and					
	director of nursing (D in-service all staff to f to specific resident ca DON or designee cou	OD OF CORRECTION: The ON) or designee could follow care plans in regards ares and services. The uld monitor for compliance is to the Quality Assurance					
	TIME PERIOD FOR ((21) days	CORRECTION: Twenty one					
2 830	MN Rule 4658.0520 Proper Nursing Care	Subp. 1 Adequate and General	2 830				
	Subpart 1. Care in g	eneral. A resident must					

STATE FORM

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMF	SURVEY PLETED
		00898	B. WING		02/11/2016	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1 •-	
GOOD SA	MARITAN SOCIETY - AN	MBASSADOR	DICINE LAKE ROA	١D		
		NEW HO	OPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	e 6	2 830			
	custodial care, and s individual needs and the comprehensive re plan of care as desc 4658.0405. A nursin of bed as much as po written order from the	preferences as identified in esident assessment and ribed in parts 4658.0400 and g home resident must be out ossible unless there is a e attending physician that the i n bed or the resident				
	by: Based on observation review, the facility fai reassess pain to ens were in place to relie (R154) with pain.	nt is not met as evidenced n, interview, and document led to comprehensively ure adequate interventions ve pain for 1 of 1 residents				
	Findings include:					
	11/12/15, indicated h					
	chronic pain/discomf gout, and neuropathy medications. The ca staff to, "Report to Nu activity attendance pa activities related to s/ c/o (complaints of) pa	ed 5/28/15, indicated he had ort related to osteoarthritis, y which was managed with re plan further instructed urse any change in usual atterns or refusal to attend /s (signs and symptoms) or ain or discomfort. Notify				
	health care provider i unsuccessful or if cur partment of Health	if interventions are				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00898	B. WING			0/44/2046
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	02	2/11/2016
	MARITAN SOCIETY - AN	ABASSADOR 8100 ME	DICINE LAKE ROA	D		
		NEW HO	PE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AU CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	e 7	2 830			
	significant change fro of pain."	om residents past experience				
	A Care Area Assessment (CAA) Worksheet dated 5/25/15, indicated he had osteoarthritis with worsening right hip pain, rated his pain as 7, and					
	indicated the pain aff	ected his sleep and mood.				
	indicated R154 had p	ection form dated 11/28/15, pain in the last 5 days that f his back and whole leg.				
	The form indicated the resident rated his pain at a 6 (on a scale from 1-10, with 10 being the worst pain) and had vocal complaints and facial					
	was stabbing, pain m	laily. In addition, the pain leds relieved the pain, pain ment, the pain did not disrupt				
	had no changes in ap	imit his day to day activities, opetite/eating ability, and was medication regimen. Under				
	Resident/Family Edu c/o increased pain (n	cation indicated, "Resident othing new) over a few days. . PRN's to be offered as				
	R154 had pain in his	n dated 2/7/16, indicated entire back and right lower ain at a 5, made protective				
	body movements or p day-to-day activities b	boostures due to pain, limited because of pain, decreased had irritability and anger.				
	not received PRN pai	tion also indicated he had in medication and the, lan addresses resident's				
	pain".					
		cian orders dated February				
		ceived Oxycodone HCL igrams (mg) (a narcotic				

innesota Department of Hea ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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ME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STATE, 1	ZIP CODE	02	./11/2010
OOD SAMARITAN SOCIETY - /	AMBASSADOR	DICINE LAKE ROAD)		
PREFIX (EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
 indicated the start of 8/14/15. R154 also HCL 5 mg every for do not exceed six ta of 6/26/15. R154 al 325 mg two tablets needed for headacd 5/31/15. R154's medication dated 2/1/16, to 2/1 R154 did not receiv medications. A HealthPartners S indicated R154 had physician had increused for gout) and a used for gout), and morephine (a pain in however, his morph to sedation and nee effects of opioid). A HealthPartners S indicated R154 use his "Mobility limited pain." A Park Nicollet Sem Visit Note dated 2/3 Park Nicollet team, syndrome and had years and was received and a semication of the semica	day for pain. The orders late of the medication was had an order for Oxycodone ar hours as needed for pain; ablets per day with a start date lso had an order for Tylenol by mouth every 4 hours as ne pain with a start date of administration record (MAR) 0/16, at 2:31 p.m. indicated re any of his PRN pain ubsequent Visit dated 11/6/15, gout in his knee and the ased allopurinol (a medication added cholchicine (medication he had been receiving medication for severe pain), ine tablets were stopped due eding narcan (reverses the Subsequent visit dated 1/4/16, d a scooter for mobility and by chronic right lower ext ior Services Nursing Home 8/16, indicated he was new to and R154 had chronic pain been on narcotics for several iving oxycodone three times a There was no indication if the		DEFICIEN		

	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	02	
		8100 ME	DICINE LAKE ROA	D		
GOOD SA	MARITAN SOCIETY - AN	NEW HO	DPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	e 9	2 830			
	the nurses he wanted however, "I get no an say they will contact the heard back and I ask The nurse practioner rarely. I haven't had the pain, she doesn't pain. They are doing stated his pain was a During a follow up int p.m. R154 stated he but it didn't help, so h R154 stated his pain sometimes a 10 and level of 5. During interview 2/10 assistant (NA)-B state and he has a lot of pa back, and because o	terview 2/10/16, at 12:44 had an order for oxycodone he doesn't take the PRN. was usually at an 8 and that he is very rarely at a 0/16, at 1:01 p.m. nursing ed she worked with R154 ain in his right leg and his f the pain R154 would refuse te, and at times would just				
	was observed to tran NA-C situated a chair the bed and placed a in front of R154 with briefly repositioned h an audible sigh and v noted. NA-C asked " today?Where?" R1 my legs." Once all se "Take your time" seve first attempt to stand. on his legs and feet h	/10/16, at 2:27 p.m. NA-C sfer R154 in his room. r at a 45 degree angle from four wheeled walker (4WW) the brakes applied. R154 imself in his wheelchair and vocalization of "Ah" were 'Are you hurting 54 stated "Yes my hands, et up to transfer, NA-C said eral times as R154 made his As he began to bear weight he yelled out "Ow" and seated position back in his				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00898			02	2/11/2016
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		02	./11/2010
OOD SA	MARITAN SOCIETY - AI	MBASSADOR	DICINE LAKE ROA	D		
		NEW HC	DPE, MN 55427			
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2 830	Continued From pag	e 10	2 830			
	wheelchair. He was breathing quickly and heavily, and then began the 2nd attempt to transfer, and again was observed to breath heavily with his mouth open and eyes tightly closed, as he took steps to turn his back to the bed. With contact guard assist he stood from his wheelchair and placed his hands on the 4WW. The NA repeated several times "Take your time do you want me to get a nurse for you?" R154 declined for the aide to get the nurse. Once seated on the bed, R154 stated his pain level was 10/10. During the transfer his right knee was visibly shaking.					
	the following: -On 2/3/16, 4:26 p.m. Physician Note Text: NP (nurse practioner (Transcutaneous Ele which is predominate pain conditions) unit knee if that was poss Awaiting return call." -A physician order wa days after the reques	bgress notes/orders indicated . Communication/Visit with "Labs from today called to b). Also questioning tens actrical Nerve Stimulation ally used for nerve related for residents pain in his right sible per resident request. as received 2/11/16, eight at for physical therapy to bain and appropriateness of				
	-On 2/4/16, at 3:00 p resident but he refus	.m. staff approached to walk ed due to pain.				
	-On 2/5/16, at 8:58 p	.m. resident refused to walk.				
		p.m. patient did not walk to himself out in his electric				
		p.m. Communication/Visit				

STATE FORM

096L11

If continuation sheet 11 of 42

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00898	B. WING			2/11/2016
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	04	2/11/2010
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR	DICINE LAKE ROA PE, MN 55427	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	e 11	2 830			
	 with Physician Note Text: NP updated on residents c/o pain in bilateral hands. Resident continues to c/o "sharp pain" in his hands. He denied that it is radiating from anywhere. He has requested PRN pain pills this shift, with little relief. Continue to monitor and update NP. On 2/10/16, at 10:01 p.m. resident refused shower, "Stating have been in pain all day." Pain meds were administered. During interview on 2/10/16, at 1:15 p.m. trained medical assistant (TMA) stated R154 had been having increased pain and he asked for a PRN today and had been asking more for his pain medication. 					
	manager for R154's u was having pain. RN switched to a new do practioner and physic to additional pain me- nurses. In addition R aware a request for a	2/10/16, at 2:30 p.m.)-A stated she was the unit and was not aware R154 I-A stated he had recently ctor and his previous nurse cian were not very receptive dication requests from the RN-A stated she was not a tens unit was made and P and re-request the order.				
	stated she worked the had a pain rating of 7	2/11/16, at 9:31 a.m. RN-F e day shift and R154 usually 2/10, and recently the eased complaints of pain.				
	p.m. NA-C stated R1 morning and afternoor his pain medication n	2/11/16, at approximelty 1:50 54 complained of pain in the ons and had been requesting nore often, and felt in the last pain has been increasing.				
	Although R154 report	ted increased pain, was				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION (X		X3) DATE SURVEY COMPLETED	
		00000	B. WING		20////2010		
AME OF PF	ROVIDER OR SUPPLIER	00898 STREET A	EET ADDRESS, CITY, STATE, ZIP CODE				
OOD SA	MARITAN SOCIETY - AN	BASSADOR 8100 ME	DICINE LAKE ROA				
		NEW HO	PE, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE	
2 830	Continued From page	e 12	2 830				
	refusing to ambulate, and was observed to be in the pain, the facility did not reassess to determine if any further interventions could be implemented to decrease the residents pain.						
	Assistance policy issuindicated the purpose assistance in pain maresidents will receive consultations on assi The policy futher india will assess current part the physician and inter interventions that mare well as pharmacologi will review response the and work closely with	interdisciplinary stance in managing pain." cated "The registered nurse ain levels and develop with					
	The DON or designed monitor to ensure all pain and receiving ap treatment. The DON	OD OF CORRECTION: e could train all staff and residents are assessed for opropriate nursing care and or designee could report the y Assurance Committee.					
	TIME PERIOD FOR ((21) days	CORRECTION: Twenty one					
2 840	MN Rule 4658.0520 S Proper Nursing Care;	Subp. 2 B Adequate and Clean skin	2 840				
	Subp. 2. Criteria for o proper care. The cri adequate and proper						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED		
		00898					
AME OF P	ROVIDER OR SUPPLIER		B. WING 02/11/2016 ET ADDRESS, CITY, STATE, ZIP CODE 02/11/2016				
000 64	MARITAN SOCIETY - AN	8100 ME	DICINE LAKE ROA				
		NEW HC	DPE, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
2 840	Continued From page 13		2 840				
	odors. A bathing plan resident's plan of care condition requires that must be given a comp other day and more of incontinent resident in every two hours, and following each episod [144A.04 Subd. 11. Notwithstanding Minn 4658.0520, an inconti checked according to written in the resident attending physician m interval longer than tw if competent, or a fam appointed conservator agent of a resident will in writing to waive phy determining this intern documented in the re Clean linens or clothin promptly each time th Perineal care includes the perineal area. Pat to keep the bed dry a comfort. Special atte skin to prevent irritation types of protectors m completely covered, a contact with the resid	at the resident remain in bed plete bath at least every often as indicated. An must be checked at least must receive perineal care de of incontinence. Incontinent residents. mesota Rules, part inent resident must be a specific time interval t's care plan. The resident's must authorize in writing any vo hours unless the resident, mily member or legally or, guardian, or health care ho is not competent, agrees ysician involvement in val, and this waiver is sident's care plan.] ng must be provided ne bed or clothing is soiled. s the washing and drying of ads or diapers must be used nd for the resident's ntion must be given to the on. Rubber, plastic, or other ust be kept clean, be and not come in direct ent. Soiled linen and oved immediately from					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00898	B. WING		02	02/11/2016	
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR	DICINE LAKE ROA DPE, MN 55427	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 840	Continued From page 14		2 840				
	by: Based on observation review, the facility fail in accordance with as maintain as much unit 1 of 3 residents (R37 incontinence. Findings include: R37's admission Mini 1/7/16, identified R37 frequently incontinent was not on a toileting extensive assistance personal hygiene, an staff for transfers and R37's Care Area Asse 1/12/16, indicated R3 fracture, was non-we lower extremity, and the assistance from two s identified R37 require toileting, had function increased risk for urin infection due to a pre had increased urinary use of diuretic medica R37's care plan dated bowel and bladder into weakness and impain directed staff to, "Offer "every two hours (and	imum Data Set (MDS) dated "s cognition was intact, was t of both bladder and bowel, program, required from staff for toilet use and d was totally dependent on bed mobility. essment (CAA) dated 7 had a prosthetic knee ight bearing on her right, required a total lift with staff to transfer. The CAA ed maximum assistance with hal incontinence, was at an nary incontinence and vious UTI, and may have y frequency secondary to her ations. d 2/2/16, identified R37 had continence related to red mobility. The care plan er and assist with toileting d as needed) while awake, every two hours (and as					
	"every two hours (and and to check/change needed) while asleep	d as needed) while awake, every two hours (and as					

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	SURVEY PLETED
		00898	B. WING		02/11/2016	
NAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	02/	11/2016
	MARITAN SOCIETY - AN	ABASSADOB 8100 ME	DICINE LAKE ROA	D		
GOOD 3A	MARITAN SOCIETT - AN	NEW HO	DPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 840	Continued From page	e 15	2 840			
	p.m. family member (assist R37 with toileti at least one instance through the supper m incontinence product During a continuous of 7:23 a.m. to 10:17 a.t toileting or checked/ 37 minutes. Observa At 7:23 a.m., R37 wa nursing assistant (NA room. At 7:30 a.m., NA-G c incontinence product sit in her wheelchair, two staff to transfer h At 7:45 a.m., NA-G b room for the breakfas At 9:00 a.m., R37 wa room, to an alcove/ d the dining room), whe with two of her peers At 9:20 a.m., R37 rer wheelchair in the day how late they get?" F	(FM)-A stated staff did not ing timely, and she knew of where R37 had to wait heal for her soiled to be changed. observation on 2/10/16, from m., R37 was not offered changed for two hours and ations included the following: is lying in her bed and A)-G was present in the hecked/ changed R37's before she was assisted to using a mechanical lift and er. rought R37 to the dining at meal. is moved from the dining lay room area (across from ere she watched television nained seated in her room area and stated, "See R37 stated she had not yet i medications, nor had she				
	sighing as she was ta At 9:40 a.m. R37 ask	ed the surveyor to find a				
	(RN)-G was made av	st her, and Registered nurse vare of R37's request for ed to RN-G, "Well I'd like to				
	get back to my room. resident room, hande	" RN-G assisted R37 to her ed her the call light and				
	assistance, nor did sl At 9:57 a.m., NA-G e	-G did not offer toileting he check/ change R37. ntered R37's room and				
		nto bed. R37 accepted and r staff person to assist with				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		00898	B. WING		02	/11/2016	
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE				
OOD SA	MARITAN SOCIETY - AI	MBASSADOR	DICINE LAKE ROA DPE, MN 55427	\D			
(X4) ID			ID	PROVIDER'S PLAN C		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	D THE APPROPRIATE	COMPLE DATE	
2 840	Continued From pag	e 16	2 840				
	the transfer.						
		NA-G had again stepped out					
		nother staff person, R37					
		ffer her use of the toilet,					
		for toileting, and stated she					
	did not believe she could use the toilet or commode because of her leg injury and						
	non-weight bearing status.						
		and licensed practical nurse					
		hanical lift to transfer R37 to					
		proceeded with changing					
		prief, with two hours and 37					
		anges. R37 was not offered					
	use of a toilet or bed	stated R37 was to be					
		very two hours and did not					
		et because she was always					
	incontinent, and NA-	-					
	incontinence brief co	ntained a small void of urine.					
		12/31/15, through 2/10/16,					
		acked evidence of R37					
	of a bedpan and che	cares, including toileting/ use					
	incontinence product						
	•	observation on 2/11/16, from					
		m., R37 was not offered					
	•	changed for three hours and					
	five minutes. Observ	ations included the					
	following: At 8:23 a m R37 wa	as seated at the dining room					
	table waiting for brea	-					
	•	If-propelled her wheelchair to					
	the day room area.	RN-H approached the					
		to her room, administered					
	-	, and then returned R37 to					
		did not offer to toilet or					
	check/ change R37.	approached R37 and asked					
	Dartment of Health	approached is and asked					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00898	B. WING		02	2/11/2016
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
OOD SA	MARITAN SOCIETY - AI	MBASSADOR	DICINE LAKE ROA DPE, MN 55427	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 840	Continued From pag	e 17	2 840			
	if she wanted to lay o offer, however, NA-A check/ change R37. At 10:31 a.m., an act attend an exercise g and remained seated room. At 10:46 a.m., NA-A R37 was to be check hours, using a mech bed. NA-A stated R37 changed at 8:00 a.m approached R37 ear wanted to lay down, NA-A stated she inter refusal to be checked would approach R37 she wanted to lay do check and change R use a toilet or comment mechanical sling lift d did not use a bedpar proceeded with assis had still not been offer changed. At 11:05 a.m., the su R37 would be offered approached R37 and to her room to check accepted and NA-A before seeking a sec the transfer. NA-A re the room to assist wi and checking/ chang with three hours and changes. At 11:29 a.m., NA-A bowel movement and	down. R37 declined this a did not offer to toilet or tivities staff invited R37 to roup, which R37 declined d in her wheelchair in the day was interviewed and stated ted/ changed every two anical lift to transfer her into 87 was last checked/ . and stated she had lier and asked her if she but the resident declined. rpreted R37's response as a d/ changed, and typically she every two hours and ask if wn, which is when she would 37. NA-A stated R37 did not ode because she required a for transfers, and stated R37 n either. NA-A then sting other residents and R37 ered to toilet or be checked/ rveyor asked NA-A when d toileting again, and NA-A d asked if she could take her her incontinence brief. R37 prought her to her room cond staff person to help with eturned and RN-H entered th transferring R37 to bed ing her incontinence brief, five minutes between stated R37 had a small d a small void of urine in her 'hough staff were not				

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00898	B. WING		02	02/11/2016	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR	DICINE LAKE ROA DPE, MN 55427	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
2 840	Continued From page	e 18	2 840				
	this observation, NA-, bedpan and R37 decl	A stated she did offer the ined.					
	stated R37 was to be and was usually incor she and NA-A did offe the above noted obse RN-H stated that she lay down did constitut checking/ changing, a offer equated a refusa During interview on 2 confirmed R37 was to bedpan every two how offered a bedpan des bowel in her incontine offer to lay down in be offer for toileting or ch R37's declining to lay refusal for toileting. F have specifically aske have her brief change	/11/16, at 3:01 p.m. RN-A be offered the use of a urs, and should have been pite identification of urine or ence brief. RN-A stated an ed was not indicative of an necking/ changing, and down did not equate a RN-A stated staff should ed if she would have liked to ed and use the bedpan, and ng R37's care planned					
	Evaluation and Retrain directed staff to ensure or bladder incontinen- treatment and service	nd Bladder Assessment ining policy dated 9/12, re each resident with bowel ce received appropriate es to restore as much der function as possible.					
	The director of nursin	OD OF CORRECTION: g (DON) or designee could nt policies and procedures					

Minnesota Depart STATE FORM

STATEMEN1	a Department of Health FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00898	B. WING		02/11/2016	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR	DICINE LAKE ROA PE, MN 55427	ND		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 840	of nursing (DON) or of as appropriate. The designee could monit ongoing compliance a Quality Assurance Co	timely services. The director designee could educate staff director of nursing (DON) or tor or audit to ensure and report the findings to the	2 840			
2 900	Ulcers Subp. 3. Pressure so	ent assessment, the director just coordinate the	2 900			
	without pressure som pressure sores unlest condition demonstrate authenticates, that the B. a resident who receives necessary t	s the individual's clinical es, and a physician ey were unavoidable; and o has pressure sores creatment and services to vent infection, and prevent				
	by: Based on observatior review, the facility fail repositioning were co prevent pressure ulco	It is not met as evidenced n, interview, and document led to ensure toileting and ompleted as assessed to ers for 1 of 3 residents (R37) entified at risk for pressure				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00808	B. WING				
	ROVIDER OR SUPPLIER	00898 STREET A	B. WING 02/11/2016 ET ADDRESS, CITY, STATE, ZIP CODE 02/11/2016				
		8100 ME	DICINE LAKE ROA				
300D SA	MARITAN SOCIETY - AN	NEW HC	PE, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
2 900	Continued From page	e 20	2 900				
	ulcer development.						
	Findings include:						
	1/7/16, identified R37 impairment, was freq bladder and bowel, w development of press extensive assistance	uently incontinent of both vas at risk for the sure ulcers, required from staff for toilet use and d was totally dependent on					
	fracture, was weak, d non-weight bearing o The CAA identified a	37 had a prosthetic knee le-conditioned, and n her right, lower extremity. goal for R37 to remain free related to incontinence and					
	1/3/16, identified R37	sessment & Evaluation dated required total assistance d directed staff to offer vo hours.					
	bowel and bladder in weakness and impair directed to offer and a hours (and as needed check/change every t while asleep. The ca assist R37 with turnin	d 2/2/16, identified R37 had continence related to red mobility, and staff were assist with toileting every two d) while awake, and to two hours (and as needed) ire plan also directed staff to ng and repositioning at least use of a mechanical lift.					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00898	B. WING				
	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STATE, ZIP CODE				
		8100 ME					
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR NEW HO	PE, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From page	e 21	2 900				
	During a telephone interview on 2/8/16, at 7:36 p.m. family member (FM)-A stated R37 did not get assisted with toileting timely, and stated she knew of at least one instance where R37 had to wait through the supper meal for her soiled incontinence product to be changed. During continuous observation on 2/10/16, from						
	7:23 a.m. to 10:17 a.t toileting, checked/ ch repositioned for two h Observations include At 7:23 a.m., R37 wa assistant (NA)-G was At 7:30 a.m., NA-G cl incontinence product	m., R37 was not offered anged, or turned/ nours and 37 minutes. d the following: s lying in bed and nursing					
	At 7:45 a.m., NA-G b room for the breakfas At 9:00 a.m., R37 wa room after breakfast, (across from the dinir watched television wi At 9:20 a.m., R37 ren	s moved from the dining to an alcove/ day room area ng room), where the resident th two of her peers. nained seated in her					
	"See how late they ge had not yet received nor had she been ass and R37 visibly and a At 9:40 a.m. R37 ask	room area and R37 stated, et?" The resident stated she her morning medications, sisted with her exercises, audibly sighed several times. ed the surveyor to find a					
	(RN)-G was asked to RN-G, "Well I'd like to RN-G assisted R37 to her the call light, and not offer toileting, che	behalf and registered nurse assist R37. R37 stated to get back to my room." o her resident room, handed exited the room. RN-G did ecking/ changing or turning/					
nesota Dor	repositioning to R37. At 9:57 a.m., NA-G e	ntered R37's room and					

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00898	B. WING		02/11/2016	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	/BASSADOR 8100 ME	DICINE LAKE ROA	D		
	1	NEW HC	OPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From page	e 22	2 900			
	NA-G got another stat transferring R37 into At 10:07 a.m., NA-G (LPN)-G used a meci- bed and proceeded to brief, with two hours a changes. NA-G confi- brief contained a smar R37 was not observe herself during this ob At 10:17 a.m., NA-G checked/ changed, a every two hours. Progress Notes from were reviewed and la refusing or declining repositioning and che- incontinence product During a continuous of 8:23 a.m. to 11:29 a.t toileting, checked/ chi- repositioned for three Observations include At 8:23 a.m., R37 wa table, awaiting her br At 9:06 a.m., R37 self the day room area. F brought her to her room medication and then room. RN-H did not change, or reposition At 10:09 a.m., NA-A if she wanted to lay d down, however, NA-/ check/ change her br	and licensed practical nurse hanical lift to transfer R37 to o change R37's incontinence and 37 minutes between irmed R37's incontinence all void of urine. d to offload or reposition servation. stated R37 was to be nd turned/ repositioned 12/31/15, through 2/10/16, acked evidence of R37 cares, including turning/ ecking/ changing her observation on 2/11/16, from m., R37 was not offered anged, or turned/ e hours and five minutes. d the following: s seated at the dining room eakfast meal. f-propelled her wheelchair to RN-H approached her, om, administered eye drop returned R37 to the day offer to toilet or check/ R37. approached R37 and asked lown. R37 declined to lay A did not offer to reposition or ouragement or education				

Minnesota Department of Health STATE FORM

6899

STATEMEN	a Department of Health T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00898	B. WING		02	2/11/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	02	2/11/2010
3000 84	MARITAN SOCIETY - AN	ABASSADOR 8100 ME	DICINE LAKE ROA	D		
		NEW HO	PE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From page 23		2 900			
	attend an exercise gr and remained seated room. At 10:46 a.m., NA-A v R37 was to be check repositioned every tw lift to transfer her into last checked/ change at 8:00 a.m. NA-A st R37 earlier and asked down, but the resider NA-A stated she inter refusal to be checked repositioned. NA-A st approach R37 every wanted to lay down, a lay down staff would NA-A then proceeded residents, and R37 ht toilet and/or checked repositioned. At 11:05 a.m., the sur staff would expect to changing and turning which time NA-A app she could take her to incontinence brief. R brought the resident the RN-H to assist. NA-A transferring R37 to he changed her incontin- and five minutes betw offloading. R37's bot slightly pink, but blan- confirmed. At 11:29 a.m., NA-A sc brief she had a small	Attated she attempted to two hours and ask if she and if the resident agreed to check and change her. d with assisting other ad still not been offered to / changed or turned/ veyor asked NA-A when offer toileting, checking/ / repositioning to R37, at roached R37 and asked if her room to check her 37 accepted and NA-A to her room, and asked A and RN-H proceeded with er bed and checked and ence brief, with three hours veen changes and tom was observed as				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00898	B. WING		02	2/11/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AM	MBASSADOR		D		
			DPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From page	e 24	2 900			
	stated R37 was to be every two hours and RN-H stated she felt down did constitute a repositioning and tolk and stated if R37's de considered a refusal repositioning. During interview on 2 stated R37 was to be toileted every two hou in bed was not indica repositioning, toileting R37's declining to lay refusals for these car staff should have spe have liked to be repo bottom, have her brie bedpan. RN-A stated interventions for repo not followed during th The facility's policy til Pressure Ulcer Preve	eting or checking/ changing, ecline to lay down, that was for toileting and 2/11/16, at 3:01 p.m. RN-A e turned/ repositioned and urs, and offering to lay down tive of an offer for turning/ g or checking/ changing; and v down did not equate res. RN-A stated the facility ecifically asked if she would sitioned to offload her ef changed, and utilize the				
	who are unable to replication independently should	position themselves I be repositioned as often as				
	directed by the care p SUGGESTION METH The director of nursin review and revise the procedures on press	blan approaches." HOD OF CORRECTION: ng (DON) or designee could				

Minnesota Department of Health STATE FORM

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		00898	B. WING		02	2/11/2016
AME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
OOD SA	MARITAN SOCIETY - A	MBASSADOR	DICINE LAKE ROA DPE, MN 55427	AD.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 900	Continued From pag	e 25	2 900			
	pressure ulcers and Quality Assurance C	report the findings to the ommittee.				
	TIME PERIOD FOR (21) days	CORRECTION: Twenty one				
21325	MN Rule 4658.0725 Emergency Oral Hea	Subp. 1 Providing Routine & alth Ser	21325			
	home must provide, resource, routine der needs of each reside include dental exami fillings and crowns, r oral surgery, bridges orthodontic procedur that are provided for	dental services. A nursing or obtain from an outside ntal services to meet the ent. Routine dental services nations and cleanings, oot canals, periodontal care, and removable dentures, res, and adjunctive services similar dental patients in the as limited by third party ies.				
	by: Based on observatio review the facility fai	nt is not met as evidenced n, interview, and document led to ensure dental follow up completed for 1 of 3 residents ental services.				
	Findings include:					
	(MDS) dated 1/6/16, moderate cognitive i	nge Minimum Data Set indicated the resident had mpairment and need for to complete activities of				
	P15's care plan date	d 2/10/16, directed staff to				

STATE FORM

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00898	B. WING		00	2/11/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	02	
GOOD SA	MARITAN SOCIETY - AM	IBASSADOR		D		
			PE, MN 55427	PROVIDER'S PLAN		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
21325	Continued From page	e 26	21325			
	provide resident with dressing and groomir performed oral care i					
	stated he had missing side of his mouth and evaluation by the der teeth and discomfort jaw. R15 stated he h be a follow up appoin	2/9/16, at 10:42 a.m. R15 g teeth on the upper right I had been seen for htist because of the missing on the right side of his upper ad understood there was to htment, however, he had ing this since his last visit				
	was observed eating problems chewing. I R15 stated he contin the upper right side of and again stated he h	n 2/10/16, at 1:03 p.m. R15 his meal with no visible During interview at this time, nued to have discomfort on of his mouth with chewing, had broken teeth and, "I was to a long time ago [with the t heard anything."				
	note dated 9/10/15, in that date for a recall of indicated, "Diagnosis High;rampant decay #12 and 13 had bucc non-restorable, Reco Several no [sic] caviti Treatment recommen	ies noted since last exam." ndations were made for s, in addition to follow up for				
	resident had no furth	ere there any follow up dental				

Minnesota	a Department of Healt	h				MAPPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY PLETED
		00898	B. WING		02	/11/2016
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	MBASSADOR	DICINE LAKE ROA DPE, MN 55427	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21325	Continued From page	e 27	21325			
	dental recommendation because when a follow appointments is communicated there had be communicated there had be communication with a since R15's visit of 9 A review of the policy Services and Assess 2012, indicated the p)-A stated it appeared the ions were not processed ow up of recommendation of pleted, the nurse will write, A review of R15's record eeen no follow up or Apple Tree dental services (10/15.				
	The director of nursin develop, review and procedures to ensure The DON or designe appropriate staff on t The DON or designe ongoing compliance.	e dental services are provide. e could educate all he policies and procedures. e could monitor to ensure				
	TIME PERIOD FOR (21) days	CORRECTION: Twenty one				
21685	Housekeeping, Oper Subp. 2. Physical pla including walls, floors	Subp. 2 Plant ation, & Maintenance ant. The physical plant, s, ceilings, all furnishings, nent must be kept in a	21685			
linneseta Dar	-	ood repair and operation alth, comfort, safety, and				

STATEMENT	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00898	B. WING		00	2/11/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AM	/BASSADOR	DICINE LAKE ROA DPE, MN 55427	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21685	well-being of the res routine maintenance This MN Requiremen by:	idents according to a written and repair program. nt is not met as evidenced	21685			
	review the facility fail the walk-in cooler to temperatures were m	n, interview, and document ed to ensure timely repair of ensure adequate naintained. This had the 66 residents who ate in the				
	facility's kitchen was dietary manager (CD walk-in cooler was of and was not sealed s no longer automatica pressed shut after ea	m. an initial tour of the conducted with certified M), and the door of the oserved resting slightly open shut. CDM stated the door Illy sealed and had to be ach entry, and he had already ance department of this				
	conducted with CDM again observed to be sealed shut. CDM st maintenance of the d approximately two we facility had experience maintenance persons requests may have b result. CDM was un documentation regar	nel and he suspected the se time to maintenance een somewhat delayed as a able to provide any ding the request for the did not document the				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00898	B. WING		02	2/11/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		./ 11/2010
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR	DICINE LAKE ROAI PE, MN 55427	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21685	entered and exited th press the door shut b to rest slightly opened noticed and pressed th During interview on 2 environmental service he had started workin approximately three v was not aware of the not sealing. He state maintenance log whe requests for repairs, a door was not identifie facility's process. ES preventative maintena back logged, he was maintenance/ repair r had known about the repaired it immediated The facility's Food Sta directed the CDM was refrigerator temperatu repair needs were to of maintenance staff. SUGGESTED METH The administrator or o review, and revise po ensure kitchen equipr appropriately. The ac could educate all app and procedures. The	e walk-in cooler, but failed to ehind him, leaving the door d/ unsealed, until CDM the door closed. /11/16, at 4:13 p.m. the es director (ESD) reported og at the facility veeks prior. He stated he facility's walk-in cooler door d the facility had a re staff entered needs or and stated the walk-in cooler d in the log as per the D stated though some of the ance tasks were slightly on schedule with equests, and stated if he issue, he would have ly. Drage policy dated 2/16, s responsible for monitoring ures. The policy added, be brought to the attention OD OF CORRECTION: designee could develop, licies and procedures to	21685			

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SUI COMPLET	
		00898	B. WING		02/11/	/2016
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR	DICINE LAKE ROA	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21685	Continued From page	e 30	21685			
	(21) days					
21805	MN St. Statute 144.68 Residents of HC Fac.		21805			
	residents have the rig courtesy and respect	treatment. Patients and ht to be treated with for their individuality by ons providing service in a				
	by: Based on observation review, the facility fail	t is not met as evidenced n, interview, and document ed to promote dignity with f 5 residents (R163 and bileting.				
	Findings include:					
	12/21/15, indicated th	mum Data Set (MDS) dated e resident was cognitively ive assist with toileting, and inent of urine.				
	R163's care plan date had bladder incontine	ed 10/08/15, indicated he nce and wore briefs.				
	was sitting in his reclining in continence brief was	10/16, at 6:51 a.m. R163 ner chair, and a soiled, white s observed from the hall or behind his wheelchair.				
	stated he was not awa was on the floor next	/16, at 6:52 a.m. R163 are the incontinence pad to him and stated, "I have t want them to see that."				

096L11

If continuation sheet 31 of 42

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		00898	B. WING		02	/11/2016
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		02	/11/2016
		8100 ME				
GOOD SA	MARITAN SOCIETY - A	MBASSADOR NEW HO	DPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21805	Continued From pag	le 31	21805			
	nurse (RN)-E stated	0/16, at 7:00 a.m. registered the pad should not be on the ee, and RN-E then entered ed the pad.				
	he was cognitively in	S dated 11/12/15, indicated ntact, needed extensive ting, and was frequently				
	-	ted 9/01/15, indicated he had and preferred a urinal or ef.				
	stated at times his ca minutes, and stated, into the bathroom. It to tell them I peed by me." R154 stated he	D/16, at 7:12 a.m. R154 all light was left on for over 30 "I am in bed wanting to go t's embarrassing when I have y pants again, please change e had incontinence episodes he had to wait so long for staff y at night.				
	Report dated from 2/	r Documentation Survey /1/16, to 2/11/16, R154 was ïve times at 7:00 p.m.				
	stated the facility doe however, they were print out to see how being left on. RN-A v audit on 1/28/16, how	1/16, at 10:58 a.m. RN-A es random call light audits, not able to do a computerized long R154's call light was was able to provide one call wever, only the morning , and the facility was unable ng audits.				
	February 2013, indic	Resident Dignity dated ated, "The facility will idents in a manner and in an				

	OF DEFICIENCIES	h (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00898	B. WING		03	2/11/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		2/11/2010
GOOD SA	MARITAN SOCIETY - AN	/IBASSADOR	DICINE LAKE ROA PE, MN 55427	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From page	e 32	21805			
	resident's dignity and his or her individuality indicated "Refraining to residents such as bags uncovered, refu residents request for SUGGESTED METH The director of nursin educate staff on dign designee could then to ensure residents fe are being maintained	OD OF CORRECTION: ag (DON) or designee could ity and respect. The DON or interview residents routinely eel their dignity and respect				
21980	Maltreatment of Vuln Subd. 3. Timing of reporter who has rea vulnerable adult is be or who has knowledg has sustained a phys reasonably explained information to the cor individual is a vulnera the individual is admir reporter is not require maltreatment of the in to admission, unless: (1) the individual was another facility and th	report. (a) A mandated son to believe that a eing or has been maltreated, the that a vulnerable adult sical injury which is not a shall immediately report the mmon entry point. If an able adult solely because tted to a facility, a mandated ed to report suspected individual that occurred prior	21980			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00898	B. WING		02	2/11/2016
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	/IBASSADOR	DICINE LAKE ROA DPE, MN 55427	D		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	O THE APPROPRIATE	COMPLET DATE
21980	Continued From page	e 33	21980			
	in section 626.5572, (b) A person not reprovisions of this sec as described above. (c) Nothing in this known or suspected is knows or has reason been made to the con (d) Nothing in this reporter from also rep agency. (e) A mandated rep reason to believe tha 626.5572, subdivision (5), occurred must m subdivision. If the rep time believes that an agency will determine the reported error wa the criteria under sec 17, paragraph (c), cla facility may provide to directly to the lead agency (5). The lead agency information when mat the report under subdivision	section shall preclude a porting to a law enforcement porter who knows or has t an error under section in 17, paragraph (c), clause ake a report under this porter or a facility, at any investigation by a lead e or should determine that s not neglect according to tion 626.5572, subdivision ause (5), the reporter or to the common entry point or gency information explaining the criteria under section in 17, paragraph (c), clause y shall consider this king an initial disposition of division 9c.				
	by:	It is not met as evidenced nd document review, the re allegations of				
	mistreatment were th reported to the state reported to the admin	oroughly investigated, agency, and immediately nistrator according to the				
	facility abuse and neg	glect policy for 2 of 2 (65) who made allegations of				

Minnesota Department of Health STATE FORM

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STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00898	B. WING		02	2/11/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	MBASSADOR	DICINE LAKE ROA DPE, MN 55427	ND		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From page	e 34	21980			
	staff mistreatment.					
	Findings include:					
	9/13, indicated "Notif immediately of any in misappropriation of re- suspected abuse, an neglect, financial exp seclusion. In case al follow the chain of co- (DNS, SW, etc) Do "Immediately," in this as possible after disc ought not to exceed to absence of a shorter requirement." The pr notify the designated and to interview staff witnesses to the incide	olicy also directed staff to stated agency immediately, , residents, or other dent.				
	12/22/15, indicated the cognitive impairment	num Data Set (MDS) dated ne resident had severe , and required extensive ity's of daily living (ADL)'s.				
	resident had a ADL s	d 4/9/15, indicated the elf care performance deficit ascular accident (CVA).				
	indicated "[R20] requ medical assistant/cer [NA-D] no longer be in that TMA/CNA "holler on 1/1/16 while cares Resident reports that (bed time cares) and	acern report dated 1/4/16, lests that TMA/CNA (trained tified nursing assistant) in her room. Resident states red" at her and swore at her s were being provided. : CNA [NA-E] provided HS that during cares [NA-D] uttered" under her breath.				

Innesota Department of Heal TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	E SURVEY
ND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
	00898	B. WING		02	2/11/2016
AME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STATE		02	
AME OF PROVIDER OR SUPPLIER					
GOOD SAMARITAN SOCIETY - A	MBASSADOR	OPE, MN 55427	-		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
21980 Continued From pag	je 35	21980			
[R20] reports that [N in her room with [NA threatened her by sta tomorrow." Residen [NA-D] fired and war this." The Investiga with [NA-D] and [NA reports that he provid and that [NA-D] was observe only. Both [no inappropriate wor [NA-D] during the tim reports that [R20] inf question that she did going to "get her fire "Care Plan includes room when providing history of making fals and has difficulty adj care plan was being incident. Resident re in her room again, re accommodated. [NA nurse pass medication other team members [R20] agreeable to th investigated R20's a was not reported the concern form was sig 1/5/16, one day after immediately accordin During interview 2/10 nurse (RN)-A stated her room per the res resident was to have	A-D] was "mean" to her while E] and states that she ating, "I'm taking care of you t reports that she wants hts something done abut tion indicated, "Interviews E] were conducted. [NA-E] ded all HS cares for [R20] told to stand by the wall and [NA-D and NA-E] report that rds or tones were used by heframe reported. [NA-E] formed him on the day of d not like [NA-D] and was d." The resolution indicated, 2 staff members in resident's g cares. Resident has a se allegations against staff justing to change. Resident's followed at the time of the equest will be respected and A-D] advised to have the ons to [R20] and switch with a for care needs. [NA-D] and he plan." Although the facility llegation of mistreatment, it e state agency, and the gned by the administrator on r the incident, and not ng to the facility policy. D/16, at 12:14 p.m. registered NA-D does not enter R20's idents request and the e two care givers in the room. d a history of making false				

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00898	B. WING		02	2/11/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	02	
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR	DICINE LAKE ROA PE, MN 55427	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF C (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIO REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO TH			CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21980		the state agency. RN-A s interview the residents or	21980			
	decision as a team to report the incident to the state agency, and stated she was not aware that allegations needed to be reported immediately to the state agency prior to a full investigation according to the facility policy.	o report the incident to the ated she was not aware that be reported immediately to r to a full investigation				
	Although R20 made an allegation of abuse the facility investigated the incident, and did not notify the state agency, nor did they notify the administrator immediately according to facility policy.					
	extensive assistance of daily living. R65's care plan dated had hearing and visu	ognitively intact and required of one to complete activities d 02/09/16, identified R65 al deficits and directed staff e time to respond, and				
	stated NA-F, "Picked bed when I asked to g incident happened ap prior, but was unable R65 stated NA-F, "Hi the far side of the bed resident to say, "Ow."	"R65 stated he received a because of the incident,				
nesota Den	A facility Suggestion (12/29/15, identified R	or Concern form dated 65 had reported a nursing ed] him up and threw him on				

STATE FORM

	Department of Healt DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED 02/11/2016	
		00898	 B. WING			
IAME OF PRO	OVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		./11/2010
GOOD SAM	IARITAN SOCIETY - AN	//BASSADOR	DICINE LAKE ROA DPE, MN 55427	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROV EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH OF CONTRACT OF CONTRACT.		PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
	The form identified a incident, which includ with resident who wa further description of [R65] endorses feelin Resident [R65] dod deficits and severe he interviewed five other as R65 for potential a no indication the allegreported to the state facility policy, nor we as part of the investig When interviewed on stated R65 had repor arms around R65's clobed without waiting for had been unable to identified on the concorreported to the State facility. SW state identified on the concorreported to the State facility policy because residents all felt safe.	d occurred, "Multiple times." facility investigation into the led, "SW [social worker] met s unable to provide any staff member Resident ng safe and denies being hurt es have severe vision earing difficult [sic]." SW r residents in the same unit abuse, however, there was gation of mistreatment was agency according to the re any other staff interviewed gation. 2/9/16, at 12:20 p.m. SW rted a staff would wrap his hest and throw him on the pr other staff to assist. R65 dentify a specific staff 65 reported he felt safe at ad the allegation of abuse cern form had not been agency according to the e the other interviewed IOD OF CORRECTION: designee could in-service all	21980	DEFICIEN	CY)	

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00898	B. WING		02	2/11/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	02	./11/2010
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR	DICINE LAKE ROA DPE, MN 55427	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From page	e 38	21995			
21995	21995 MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults		21995			
	 (a) Each facility shall ongoing written proc applicable licensing r of suspected maltrea facility has an interna mandated reporter m requirements of this s internally. However, responsible for comp reporting requiremen This MN Requirement by: Based on interview a facility failed to ensur mistreatment were th reported to the state reported to the admin 	the facility remains lying with the immediate ts of this section. It is not met as evidenced nd document review, the				
	Findings include: R20's quarterly Minimum Data Set (MDS) dated 12/22/15, indicated the resident had severe cognitive impairment, and required extensive assistance with activity's of daily living (ADL)'s.					
	resident had a ADL s	d 4/9/15, indicated the elf care performance deficit scular accident (CVA).				
	indicated "[R20] requ	cern report dated 1/4/16, ests that TMA/CNA (trained tified nursing assistant)				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00898	B. WING		02	2/11/2016
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	02	./11/2010
	MARITAN SOCIETY - AN	IBASSADOR 8100 ME	DICINE LAKE ROA	D		
		NEW HO	PE, MN 55427			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		CTION SHOULD BE	(X5) COMPLET DATE
21995	Continued From page	9 39	21995			
	that TMA/CNA "holler on 1/1/16 while cares Resident reports that (bed time cares) and swore at her and "mu [R20] reports that [NA- in her room with [NA- threatened her by stat tomorrow." Resident [NA-D] fired and want this." The Investigat with [NA-D] and [NA- reports that he provid and that [NA-D] was to observe only. Both [In no inappropriate word [NA-D] during the tim reports that [R20] info question that she did going to "get her fired "Care Plan includes 2 room when providing history of making fals and has difficulty adju care plan was being f incident. Resident re in her room again, rea accommodated. [NA- nurse pass medicatio other team members [R20] agreeable to th investigated R20's all was not reported the concern form was sig 1/5/16, one day after	n her room. Resident states red" at her and swore at her were being provided. CNA [NA-E] provided HS that during cares [NA-D] ttered" under her breath. A-D] was "mean" to her while E] and states that she ting, "I'm taking care of you reports that she wants ts something done abut ion indicated, "Interviews E] were conducted. [NA-E] ed all HS cares for [R20] told to stand by the wall and NA-D and NA-E] report that ds or tones were used by eframe reported. [NA-E] ormed him on the day of not like [NA-D] and was I." The resolution indicated, the resolution indicated, the tast fi members in resident's cares. Resident has a e allegations against staff usting to change. Resident's followed at the time of the quests that [NA-D] not come quest will be respected and -D] advised to have the ns to [R20] and switch with for care needs. [NA-D] and e plan." Although the facility egation of mistreatment, it state agency, and the ned by the administrator on the incident.				
magata Dar		NA-D does not enter R20's dents request and the				

	a Department of Healt	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED	
		00898	B. WING		02	2/11/2016	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·		
	MARITAN SOCIETY - AN	ABASSADOR 8100 ME	DICINE LAKE ROA	D			
		NEW HC	PE, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
21995	Continued From page	e 40	21995				
	resident was to have RN-A stated R20 had accusations of staff in stated after they conf allegation did not hap needed to report it to stated the facility doe staff involved before decision as a team to state agency, and sta allegations need to be the state agency. R65's quarterly MDS indicated R65 was co extensive assistance of daily living. R65's care plan dated had hearing and visu to allow him adequate repeat things as nece During interview on 2 stated NA-F, "Picked bed when I asked to incident happened ap prior, but was unable R65 stated NA-F, "Hit the far side of the bed resident to say, "Ow." sore spot on his head and reported it to a m A facility Suggestion 12/29/15, identified R assistant had, "Pick[et the bed," and this had	two care givers in the room. I a history of making false instreatment, and RN-A firmed with NA-E the open, they did not feel they the state agency. RN-A es interview the residents or they would make the o report the incident to the ated she was not aware that e reported immediately to , completed 11/26/15, ognitively intact and required of one to complete activities d 02/09/16, identified R65 al deficits and directed staff e time to respond, and essary. 2/8/16, at 5:15 p.m. R65 me up and threw me into go to bed." R65 stated this oproximately three months to provide a specific date. t my head on the metal on d," which caused the " R65 stated he received a d because of the incident, urse. or Concern form dated 85 had reported a nursing ed] him up and threw him on d occurred, "Multiple times."					
	incident, which includ with resident who wa	facility investigation into the led, "SW [social worker] met s unable to provide any staff member Resident					

ND PLAN (a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00898	B. WING		02/11/2016		
IAME OF P	ROVIDER OR SUPPLIER		B. WING 02/11/2016 raddress, city, state, zip code 02/11/2016				
GOOD SA	MARITAN SOCIETY - AN	MBASSADOR		D			
(X4) ID PREFIX TAG	(EACH DEFICIENC	NEW HOPE, MN 55427 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF PREFIX TAG		CTION SHOULD BE CON THE APPROPRIATE C			
21995	Resident [R65] dou deficits and severe h interviewed five other as R65 for potential a no indication the aller reported to the state staff interviewed as p When interviewed as p When interviewed as p When interviewed as p When interviewed as p arms around R65's c bed without waiting for had been unable to io member, however, R the facility. SW state identified on the cond reported to the State interviewed residents SUGGESTED METH The administrato in-service all staff on report suspected abu state agency. The di	ng safe and denies being hurt es have severe vision earing difficult [sic]." SW r residents in the same unit abuse, however, there was gation of mistreatment was agency, nor were any other part of the investigation. a 2/9/16, at 12:20 p.m. SW rted a staff would wrap his thest and throw him on the or other staff to assist. R65 dentify a specific staff c65 reported he felt safe at ed the allegation of abuse cern form had not been agency because the other	21995	DEFICIENC	57)		

Minneso	ota Department of He	alth				-	-
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N	IMDED.	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00898		B. WING		02/1	1/2016
NAME OF	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		CINE LAKE E, MN 5542	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCI / MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION OR	DER				
	In accordance with 144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall with a schedule of f the Minnesota Depa	ction order has been y. If, upon reinspect iency or deficiencies ected, a fine for each be assessed in accor- ines promulgated b	n issued tion, it is s cited n violation ordance				
	Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du corrected.	compliance with all a rule provided at the ile number indicated ns several items, fa the items will be con Lack of complianc ny item of multi-par ment of a fine even	e tag d below. llure to nsidered e upon t rule will if the item				
	You may request a that may result fron orders provided tha the Department wit notice of assessme	n non-compliance w It a written request i hin 15 days of recei	ith these s made to pt of a				
	INITIAL COMMENT You have agreed to receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the ensure orders consist artment of Health in 14-01, available a tate.mn.us/divs/fpc/ elicensing orders a	tent with at profinfo/inf				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESE	NTATIVE'S SIGN	ATURE	TITLE		(X6) DATE 03/04/16

STATE FORM

If continuation sheet 1 of 42

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	or connection	DENTIFICATION NOMBER.	A. BUILDING: _			
		00898	B. WING		02/	11/2016
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
OOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading the date your orders will be lectronically submitting to the ment of Health.				
	Department's staff, the following correct Please indicate in y correction that you	2016, surveyors of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, we when they will be completed				
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "IE statute/rule out of co "Summary Stateme and replaces the "T correction order. The findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute c, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, NN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. IR ON EACH PAGE.				

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		PLETED
		00898	B. WING	02 /1	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY				
	SUMMARY STA		PE, MN 55427	BRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE
2 000	Continued From pa	ge 2	2 000		
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
	completed at the tir	gation (s) H5149028 was also ne of the standard survey and ed during this survey.			
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		3/16/16
		omprehensive plan of care personnel involved in the			
	by: Based on observati review, the facility fa interventions were facility residents (R34) rev	ent is not met as evidenced on, interview, and document ailed to ensure care plan followed by staff for 1 of 3 iewed for accidents and for 1) reviewed for toileting and	THERE IS NO REQUIREM SUBMIT A PLAN OF CORI VIOLATIONS OF MINNES STATUTES/RULES.	RECTION FOR	
	Findings include:				
	1/13/16, indicated F impairment, had ca failure. The MDS i extensive assist of dressing, bed mobi	inimum Data Set (MDS) dated R34 had moderate cognitive ncer, anemia, and heart indicated the resident needed two with transfers, toileting, lity, was incontinent of bowel ad no falls in the last month.			
	R34's care plan dat	ed 1/14/16, indicated the			

STATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00898	B. WING	B. WING		11/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	• • •	
GOOD S	AMARITAN SOCIETY	- AMRASSADOR		-		
			OPE, MN 55427	PROVIDER'S PLAN OF	CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 3	2 565			
	mass, was at risk f mobility, had a hist mat, concave matt care plan directed call light with in her During observation observed laying in observed in the low mat on the floor. During observation observed laying in the low position, ho	stic breast cancer with brain or falls related to impaired ory of falls, had low bed, floor ress, and a body pillow. The staff to ensure R34 had her reach. 2/9/15, at 8:21 a.m. R34 was her bed. R34's bed was not v position, nor was there a floo 2/9/15, at 9:32 a.m. R34 was bed dressed. The bed was in owever, the floor mat was the wall behind the oxygen	r			
	During interview 2/ nurse (RN)-I stated floor and the bed s all times. RN-I ent	9/16, at 11:39 a.m. registered I the fall mat should be on the hould be in the low position at ered R34's room and placed floor next to resident.				
	observed laying in low position with fa the residents call li floor out of R34's r (DON) was informed	2/10/16, at 8:01 a.m. R34 was bed and the bed was in the Il mat on the floor. However, ght was observed laying on the each. Director of nursing ed of the call light being out of he entered the residents room all light.	9			
	stated she didn't kr the low position, ar NA who was workin the NA stated she he had left the bed	10/16, at 12:31 p.m. RN-A now why R34's bed was not in nd stated she had talked to the ng with R34 on 02/9/16, and thought during a physician visit up. RN-A stated R34 was a have all the assessed				

	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00898			02/	11/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 565	Continued From pa	age 4	2 565			
	including having the	ce according to the care plan, e call light available because e it to call for staff assistance.				
	R37 had no cogniti incontinent of both for the developmen extensive assistant	DS dated 1/7/16, identified ve impairment, was frequently bladder and bowel, was at risk at of pressure ulcers, required ce from staff for toilet use and and was totally dependent on nd bed mobility.				
	bowel and bladder weakness and imp directed to offer an hours (and as need check/change ever while asleep. The assist R37 with turn	ted 2/2/16, identified R37 had incontinence related to aired mobility, and staff were d assist with toileting every two ded) while awake, and to y two hours (and as needed) care plan also directed staff to hing and repositioning at least th use of a mechanical lift.				
	7:23 a.m. to 10:17 toileting, checked/	observation on 2/10/16, from a.m., R37 was not offered changed, or turned/ o hours and 37 minutes.				
	8:23 a.m. to 11:29 a toileting, checked/	s observation on 2/11/16, from a.m., R37 was not offered changed, or turned/ ee hours and five minutes.				
	stated R37 was to toileted every two h in bed was not indiv repositioning, toilet RN-A stated the fac ask R37 if she wou	a 2/11/16, at 3:01 p.m. RN-A be turned/ repositioned and nours, and offering to lay down cative of an offer for turning/ ing or checking/ changing. cility staff should specifically ild like to be repositioned to have her brief changed, and				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COM	FLETED
		00898	B. WING		02/	11/2016
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE PE, MN 55427	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 5	2 565			
	planned interventio	RN-A stated R37's care ns for repositioning and Ilowed during the above				
	indicated, "Residen the necessary care highest practicable the comprehensive will have an individu care that will includ timetables directed maintaining the res nursing physical, fu psychosocial and e use of departmenta Assessment Instrum	Policy dated September 2013 ts will receive and be provided and services to maintain the well-being in accordance with assessment. Each resident ualized comprehensive plan of e measurable goals and toward achieving and ident's optimal medical, nctional, spiritual, emotional, ducational needs. Through I assessments, the Resident nent and review of the any problems, needs and will be addressed."				
	director of nursing (in-service all staff to to specific resident DON or designee c	HOD OF CORRECTION: The DON) or designee could o follow care plans in regards cares and services. The ould monitor for compliance ngs to the Quality Assurance				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty one				
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and re; General	2 830			3/16/16
	Subpart 1. Care in	general. A resident must				
	epartment of Health					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00898	B. WING		02/11/2016	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKI PE, MN 5542	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 6	2 830			
	custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.	1			
	by: Based on observat review, the facility f reassess pain to er	ent is not met as evidenced ion, interview, and document ailed to comprehensively nsure adequate interventions ieve pain for 1 of 1 residents		THERE IS NO REQUIREN SUBMIT A PLAN OF COR VIOLATIONS OF MINNES STATUTES/RULES.	RECTION FOR	
	11/12/15, indicated was on a schedule	inimum Data Set (MDS) dated he was cognitively intact and d pain regimen, received prn nedications, and had erate pain.				
	chronic pain/discor gout, and neuropat medications. The of staff to, "Report to activity attendance activities related to c/o (complaints of) health care provide	ated 5/28/15, indicated he had nfort related to osteoarthritis, hy which was managed with care plan further instructed Nurse any change in usual patterns or refusal to attend s/s (signs and symptoms) or pain or discomfort. Notify er if interventions are current complaint is a				

TATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00898	B. WING		02/	02/11/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	ADDRESS, CITY, STATE, ZIP CODE				
OOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE PE, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
2 830	Continued From pa	age 7	2 830				
	significant change of pain."	from residents past experience	•				
	5/25/15, indicated H worsening right hip indicated the pain a R154 Pain Data Co indicated R154 had was frequent on all The form indicated 6 (on a scale from pain) and had voca expressions of pair was stabbing, pain increased with mow his sleep at night o had no changes in on a scheduled pai Resident/Family Ec c/o increased pain Goal is tolerable pa	sment (CAA) Worksheet dated he had osteoarthritis with pain, rated his pain as 7, and affected his sleep and mood. ollection form dated 11/28/15, d pain in the last 5 days that of his back and whole leg. the resident rated his pain at a 1-10, with 10 being the worst complaints and facial in daily. In addition, the pain meds relieved the pain, pain wement, the pain did not disrupt r limit his day to day activities, appetite/eating ability, and was n medication regimen. Under ducation indicated, "Resident (nothing new) over a few days. ain. PRN's to be offered as	t				
	R154 had pain in h extremity, rated his body movements o day-to-day activities interest pursuits, ar The Pain Data Coll not received PRN p	tion dated 2/7/16, indicated is entire back and right lower pain at a 5, made protective r postures due to pain, limited s because of pain, decreased nd had irritability and anger. ection also indicated he had pain medication and the, t plan addresses resident's					
	2016, indicated he (hydrochloride) 5 m	sician orders dated February received Oxycodone HCL nilligrams (mg) (a narcotic moderate to severe pain) one					

Minneso	ta Department of He	ealth			FURIM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00898	B. WING		02/	11/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	age 8	2 830			
	indicated the start of 8/14/15. R154 also HCL 5 mg every fo do not exceed six t of 6/26/15. R154 a 325 mg two tablets	a day for pain. The orders date of the medication was o had an order for Oxycodone ur hours as needed for pain; ablets per day with a start date also had an order for Tylenol by mouth every 4 hours as he pain with a start date of				
	R154's medication administration record (MAR) dated 2/1/16, to 2/10/16, at 2:31 p.m. indicated R154 did not receive any of his PRN pain medications.					
	indicated R154 had physician had incre- used for gout) and used for gout), and morephine (a pain however, his morp	Subsequent Visit dated 11/6/15, d gout in his knee and the eased allopurinol (a medication added cholchicine (medication I he had been receiving medication for severe pain), hine tablets were stopped due eding narcan (reverses the				
	indicated R154 use	Subsequent visit dated 1/4/16, ed a scooter for mobility and I by chronic right lower ext				
	Visit Note dated 2/3 Park Nicollet team, syndrome and had years and was rece	nior Services Nursing Home 3/16, indicated he was new to , and R154 had chronic pain been on narcotics for several eiving oxycodone three times a There was no indication if the en was effective.				
/innesota D		n 2/8/16, 6:43 p.m. R154 stated was getting worse, he wanted				
STATE FOR			6899 (096L11	lf continua	tion sheet 9 of 4

TATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00898		B. WING		11/2016
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOB				
	SUMMARY ST		OPE, MN 55427	PROVIDER'S PLAN OF		(УБ)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 9	2 830			
	the nurses he want however, "I get no say they will contact heard back and I a The nurse praction rarely. I haven't ha the pain, she does	ns increased, and he had told ted more pain medication, answer and they [the nurses] ct the nurse practioner. I neve sk again and never hear back her comes and see's me but ad a chance to talk to her about n't come and ask me about my ng nothing for me." R154 s at an 8.	t			
	p.m. R154 stated but it didn't help, so R154 stated his pa	interview 2/10/16, at 12:44 he had an order for oxycodone o he doesn't take the PRN. in was usually at an 8 and nd that he is very rarely at a				
	assistant (NA)-B st and he has a lot of back, and because	10/16, at 1:01 p.m. nursing tated she worked with R154 pain in his right leg and his of the pain R154 would refuse late, and at times would just te of the pain.	9			
	was observed to tra NA-C situated a ch the bed and placed in front of R154 wit briefly repositioned an audible sigh and noted. NA-C asket today?Where?" F my legs." Once all "Take your time" se first attempt to star on his legs and fee	a 2/10/16, at 2:27 p.m. NA-C ansfer R154 in his room. hair at a 45 degree angle from d a four wheeled walker (4WW th the brakes applied. R154 I himself in his wheelchair and d vocalization of "Ah" were d "Are you hurting R154 stated "Yes my hands, set up to transfer, NA-C said everal times as R154 made his hd. As he began to bear weigh at he yelled out "Ow" and a seated position back in his	;			

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00898	B. WING		02/	11/2016
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
OOD S	AMARITAN SOCIETY	- AMRASSADOR				
(X4) ID	SUMMARY ST		PE, MN 55427	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 10	2 830			
	heavily, and then be transfer, and again heavily with his mo closed, as he took bed. With contact wheelchair and pla The NA repeated s do you want me to declined for the aid seated on the bed,	s breathing quickly and began the 2nd attempt to was observed to breath uth open and eyes tightly steps to turn his back to the guard assist he stood from his ced his hands on the 4WW. everal times "Take your time get a nurse for you?" R154 le to get the nurse. Once R154 stated his pain level was ransfer his right knee was				
	the following: -On 2/3/16, 4:26 p. Physician Note Tex NP (nurse praction (Transcutaneous E which is predomina pain conditions) un knee if that was po Awaiting return call -A physician order days after the requ	progress notes/orders indicated m. Communication/Visit with it: "Labs from today called to er). Also questioning tens dectrical Nerve Stimulation ately used for nerve related it for residents pain in his right ssible per resident request. ." was received 2/11/16, eight est for physical therapy to a pain and appropriateness of				
	-On 2/4/16, at 3:00 resident but he refu	p.m. staff approached to walk used due to pain.				
	-On 2/5/16, at 8:58	p.m. resident refused to walk.				
		0 p.m. patient did not walk to d himself out in his electric				
	-On 2/10/16. at 3:2	4 p.m. Communication/Visit				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		E SURVEY PLETED
		00898			02/	11/2016
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE	02/	11/2010
GOOD S	AMARITAN SOCIETY		DICINE LAKE	-		
		NEW HO	PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 11	2 830			
	residents c/o pain i continues to c/o "si denied that it is rac requested PRN pa Continue to monito - On 2/10/16, at 10 shower, "Stating ha meds were administ During interview or	:01 p.m. resident refused ave been in pain all day." Pain				
	having increased p today and had bee medication. During interview or registered nurse (F	ain and he asked for a PRN n asking more for his pain n 2/10/16, at 2:30 p.m. RN)-A stated she was the				
	was having pain. F switched to a new practioner and phy to additional pain n nurses. In addition aware a request fo	s unit and was not aware R154 RN-A stated he had recently doctor and his previous nurse sician were not very receptive nedication requests from the n RN-A stated she was not r a tens unit was made and NP and re-request the order.				
	stated she worked had a pain rating o	n 2/11/16, at 9:31 a.m. RN-F the day shift and R154 usually f 7/10, and recently the ncreased complaints of pain.				
	p.m. NA-C stated F morning and aftern his pain medication	A 2/11/16, at approximelty 1:50 R154 complained of pain in the boons and had been requesting a more often, and felt in the las s pain has been increasing.				
	• •	orted increased pain, was				
TE FOR	epartment of Health M		⁶⁸⁹⁹ 0	96L11	If continuati	on sheet 12 c

AND PLAN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00898	B. WING		02/	11/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	· · · ·	
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 830	Continued From pa	age 12	2 830			
	the pain, the facility	te, and was observed to be in a did not reassess to determine entions could be implemented sidents pain.				
	Assistance policy is indicated the purper assistance in pain residents will receiv consultations on as The policy futher in will assess current the physician and i interventions that n well as pharmacolo will review respons and work closely w	d Pain Management-Resident ssued September 2012, ose was to provide resident management and, "All ve interdisciplinary ssistance in managing pain." indicated "The registered nurse pain levels and develop with interdisciplinary team nay be non-pharmacological a ogical. The registered nurse is to medication interventions with the physician to assist in pain measurement plan."				
	SUGGESTED ME ⁻ The DON or design monitor to ensure a pain and receiving treatment. The DC	THOD OF CORRECTION: nee could train all staff and all residents are assessed for appropriate nursing care and DN or designee could report th lity Assurance Committee.	e			
	TIME PERIOD FO (21) days	R CORRECTION: Twenty one				
	MN Rule 4658.052		2 840			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00898	B. WING		02/11/2016	
AME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
OOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE PE, MN 55427	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 840	Continued From pa	age 13	2 840			
	odors. A bathing pl resident's plan of c condition requires t must be given a co other day and more incontinent residen every two hours, ar following each epis [144A.04 Subd. 1 ⁻ Notwithstanding Mi 4658.0520, an inco checked according written in the reside attending physician interval longer than if competent, or a fa appointed conserva agent of a resident in writing to waive p determining this int documented in the Clean linens or clot promptly each time Perineal care includ the perineal area. to keep the bed dry comfort. Special at skin to prevent irrita types of protectors completely covered contact with the resident	and freedom from offensive lan must be part of each are. A resident whose that the resident remain in bed implete bath at least every e often as indicated. An t must be checked at least nd must receive perineal care ode of incontinence. 1. Incontinent residents. Innesota Rules, part ontinent resident must be to a specific time interval ent's care plan. The resident's in must authorize in writing any two hours unless the resident amily member or legally ator, guardian, or health care who is not competent, agrees obysician involvement in erval, and this waiver is resident's care plan.] thing must be provided the bed or clothing is soiled. des the washing and drying of Pads or diapers must be used <i>i</i> and for the resident's ttention must be given to the ation. Rubber, plastic, or other must be kept clean, be d, and not come in direct sident. Soiled linen and emoved immediately from revent odors.	,			

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00898	B. WING		02/1	1/2016
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
OOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 840	Continued From pa	age 14	2 840			
	by: Based on observat review, the facility f in accordance with maintain as much u	ent is not met as evidenced ion, interview, and document ailed to ensure timely toileting assessed needs, in order to urinary function as possible, for 37) reviewed for urinary	-	THERE IS NO REQUIRE SUBMIT A PLAN OF COF VIOLATIONS OF MINNES STATUTES/RULES.	RRECTION FOR	
	Findings include:					
	1/7/16, identified Ra frequently incontine was not on a toiletin extensive assistant	inimum Data Set (MDS) dated 37's cognition was intact, was ent of both bladder and bowel, ng program, required ce from staff for toilet use and and was totally dependent on nd bed mobility.				
	1/12/16, indicated F fracture, was non-w lower extremity, an assistance from two identified R37 requ toileting, had function increased risk for u infection due to a p	ssessment (CAA) dated R37 had a prosthetic knee veight bearing on her right, d required a total lift with o staff to transfer. The CAA ired maximum assistance with onal incontinence, was at an irinary incontinence and revious UTI, and may have ary frequency secondary to her lications.				
	bowel and bladder weakness and imp directed staff to, "O "every two hours (a	ted 2/2/16, identified R37 had incontinence related to aired mobility. The care plan offer and assist with toileting and as needed) while awake, ge every two hours (and as ep.				
	During a telephone	interview on 2/8/16, at 7:36				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00898	B. WING		02/	02/11/2016	
	PROVIDER OR SUPPLIER		.DDRESS, CITY, S		02/	11/2010	
AIVIE OF F	ROVIDER OR SUPPLIER						
OOD S	AMARITAN SOCIETY	- AMRASSADOR	OPE, MN 55427				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	THE APPROPRIATE	COMPLE DATE	
				DEFICIENC	(Y)		
2 840	Continued From pa	age 15	2 840				
		er (FM)-A stated staff did not					
		eting timely, and she knew of					
		ce where R37 had to wait					
		meal for her soiled					
	incontinence produ	ict to be changed.					
	During a continuou	s observation on 2/10/16, from	1				
		a.m., R37 was not offered					
		d/ changed for two hours and					
		rvations included the following:					
		was lying in her bed and					
	room.	NA)-G was present in the					
		i checked/ changed R37's					
		ict before she was assisted to					
	sit in her wheelcha	ir, using a mechanical lift and					
	two staff to transfe						
		brought R37 to the dining					
	room for the break	vas moved from the dining					
		/ day room area (across from					
		here she watched television					
	with two of her pee	ers.					
		remained seated in her					
		ay room area and stated, "See)				
		'R37 stated she had not yet ng medications, nor had she					
		her exercises, and was					
	sighing as she was						
		sked the surveyor to find a					
		sist her, and Registered nurse					
		aware of R37's request for					
		tated to RN-G, "Well I'd like to m." RN-G assisted R37 to her					
		ided her the call light and					
		N-G did not offer toileting					
		she check/ change R37.					
	At 9:57 a.m., NA-G	entered R37's room and					
		er into bed. R37 accepted and					
	NA-G sought anoth	ner staff person to assist with					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00898	B. WING		02/	02/11/2016	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE			
GOOD SA	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE PE, MN 55427	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
	Continued From pa	age 16	2 840				
	of the room to find stated staff did not commode or bedpa did not believe she commode because non-weight bearing At 10:07 a.m., NA-4 (LPN)-G used a me bed, and NA-G the R37's incontinence minutes between c use of a toilet or be At 10:17 a.m., NA-4 checked/ changed use a bedpan or to incontinent, and NA incontinence brief of Progress Notes fro were reviewed and refusing or declinin of a bedpan and ch incontinence produ During a continuou 8:23 a.m. to 11:29 toileting or checked	G and licensed practical nurse echanical lift to transfer R37 to n proceeded with changing brief, with two hours and 37 hanges. R37 was not offered edpan. G stated R37 was to be every two hours and did not ilet because she was always A-G confirmed R37's contained a small void of urine m 12/31/15, through 2/10/16, lacked evidence of R37 g cares, including toileting/ use necking/ changing her					
	At 8:23 a.m., R37 w table waiting for bread At 9:06 a.m., R37 s the day room area. resident, brought h eye drop medication the day room. RN-	self-propelled her wheelchair to RN-H approached the er to her room, administered in, and then returned R37 to H did not offer to toilet or					
nesota De	check/ change R37 At 10:09 a.m., NA- epartment of Health	A approached R37 and asked					

-	NT OF DEFICIENCIES	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
2000 S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE			
3000 3	AMANITAN SOCIETT	NEW HO	PE, MN 55427	1		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 840	Continued From pa	ge 17	2 840			
	offer, however, NA- check/ change R37 At 10:31 a.m., an a attend an exercise and remained seate room. At 10:46 a.m., NA-/ R37 was to be check hours, using a mec bed. NA-A stated F changed at 8:00 a.r approached R37 ea wanted to lay down NA-A stated she int refusal to be check would approach R3 she wanted to lay do check and change use a toilet or comr mechanical sling lif did not use a bedpa proceeded with ass had still not been of changed. At 11:05 a.m., the s R37 would be offer approached R37 ar to her room to check accepted and NA-A before seeking a se the transfer. NA-A the room to assist w and checking/ char with three hours an changes. At 11:29 a.m., NA-A bowel movement a incontinence brief.	down. R37 declined this A did not offer to toilet or civities staff invited R37 to group, which R37 declined ed in her wheelchair in the day A was interviewed and stated cked/ changed every two hanical lift to transfer her into R37 was last checked/ m. and stated she had arlier and asked her if she , but the resident declined. erpreted R37's response as a ed/ changed, and typically she 7 every two hours and ask if own, which is when she would R37. NA-A stated R37 did not node because she required a t for transfers, and stated R37 an either. NA-A then bisting other residents and R37 ffered to toilet or be checked/ surveyor asked NA-A when ed toileting again, and NA-A nd asked if she could take her ck her incontinence brief. R37 brought her to her room econd staff person to help with returned and RN-H entered with transferring R37 to bed uging her incontinence brief, d five minutes between A stated R37 had a small nd a small void of urine in her Though staff were not 837 the use of a bedpan during				

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 840	Continued From pa	ige 18	2 840			
	this observation, NA-A stated she did offer the bedpan and R37 declined.					
	stated R37 was to I and was usually ind she and NA-A did of the above noted ob RN-H stated that sl lay down did consti checking/ changing offer equated a refu During interview on confirmed R37 was bedpan every two h offered a bedpan d bowel in her inconti offer to lay down in offer for toileting or R37's declining to I refusal for toileting. have specifically as have her brief char	2/11/16, at 3:01 p.m. RN-A to be offered the use of a nours, and should have been espite identification of urine or inence brief. RN-A stated an bed was not indicative of an checking/ changing, and ay down did not equate a RN-A stated staff should sked if she would have liked to iged and use the bedpan, and ving R37's care planned				
	Evaluation and Ret directed staff to ensorr or bladder incontine treatment and serv	and Bladder Assessment raining policy dated 9/12, sure each resident with bowel ence received appropriate ices to restore as much adder function as possible.				
	The director of nurs develop and impler	THOD OF CORRECTION: sing (DON) or designee could nent policies and procedures lents who require assistance				

	DIT DEPARTMENT OF HE NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY
		00898	B. WING		02/11/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE PE, MN 5542	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 840	Continued From pa	ge 19	2 840		
	of nursing (DON) of as appropriate. The designee could more	e timely services. The director r designee could educate staff e director of nursing (DON) or nitor or audit to ensure e and report the findings to the Committee.			
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty one			
2 900	MN Rule 4658.0528 Ulcers	5 Subp. 3 Rehab - Pressure	2 900		3/16/16
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which			
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and			
	receives necessary	ho has pressure sores (treatment and services to event infection, and prevent veloping.			
	by: Based on observati review, the facility fa repositioning were of prevent pressure ul	ent is not met as evidenced on, interview, and document ailed to ensure toileting and completed as assessed to cers for 1 of 3 residents (R37) dentified at risk for pressure		THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FO VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	OR

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 20	2 900			
	ulcer development.					
	Findings include:					
	1/7/16, identified R impairment, was fre bladder and bowel, development of pre extensive assistant personal hygiene, a staff for transfers a R37's Care Area As	essure ulcers, required ce from staff for toilet use and and was totally dependent on				
	fracture, was weak non-weight bearing The CAA identified	, de-conditioned, and on her right, lower extremity. a goal for R37 to remain free vn related to incontinence and				
	1/3/16, identified R	Assessment & Evaluation dated 37 required total assistance and directed staff to offer two hours.	Ł			
	bowel and bladder weakness and imp directed to offer an hours (and as need check/change ever while asleep. The assist R37 with turn	ted 2/2/16, identified R37 had incontinence related to aired mobility, and staff were d assist with toileting every two ded) while awake, and to y two hours (and as needed) care plan also directed staff to hing and repositioning at least th use of a mechanical lift.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE PE, MN 55427				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
2 900	Continued From pa	age 21	2 900				
	p.m. family member get assisted with to knew of at least on wait through the su incontinence produ During continuous 7:23 a.m. to 10:17 toileting, checked/or repositioned for two Observations inclue At 7:23 a.m., R37 v assistant (NA)-G w At 7:30 a.m., NA-G incontinence produ her wheelchair usin staff to transfer. At 7:45 a.m., NA-G room for the breakfar (across from the di watched television At 9:20 a.m., R37 v room after breakfar (across from the di watched television At 9:20 a.m., R37 r wheelchair in the d "See how late they had not yet receive nor had she been a and R37 visibly and At 9:40 a.m. R37 a staff member on he (RN)-G was asked RN-G, "Well I'd like RN-G assisted R37 her the call light, ar not offer toileting, or	observation on 2/10/16, from a.m., R37 was not offered changed, or turned/ o hours and 37 minutes. ded the following: was lying in bed and nursing ras present in the room. a checked/ changed R37's not before assisting R37 to sit in a mechanical lift and two a brought R37 to the dining fast meal. was moved from the dining st, to an alcove/ day room area ning room), where the resident with two of her peers. remained seated in her ay room area and R37 stated, get?" The resident stated she of her morning medications, assisted with her exercises, d audibly sighed several times. sked the surveyor to find a er behalf and registered nurse to assist R37. R37 stated to e to get back to my room." 7 to her resident room, handed nd exited the room. RN-G did shecking/ changing or turning/					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00898	B. WING		02/	11/2016
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		02/	11/2010
		8100 ME	DICINE LAKE			
3000 3		NEW HC	PE, MN 55427			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 22	2 900			
	NA-G got another s transferring R37 int At 10:07 a.m., NA-C (LPN)-G used a me bed and proceeded brief, with two hours changes. NA-G co brief contained a sr R37 was not obsern herself during this of At 10:17 a.m., NA-C checked/ changed, every two hours.	G and licensed practical nurse echanical lift to transfer R37 to I to change R37's incontinence s and 37 minutes between nfirmed R37's incontinence nall void of urine. ved to offload or reposition observation. G stated R37 was to be and turned/ repositioned				
	were reviewed and refusing or declining	m 12/31/15, through 2/10/16, lacked evidence of R37 g cares, including turning/ hecking/ changing her ct.				
	8:23 a.m. to 11:29 a toileting, checked/or repositioned for thre Observations includ At 8:23 a.m., R37 w table, awaiting her I At 9:06 a.m., R37 s the day room area. brought her to her r medication and the room. RN-H did no change, or reposition At 10:09 a.m., NA-A if she wanted to lay down, however, NA	vas seated at the dining room breakfast meal. self-propelled her wheelchair to RN-H approached her, room, administered eye drop n returned R37 to the day of offer to toilet or check/				

	<u>ota Department of He</u>	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		BERTH TO/THOM BERT	A. BUILDING:			
		00898	B. WING		02/	11/2016
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE I	-		
		NEW HO	PE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 23	2 900			
	attend an exercise and remained seate room. At 10:46 a.m., NA-/ R37 was to be check repositioned every lift to transfer her in last checked/ chang at 8:00 a.m. NA-A R37 earlier and ask down, but the resid NA-A stated she int refusal to be check repositioned. NA-A approach R37 ever wanted to lay down lay down staff would NA-A then proceed residents, and R37 toilet and/or checker repositioned. At 11:05 a.m., the s staff would expect t changing and turnin which time NA-A ap she could take her incontinence brief. brought the residen RN-H to assist. NA transferring R37 to changed her incont and five minutes be offloading. R37's b slightly pink, but bla confirmed. At 11:29 a.m., NA-A	ctivities staff invited R37 to group. R37 declined this offer ed in her wheelchair in the day A was interviewed and stated cked/ changed and turned/ two hours, using a mechanical to bed. NA-A stated R37 was ged and turned/ repositioned stated she had approached ked her if she wanted to lay ent declined to lay down. terpreted R37's response as a ed/ changed and/ or a stated she attempted to y two hours and ask if she , and if the resident agreed to d check and change her. ed with assisting other had still not been offered to ed/ changed or turned/ surveyor asked NA-A when to offer toileting, checking/ ng/ repositioning to R37, at oproached R37 and asked if to her room to check her R37 accepted and NA-A at to her room, and asked A-A and RN-H proceeded with her bed and checked and inence brief, with three hours etween changes and ottom was observed as anchable, which RN-H				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00898	B. WING		02/11/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE PE, MN 55427	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	During interview or stated R37 was to l every two hours an RN-H stated she fe down did constitute repositioning and to and stated if R37's considered a refuse repositioning. During interview or stated R37 was to l toileted every two h in bed was not india repositioning, toilet R37's declining to l refusals for these of staff should have s have liked to be rep bottom, have her b bedpan. RN-A state interventions for rep not followed during The facility's policy Pressure Ulcer Pre Requirements date who are unable to re independently should directed by the card SUGGESTION ME	 2/11/16, at 2:25 p.m. RN-H be repositioned and toileted d was usually incontinent. an offer for turning/ bileting or checking/ changing, decline to lay down, that was al for toileting and 2/11/16, at 3:01 p.m. RN-A be turned/ repositioned and hours, and offering to lay down cative of an offer for turning/ changing; and ay down did not equate sares. RN-A stated the facility pecifically asked if she would bositioned to offload her rief changed, and utilize the ed R37's care planned positioning and toileting were the above observations. titled Skin Assessment, expension of the meselves and be repositioned as often as a plan approaches." 		DEFICIEN	57)	
	The director of nurs review and revise t procedures on pres designee could pro turning and repositi or designee could p	sing (DON) or designee could he current policy and ssure ulcers. The DON or vide education to all staff on ioning schedules. The DON provide monitoring for ment and prevention of				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
		00898	B. WING	0	2/11/2016
	PROVIDER OR SUPPLIER	- AMBASSADOB 8100 ME	DDRESS, CITY, DICINE LAK	STATE, ZIP CODE E ROAD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 900	Continued From pa	ge 25	2 900		
	pressure ulcers and Quality Assurance (d report the findings to the Committee.			
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty one	,		
21325	MN Rule 4658.072 Emergency Oral He	5 Subp. 1 Providing Routine & ealth Ser	21325		3/16/16
	home must provide resource, routine de needs of each resid include dental exan fillings and crowns, oral surgery, bridge orthodontic procede that are provided for	e dental services. A nursing e, or obtain from an outside ental services to meet the dent. Routine dental services ninations and cleanings, root canals, periodontal care, es and removable dentures, ures, and adjunctive services or similar dental patients in the , as limited by third party rcies.			
		ent is not met as evidenced			
	review the facility fa	ion, interview, and document ailed to ensure dental follow up completed for 1 of 3 residents dental services.		THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FO VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	PR
	Findings include:				
	(MDS) dated 1/6/16 moderate cognitive	ange Minimum Data Set 6, indicated the resident had impairment and need for ce to complete activities of			
	R15's care plan dat	ted 2/10/16, directed staff to			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00898	B. WING		02/	11/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE PE, MN 55427	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21325	Continued From pa	ge 26	21325			
		th assistance to complete ning, and the resident e independently.				
	stated he had miss side of his mouth a evaluation by the do teeth and discomfo jaw. R15 stated he be a follow up appo	2/9/16, at 10:42 a.m. R15 ing teeth on the upper right nd had been seen for entist because of the missing rt on the right side of his upper had understood there was to bintment, however, he had rding this since his last visit				
	was observed eatin problems chewing. R15 stated he con- the upper right side and again stated he	on 2/10/16, at 1:03 p.m. R15 ig his meal with no visible During interview at this time, tinued to have discomfort on of his mouth with chewing, e had broken teeth and, "I was up a long time ago [with the n't heard anything."				
	note dated 9/10/15, that date for a reca indicated, "Diagnos High;rampant deca #12 and 13 had bug non-restorable, Rec Several no [sic] cav Treatment recomm fillings and extractio	e Tree Coon Rapids progress indicated (R15) was seen on ll exam. The progress note sis/Assessment: Caries risk: y . See oral exam form. Tooth ccal cusps have fractured off; commend extractions " vities noted since last exam." endations were made for ons, in addition to follow up for ent every three months.				
	resident had no fur	edical records indicated the ther follow up dental were there any follow up denta duled.				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00898	B. WING		02/	11/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21325	Continued From pa	age 27	21325			
	registered nurse (F dental recommend because when a fo appointments is co "Noted," on the forr indicated there had communication with since R15's visit of A review of the poli Services and Asses 2012, indicated the	cy titled Dental/Oral Health ssments, issued September				
	The director of nurs develop, review and procedures to ensu The DON or design appropriate staff or	THOD OF CORRECTION: sing (DON) or designee could d revise policies and ure dental services are provide nee could educate all n the policies and procedures. nee could monitor to ensure e.				
	TIME PERIOD FOI (21) days	R CORRECTION: Twenty one	9			
21685	MN Rule 4658.141 Housekeeping, Op	5 Subp. 2 Plant eration, & Maintenance	21685			3/16/16
	including walls, floo systems, and equip continuous state of	plant. The physical plant, ors, ceilings, all furnishings, oment must be kept in a good repair and operation health, comfort, safety, and				

6899

	It of Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		00898	B. WING		02/11/2	016
	PROVIDER OR SUPPLIER	8100 ME	DDRESS, CITY, DICINE LAK I	STATE, ZIP CODE E ROAD		
OOD S	AMARITAN SOCIET	- AMBASSADOR NEW HO	PE, MN 554	27		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE C THE APPROPRIATE	(X5) OMPLE DATE
21685	Continued From pa	age 28	21685			
		esidents according to a written ce and repair program.				
	by: Based on observative review the facility f the walk-in cooler temperatures were potential to affect a facility. Findings include:	nent is not met as evidenced tion, interview, and document failed to ensure timely repair of to ensure adequate e maintained. This had the all 66 residents who ate in the		THERE IS NO REQUIRI SUBMIT A PLAN OF CO VIOLATIONS OF MINNE STATUTES/RULES.	RRECTION FOR	
	facility's kitchen wa dietary manager (0 walk-in cooler was and was not seale no longer automat pressed shut after	p.m. an initial tour of the as conducted with certified CDM), and the door of the observed resting slightly open d shut. CDM stated the door ically sealed and had to be each entry, and he had already tenance department of this				
	conducted with CE again observed to sealed shut. CDM maintenance of the approximately two facility had experies maintenance perso departments response requests may have result. CDM was documentation rego repair, and stated request but just sp	3 p.m. a follow-up tour was DM and the walk-in cooler was be resting slightly open/ not I stated again he had informed e door/seal needing repair weeks prior, however, the enced a turn-over of onnel and he suspected the onse time to maintenance e been somewhat delayed as a unable to provide any garding the request for the he did not document the toke to the maintence ing this follow-up tour, cook-A				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00898	B. WING		02/	02/11/2016	
	PROVIDER OR SUPPLIER	- AMBASSADOB 8100 ME	DDRESS, CITY, ST DICINE LAKE PE, MN 55427	ROAD	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE	
	press the door shut to rest slightly open noticed and presse During interview on environmental serv he had started worl approximately three was not aware of th not sealing. He sta	2/11/16, at 4:13 p.m. the ices director (ESD) reported					
	requests for repairs door was not identi facility's process. E preventative mainte back logged, he wa maintenance/ repairs	s, and stated the walk-in cooler fied in the log as per the ESD stated though some of the enance tasks were slightly as on schedule with ir requests, and stated if he ne issue, he would have					
	directed the CDM v refrigerator temper	Storage policy dated 2/16, vas responsible for monitoring atures. The policy added, to be brought to the attention .ff.					
	The administrator of review, and revise ensure kitchen equi appropriately. The could educate all a and procedures. T	THOD OF CORRECTION: or designee could develop, policies and procedures to ipment was maintained administrator or designee ppropriate staff on the policies he administrator or designee itoring systems to ensure e.					
	TIME PERIOD FOI	R CORRECTION: Twenty one					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/11/2016	
		00898	B. WING			
AME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
OOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAK	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMP	
21685	Continued From pa	age 30	21685			
	(21) days					
21805	MN St. Statute 144 Residents of HC F	I.651 Subd. 5 Patients & ac.Bill of Rights	21805		3/16/	
	residents have the courtesy and respe	ous treatment. Patients and right to be treated with ect for their individuality by ersons providing service in a				
	by: Based on observat review, the facility	tion, interview, and document failed to promote dignity with 2 of 5 residents (R163 and r toileting.		THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORRECT VIOLATIONS OF MINNESOTA S STATUTES/RULES.	ION FOR	
	Findings include:					
	12/21/15, indicated	linimum Data Set (MDS) dated the resident was cognitively ensive assist with toileting, and portinent of urine.				
		ated 10/08/15, indicated he inence and wore briefs.				
	was sitting in his re incontinence brief	2/10/16, at 6:51 a.m. R163 ccliner chair, and a soiled, white was observed from the hall loor behind his wheelchair.	Э			
	stated he was not a was on the floor ne	10/16, at 6:52 a.m. R163 aware the incontinence pad ext to him and stated, "I have not want them to see that."				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00898	B. WING	B. WING		11/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE PE, MN 55427	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21805	Continued From pa	age 31	21805			
	nurse (RN)-E state	10/16, at 7:00 a.m. registered d the pad should not be on the see, and RN-E then entered wed the pad.				
	he was cognitively	DS dated 11/12/15, indicated intact, needed extensive eting, and was frequently				
		ated 9/01/15, indicated he had ce and preferred a urinal or rief.				
	stated at times his minutes, and stated into the bathroom. to tell them I peed I me." R154 stated	10/16, at 7:12 a.m. R154 call light was left on for over 30 d, "I am in bed wanting to go It's embarrassing when I have by pants again, please change he had incontinence episodes he had to wait so long for staf Ily at night.				
	Report dated from	er Documentation Survey 2/1/16, to 2/11/16, R154 was five times at 7:00 p.m.				
	stated the facility de however, they were print out to see how being left on. RN-A audit on 1/28/16, ho	11/16, at 10:58 a.m. RN-A oes random call light audits, e not able to do a computerized v long R154's call light was was able to provide one call owever, only the morning d, and the facility was unable ning audits.	ł			
	February 2013, ind	d Resident Dignity dated icated, "The facility will esidents in a manner and in an				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00898	B. WING		02/	11/2016
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	ge 32	21805			
	resident's dignity ar his or her individual indicated "Refrainin to residents such a bags uncovered, re- residents request for SUGGESTED MET The director of nurs educate staff on dig designee could the to ensure residents are being maintaine	THOD OF CORRECTION: sing (DON) or designee could gnity and respect. The DON o n interview residents routinely feel their dignity and respect	r			
21980	(21) days MN St. Statute 626 Maltreatment of Vu	.557 Subd. 3 Reporting - Inerable Adults	21980			3/16/16
	Subd. 3. Timing of reporter who has re- vulnerable adult is l or who has knowled has sustained a ph reasonably explained information to the of individual is a vulner the individual is adur reporter is not requi	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the common entry point. If an erable adult solely because mitted to a facility, a mandated ired to report suspected e individual that occurred prior	9			
	another facility and believe the vulneral previous facility; or	as admitted to the facility from the reporter has reason to ble adult was maltreated in the mows or has reason to believe)			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X	3) DATE SURVEY COMPLETED	
		00898	B. WING		02/11/2016	
IAME OF I	PROVIDER OR SUPPLIER	4	DDRESS, CITY, S	TATE, ZIP CODE	02/11/2010	
OOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
21980	Continued From pa	ge 33	21980			
	in section 626.5572 (b) A person not provisions of this s as described above (c) Nothing in thi known or suspecte knows or has rease been made to the c (d) Nothing in thi reporter from also agency. (e) A mandated n reason to believe th 626.5572, subdivis (5), occurred must subdivision. If the time believes that a agency will determin the reported error w the criteria under se 17, paragraph (c), of facility may provide directly to the lead how the event mee 626.5572, subdivis (5). The lead agen	s section requires a report of d maltreatment, if the reporter on to know that a report has common entry point. s section shall preclude a reporting to a law enforcement reporter who knows or has hat an error under section on 17, paragraph (c), clause make a report under this reporter or a facility, at any in investigation by a lead ne or should determine that vas not neglect according to ection 626.5572, subdivision clause (5), the reporter or a to the common entry point or agency information explaining ts the criteria under section on 17, paragraph (c), clause may an initial disposition of				
	by: Based on interview facility failed to ens mistreatment were reported to the stat reported to the adn facility abuse and n	ent is not met as evidenced and document review, the ure allegations of thoroughly investigated, e agency, and immediately ninistrator according to the eglect policy for 2 of 2 R65) who made allegations of		THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA STAT STATUTES/RULES.		

Minnesc	ta Department of He	ealth	-		<u> </u>	IAPPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		BERTH TOXITOT TOMBET.	A. BUILDING: _	·····		
		00898	B. WING		02/	11/2016
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻			
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE PE, MN 55427			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET
21980	Continued From pa	age 34	21980			
	staff mistreatment.					
	Findings include:					
	9/13, indicated "No immediately of any misappropriation o suspected abuse, a neglect, financial e seclusion. In case follow the chain of (DNS, SW, etc) I "Immediately," in th as possible after di ought not to excee absence of a short requirement." The notify the designate	ed Abuse And Neglect revised offy the location administrator r incidents of resident abuse, f resident property, alleged or and injury of unknown origin, xploitation or involuntary absence of the administrator, command for notification Document this notification. his procedure means "as soon iscovery of the incident, and d the end of the shift, in the er state time frame policy also directed staff to ed stated agency immediately, aff, residents, or other cident.				
	12/22/15, indicated cognitive impairme assistance with act R20's care plan da resident had a ADL	himum Data Set (MDS) dated I the resident had severe ent, and required extensive tivity's of daily living (ADL)'s. ted 4/9/15, indicated the self care performance deficit				
	A Suggestion Or C indicated "[R20] re- medical assistant/c [NA-D] no longer b that TMA/CNA "hol on 1/1/16 while car Resident reports th (bed time cares) as	vascular accident (CVA). oncern report dated 1/4/16, quests that TMA/CNA (trained certified nursing assistant) e in her room. Resident states llered" at her and swore at her res were being provided. nat CNA [NA-E] provided HS nd that during cares [NA-D] muttered" under her breath.	\$			

	ta Department of He	eaith (X1) Provider/Supplier/Clia				(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED	
		00898	B. WING		02/	11/2016	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
GOOD S	AMARITAN SOCIETY	- AMBASSADOB	DICINE LAKE PE, MN 55427				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE	
21980	Continued From pa	age 35	21980				
	[R20] reports that [NA-D] was "mean" to her while	•				
	in her room with [N	A-E] and states that she					
		stating, "I'm taking care of you					
		ent reports that she wants					
		ants something done abut ation indicated, "Interviews					
		A-E] were conducted. [NA-E]					
		vided all HS cares for [R20]					
		s told to stand by the wall and					
		[NA-D and NA-E] report that					
		ords or tones were used by imeframe reported. [NA-E]					
		nformed him on the day of					
	question that she d	lid not like [NA-D] and was					
		ed." The resolution indicated,					
		s 2 staff members in resident's					
		ng cares. Resident has a alse allegations against staff					
		djusting to change. Resident's					
		g followed at the time of the					
		requests that [NA-D] not come	•				
		request will be respected and					
		NA-D] advised to have the tions to [R20] and switch with					
	other team membe	ers for care needs. [NA-D] and					
		the plan." Although the facility					
		allegation of mistreatment, it					
		ne state agency, and the					
		signed by the administrator on					
		er the incident, and not ding to the facility policy.					
	-	10/16, at 12:14 p.m. registered					
		d NA-D does not enter R20's					
		esidents request and the					
	resident was to have	ve two care givers in the room.					
		ad a history of making false					
		f mistreatment, and RN-A					
		nfirmed with NA-E the appen, they did not feel they					
nonata D	epartment of Health		l			<u> </u>	

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI	E CONSTRUCTION		
			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00898	B. WING		02/	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21980	Continued From pa	age 36	21980			
	stated the facility destaff involved before decision as a team state agency, and state agency a	to the state agency. RN-A oes interview the residents or re they would make the to report the incident to the stated she was not aware that to be reported immediately to rior to a full investigation cility policy.				
	facility investigated the state agency, n	e an allegation of abuse the the incident, and did not notify or did they notify the ediately according to facility				
	indicated R65 was extensive assistant of daily living. R65's care plan da had hearing and vis	OS completed 11/26/15, cognitively intact and required ce of one to complete activities ted 02/09/16, identified R65 sual deficits and directed staff ate time to respond, and ecessary.				
	stated NA-F, "Picke bed when I asked t incident happened prior, but was unab R65 stated NA-F, " the far side of the b resident to say, "O	a 2/8/16, at 5:15 p.m. R65 ed me up and threw me into to go to bed." R65 stated this approximately three months ble to provide a specific date. Hit my head on the metal on bed," which caused the w." R65 stated he received a ead because of the incident, a nurse.				
	12/29/15, identified assistant had, "Pick	n or Concern form dated I R65 had reported a nursing k[ed] him up and threw him on				
linnesota D TATE FOR	epartment of Health M		6899 C	096L11	If continuation	on sheet 37 of 4

00896 B. WING 02 MARE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BIOD SAMARITAN SOCIETY - AMBASSADOR SUMMARY STATEMENT OF DEFICIENCES TAG SUMMARY STATEMENT OF DEFICIENCES TAG PROVIDER OF NOT STATE ZIP CODE SUMMARY STATEMENT OF DEFICIENCES TAG PROVIDER OF NOT STATE ZIP CODE SUMMARY STATEMENT OF DEFICIENCES TAG PROVIDER PLAN OF CORRECTION TAG 21980 Continued From page 37 121980 Continued From page 37 121980 Continued From age 37 List colspan="2">Contraction to staff mothemer:			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
Bit of MEDICINE LAKE ROAD NEW HOPE, MN 55327 Image: Constraint of the period the period of the period the period the period the period of the period to the period period to the period to the period the period the period to the period t			00898	B. WING		02/	11/2016
(X4) ID PREFIX TAG ID IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL TAG 21980 Continued From page 37 21980 The bed," and this had occurred, "Multiple times." The form identified a facility investigation into the incident, which included, "SW [social worker] met with resident who was unable to provide any further description of staff member Resident [R65] endorses feeling safe and denies being hurt Resident [R65] does have severe vision deficits and severe hearing difficult [sic]." SW interviewed five other residents in the same unit as R65 for potential abuse, however, there was no indication the allegation. When interviewed on 2/9/16, at 12:20 p.m. SW stated R65 had reported a staff would wrap his arms around R65's chest and throw him on the bed without waiting for other staff to assist. R65 had been unable to identify a specific staff member, however, R65 reported he felt safe at the facility. SW stated the allegation of abuse identified on the concern form had not been reported to the State agency according to the facility policy. State agency according to the facility policy because the other interviewed residents all felt safe. SUGGESTED METHOD OF CORRECTION: The administrator or designee could in-service all staff on the need to follow the facility abuse policy in regards to immediately reporting suspected			AMBASSADOR 8100 ME	DICINE LAKE	ROAD		
 the bed," and this had occurred, "Multiple times." The form identified a facility investigation into the incident, which included, "SW [social worker] met with resident who was unable to provide any further description of staff member Resident [R65] endorses feeling safe and denies being hurt Resident [R65] does have severe vision deficits and severe hearing difficult [sic]." SW interviewed five other residents in the same unit as R65 for potential abuse, however, there was no indication the allegation of mistreatment was reported to the state agency according to the facility policy, nor were any other staff interviewed as part of the investigation. When interviewed on 2/9/16, at 12:20 p.m. SW stated R65 had reported a staff would wrap his arms around R65's chest and throw him on the bed without waiting for other staff to assist. R65 had been unable to identify a specific staff member, however, R65 reported he felt safe at the facility. SW stated the allegation of abuse identified on the concern form had not been reported to the State agency according to the facility policy because the other interviewed residents all felt safe. SUGGESTED METHOD OF CORRECTION: The administrator or designee could in-service all staff on the need to follow the facility abuse policy in regards to immediately reporting suspected 	PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
TIME PERIOD FOR CORRECTION: Twenty one	21980	the bed," and this h The form identified incident, which incl with resident who w further description [R65] endorses fee Resident [R65] of deficits and severe interviewed five oth as R65 for potentia no indication the al reported to the stat facility policy, nor w as part of the invest When interviewed stated R65 had rep arms around R65's bed without waiting had been unable to member, however, the facility. SW stat identified on the cor reported to the Stat facility policy becau residents all felt sat SUGGESTED MET The administrator of staff on the need to in regards to imme abuse to the design re-education of stat	had occurred, "Multiple times." a facility investigation into the luded, "SW [social worker] met was unable to provide any of staff member Resident eling safe and denies being hur does have severe vision a hearing difficult [sic]." SW her residents in the same unit al abuse, however, there was legation of mistreatment was te agency according to the were any other staff interviewed stigation. on 2/9/16, at 12:20 p.m. SW ported a staff would wrap his is chest and throw him on the g for other staff to assist. R65 b identify a specific staff R65 reported he felt safe at ated the allegation of abuse oncern form had not been te agency according to the use the other interviewed fe. THOD OF CORRECTION: or designee could in-service all o follow the facility abuse policy diately reporting suspected nated state agency, document ff.	t			

	ta Department of He	alth				APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00898	B. WING		02/1	1/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	DICINE LAKI PE, MN 5542	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	Continued From pa	ge 38	21995			
21995	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4a Reporting - Inerable Adults	21995			3/16/16
	ongoing written pro applicable licensing of suspected maltre facility has an interr mandated reporter requirements of this internally. However responsible for com reporting requirement This MN Requirement by:	ent is not met as evidenced				
	facility failed to ensumistreatment were reported to the state reported to the adm	and document review, the ure allegations of thoroughly investigated, e agency, and immediately ninistrator, for 2 of 2 residents ose made allegations of staff		THERE IS NO REQUIREMENT T SUBMIT A PLAN OF CORRECTIONS VIOLATIONS OF MINNESOTA S STATUTES/RULES.	ON FOR	
	Findings include:					
	12/22/15, indicated cognitive impairment	imum Data Set (MDS) dated the resident had severe nt, and required extensive ivity's of daily living (ADL)'s.				
	resident had a ADL	ed 4/9/15, indicated the self care performance deficit vascular accident (CVA).				
	indicated "[R20] rec	oncern report dated 1/4/16, quests that TMA/CNA (trained ertified nursing assistant)				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00898	B. WING		02/	02/11/2016	
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
OOD S	AMARITAN SOCIETY						
(X4) ID			PE, MN 55427	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLE	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	DATE	
21995	Continued From page 39		21995				
	that TMA/CNA "holl on 1/1/16 while card Resident reports th (bed time cares) an swore at her and "n [R20] reports that [I in her room with [N, threatened her by s tomorrow." Reside [NA-D] fired and wa this." The Investig with [NA-D] and [N/ reports that he prov and that [NA-D] and [N/ reports that he prov and that [NA-D] wa observe only. Both no inappropriate wo [NA-D] during the ti reports that [R20] ir question that she d going to "get her fir "Care Plan includes room when providir history of making fa and has difficulty ac care plan was being incident. Resident in her room again, n accommodated. [N nurse pass medica other team membe [R20] agreeable to investigated R20's was not reported th concern form was s 1/5/16, one day after	10/16, at 12:14 p.m. registered					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00898	B. WING		02/11/2016	
NAME OF	PROVIDER OR SUPPLIER		EET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- AMBASSADOR	DICINE LAKE PE, MN 55427			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21995	Continued From pa	age 40	21995			
	RN-A stated R20 has accusations of staff stated after they coallegation did not has needed to report it stated the facility do staff involved before decision as a team state agency, and sa allegations need to the state agency. R65's quarterly MD indicated R65 was extensive assistant of daily living. R65's care plan dat had hearing and visito allow him adequate repeat things as nee During interview on stated NA-F, "Picked bed when I asked t incident happened prior, but was unab R65 stated NA-F, "the far side of the bar si	2/8/16, at 5:15 p.m. R65 ed me up and threw me into o go to bed." R65 stated this approximately three months le to provide a specific date. Hit my head on the metal on bed," which caused the w." R65 stated he received a ad because of the incident,	5			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00898	B. WING		02/	11/2016
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
GOOD S	AMARITAN SOCIETY		DICINE LAKE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	age 41	21995			
	Resident [R65] of deficits and severe interviewed five oth as R65 for potentia no indication the al reported to the stat staff interviewed as When interviewed as When interviewed as stated R65 had rep arms around R65's bed without waiting had been unable to member, however, the facility. SW stat identified on the co	ling safe and denies being hurt loes have severe vision hearing difficult [sic]." SW her residents in the same unit abuse, however, there was legation of mistreatment was e agency, nor were any other a part of the investigation. on 2/9/16, at 12:20 p.m. SW horted a staff would wrap his to chest and throw him on the for other staff to assist. R65 to identify a specific staff R65 reported he felt safe at the dthe allegation of abuse ncern form had not been the agency because the other hts all felt safe.				
	The administra in-service all staff or report suspected al state agency. The monitor incident rep requirement.	THOD OF CORRECTION: tor or designee could on the need to immediately buse/neglect to the designated director of nurses could ports for implementation of this R CORRECTION: Twenty one				



Minnesota Department of Health Protecting, maintaining and improving the health of all Minnesotans



Confirmation page! Thank you for using the data entry system. If you have comments please send to: <u>monica.larson@health.state.mn.us</u>

Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-672 form for data entry?	Go to CMS-672
I'm finished and would like to exit the application.	Exit

Standard Survey Date Format: mm/dd/yy From F1: 02/08/16 To F2: 02/11/16	Extended Survey Date Format: mm/dd/yy From F3: To F4:							
Name of Facility: GOOD SAMARITAN SOCIETY - AMBAS	Provider Number: 245149	Fiscal Year ending:						
Address: 8100 MEDICINE LAKE ROAD, NEW HOPE, HENNEPIN, MN 55427								
Telephone Number: F6 763-544-4171								
 A. F9 01 - Skilled Nursing Facility (SNF) - Medicare Participation B. Is this facility hospital based? F10 No If yes, indicate Hopsital Provider Number: F11 								
Ownership: F12 05 - Non Profit - Nonprofit	Corporation							
Owned or leased by Multi-Facility Organization: F13 Yes Name of Multi-Facility Organization: F14 The Evangelical Lutheran Good Samarita								
Dedicated Special Care Units (show number of beds for all that apply)								
AIDS F15 0 Alz	IDS F15 0 Alzheimer's Disease F16 0							
Dialysis F17 0 Dis	Disabled Child Young Adult F18 0							
Head Trama F19 0 Hos	Hospice F20 0							

Huntington's Disease F21 0 Other Spec Rehab. F23 33	Ven	tilatoı	/Respiratory Car	re F22 0		
Does the facility currently have a	in organized re	esiden	t group? F24	Yes		
Does the facility currently have a members of residents? F25	in organized g	roup o	of family	No		
Does the facility conduct experim	nental researcl	n? F26)	No		
Is the facility part of a continuing (CCRC)? F27	g care retireme	ent cor	nmunity	No		
If the facility currently has a staf the date(s) of the last approval. I granted. If the facility does not h	ndicate the nu	mber	of hours waived	for each type o	•	
Waiver of seven day RN require	Taiver of seven day RN requirement. Date: mm/dd/yy F28				Hours waived per week: F29	
Waiver of 24 hr licensed nursing	Waiver of 24 hr licensed nursing requirement. Date: $mm/dd/yy$ F30					
Does the facility currently have a competency program? F32	in approved nu	irse ai	de training and	No		
The following three questions a 1) Was this a staggered Survey? 2) If staggered, day of the week 3) If staggered, starting time?		pleteo	No - Not S Surveyor		M	
	FACILITY	STA	FFING			
	A		В	С	D	

		А	В	С	D
	Tag #	Services Provided 123	Full-Time Staff (hours)	Part-Time Staff (hours)	Contract (hours)
Administration	F33		272	249	0
Physician Services	F34	Yes No No			
Medical Director	F35		0	0	4
Other Physician	F36		0	0	0
Physician Extender	F37	No No No	0	0	0

Nursing Services	F38	Yes No No			
RN Director of Nursing	F39		80	0	0
Nurses with Admin Duties	F40		472	0	0
Registered Nurses	F41		1163	3	0
Licensed Practical/ Vocational Nurses	F42		575	58	0
Certified Nurse Aides	F43		1490	521	0
Nurse Aides in Training	F44		0	0	0
Medication	F45		227	114	0
Pharmacists	F46	Yes No No	0	0	8
Dietary Services	F47	Yes No No			
Dietitian	F48		59	0	0
Food Service Workers	F49		443	142	0
Therapeutic Services	F50				
Occupational Therapist	F51	Yes No No	90	0	0
Occupational Therapy Assistant	F52		281	0	0
Occupational Therapy Aides	F53		0	0	0
Physical Therapist	F54	Yes No No	94	0	0
Physical Therapy Assist	F55		150	0	0
Physical Therapy Aides	F56		0	0	0
Speech/Language	F57	Yes No No	74	0	0
Therapeutic Recreation Spec.	F58	No No No		0	0
Qualified Activities Prof.	F59	Yes No No	156	0	0
Other Activities Staff	F60	Yes No No	61	27	0
Qualified Social Workers	F61	Yes No No	160	0	0

Other Social Services Staff	F62	Yes No No	76	12	0
Dentists	F63	Yes No No	0	0	0
Podiatrists	F64	Yes No No	0	0	0
Mental Health Services	F65	Yes No No	0	0	4
Vocational Services	F66	No No No			
Clinical Laboratory Services	F67	No No No			
Diagnostic X-ray Services	F68	No No No			
Administration Storage of Blood	F69	No No No			
Housekeeping Services	F70	Yes No No	276	196	0
Other	F71		0	58	0
Name of Person Completing Form: marie barta					

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- Emergency Preparedness
- Environments & Your Health
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Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-671 form for data entry?	Go to CMS-671
I'm finished and would like to exit the application.	Exit

GOOD SAMARITAN SOCIETY - AMBAS						
Provider No. 245149	Medicare F75 15	Medicaid F76 17	Other F77 39	Total Residents F78 71		

ADL	Independent	Assist of One Two Staff	Dependent
Bathing	F79 1	F80 63	F81 7
Dressing	F82 3	F83 62	F84 6
Transferring	F85 8	F86 51	F87 12
Toilet Use	F88 5	F89 58	F90 8
Eating	F91 61	F92 5	F93 5

A. Bowel/Bladder Status	B. Mobility
F94 9 With indwelling or external catheter.	F100 3 Bedfast all or most of time
F95 Of total number of residents with catheters, 9 were present on admission.	F101 47 In chair all or most of time.
	F102 2 Independently ambulatory.

 F96 39 Occasionally or frequently incontinent of bladder. F97 29 Occasionally or frequently incontinent of bowel. F98 21 On individually written bladder training program. F99 0 On individually written bowel training program. 	 F103 19 Ambulation with assistance or assistive device. F104 0 Physically restrained. F105 Of total number of residents with restrained, 0 were admitted with orders for restraints. F106 6 With contractures. F107 Of total number of residents with contractures, 6 had contractures on admission.
C. Mental Status	D. Skin Integrity
F108 0 With mental retardation.	F115 1 With pressure sores (exclude stage I).
F109 25 With documentation signs and symptoms of depression.	F116 0 Of the total number of residents with pressure sores excluding stage I, how many residents had pressure sores on admission?
 F110 12 With documentation psychiatric diagnosis (excluding dementias and depression). F111 20 Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type. F112 6 With behavioral symptoms. F113 2 Of the total number of residents with behavioral symptoms, the total number receiving a behavior management prpgram. F114 0 Receiving health rehabilitative services for MI/MR. 	F117 60 Receiving preventive skin care. F118 0 With rashes.
E. Special Care	
F119 10 Receiving hospice care benefit.	F127 0 Receiving suction.
F120 0 Receiving radiation therapy.	F127 6 Receiving suction. F128 13 Receiving injections (exclude vitamin B12 injections)
F121 0 Receiving chemotherapy.	F129 2 Receiving tube feedings.

F122 2 Receiving dialysis.	F130 8 Receiving mechanically altered diets including pureed and all chopped food (not only meat).
F123 0 Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion.	F131 35 Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy).
F124 6 Receiving respiratory treatment.	F132 7 Assistive devices while eating.
F125 0 Receiving tracheostomy care.	
F126 2 Receiving ostomy care.	

F. Medication	G. Other
F133 40 Receiving any psychoactive medication.	F140 9 With unplanned significant weight loss/gain.
F134 9 Receiving antipsychotic medications.	F141 1 Who do not communicate in the dominant language of the facility (includes those who use sign language).
F135 14 Receiving antianxiety medications.	F142 2 Who use non-oral communicationdevices.
F136 30 Receiving antidepressant medications.	F143 41 With advance directives.
F137 1 Receiving hypnotic medication.	F144 65 Received influenza immunization.
F138 4 Receiving antibiotics.	F145 68 Received pneumococcal vaccine.
F139 63 On pain management program.	

I certify that this Information is accurate to the best of my knowledge.					
Name of Person Completing Title Date					
marie barta	administrator	02/16/2016			

To be completed by MDH survey team.
F146 Was ombudsman office notified prior to survey? Yes
F147 Was ombudsman present during any portion of the survey? No
F148 Medication error rate 0%

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1

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
245149	GOOD SAM SOCIETY AMBASSADOR
Type of Survey (select all that app	ply): A Complaint Investigation E Initial Certification I Recertification
АІК	B Dumping Investigation F Inspection of Care J Sanction/Hearing
	C Federal Monitoring G Validation K State License
	D Follow-up Visit H Life safety Code L Chow
Extent of Survey (Select all that a	apply):
	A Routine/Standard (all providers/suppliers)
A	B Extended Survey (HHA or long term care facility)
	C Partial Extended Survey (HHA)

D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. | Use the surveyor's information number.

1.									
Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel (Hours (H)	off-Site Report Preparation Hours (I)	
1. 27955	02-08-2016	02-11-2016	0.25	1.25	29.50	3.25	2.50	0.00	
2. 28598	02-08-2016	02-11-2016	0.50	1.25	26.50	3.50	1.25	18.75	
³ . 29437	02-08-2016	02-11-2016	0.25	1.25	29.75	3.00	2.50	7.00	
4. Team Leader 34987	02-08-2016	02-11-2016	1.50	1.25	29.50	3.50	2.50	3.75	
⁵ . 35992	02-08-2016	02-11-2016	0.50	1.25	29.50	3.25	2.50	14.50	
6.									
7.									
8.									
9.									
10.									

Total Supervisory Review Hours	8.00
Fotal Clerical/Data Entry Hours	3.25
Nas Statement of Deficiencies given to the provider on-site at completion of the survey? \ldots .	Y

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
245149	GOOD SAM SOCIETY AMBASSADOR
Type of Survey (select all that app.	ly): A Complaint Investigation E Initial Certification I Recertification B Dumping Investigation F Inspection of Care J Sanction/Hearing C Federal Monitoring G Validation K State License D Follow-up Visit H Life safety Code L Chow
Extent of Survey (Select all that ag	oply): A Routine/Standard (all providers/suppliers) B Extended Survey (HHA or long term care facility) C Partial Extended Survey (HHA)

D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. | Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel (Hours (H)	off-Site Report Preparation Hours (I)	
1. 28598	02-10-2016	02-10-2016	0.00	0.00	3.00	0.00	1.25	0.00	
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									ſ

Total Supervisory Review Hours	0.00
Total Clerical/Data Entry Hours	2
Was Statement of Deficiencies given to the provider on-site at completion of the survey?	

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number H			P	rovider/Supplier Name								
245149			G	OOD SAM SOCIETY AMBASSADOR								
Type of	Surve	y (sel	lect a	ll tha	at app	ly):	A Complaint Investigation	E Initial Certification	I Recertification			
н	I	ĸ					B Dumping Investigation	F Inspection of Care	J Sanction/Hearing			
	-	-					C Federal Monitoring	G Validation	K State License			
							D Follow-up Visit	H Life safety Code	L Chow			
Extent c	of Surv	vey (S	Select	all t	hat a	pply):						
							A Routine/Standard (all providers/suppliers)					
A							B Extended Survey (HHA or	long term care facility)				
<u> </u>		1	<u> </u>	I			C Partial Extended Survey (HHA)					

D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. | Use the surveyor's information number.

			-		-				
Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel (Hours (H)	off-Site Report Preparation Hours (I)	
1. 19251	02-12-2016	02-12-2016	1.00	0.00	3.00	0.00	3.00	0.00	
Team Leader 2. 37009	02-12-2016	02-12-2016	1.00	0.00	4.00	0.00	1.00	1.00	
3.									
4.									
5.									
6.									
7.									_
8.									
9.									
10.									

 Total Supervisory Review Hours
 0.00

 Total Clerical/Data Entry Hours
 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?

FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS-2786 FORMS)

PROVIDER N	OVIDER NUMBER FACILITY NAME								SURVEY DATE	
K1 245	5149		GOOI) SAMARITAN SOCIET	TY - AMBA	SSADOR			*K4 02/12/2016	
110	TE OF F PROVA			K3 : MULTIPLE CONSTRU- TOTAL NUMBER OF BUILD NUMBER OF THIS BUILDIN	INGS	01		А	A BUILDING B WING C FLOOR D APARTMENT UNIT	
LSC FORM	1 INDIC	ATOR				COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21				
Г		Не	alth Car	Form	ا ٦	SMALL		(16 BEDS OR	LESS)	
ŀ	12	2786 R		2000 EXISTING	-			1 PROMPT		
ŀ	12	2786 R		2000 EABSTING	-	K8:		2 SLOW		
L	10	2760 K		2000 112 11				3 IMPRACTI	CAL	
			ASC Fo	rm	·					
	14	2786 U		2000 EXISTING		LARGE				
	15	2786 U		2000 NEW				4 PROMPT 5 SLOW		
ICF/MR Form			٦ T	K8:		6 IMPRACTI	CAL			
ł	16	2786 V, W, X		2000 EXISTING						
	17	2786 V, W, X		2000 EABSTING	-		NT HOUSE			
L	17	2700 V, W, A		2000 1121		AFAKIWE	NT HOUSE			
*K7 12				ED FROM ABOVE		K8: 7 PROMPT 8 SLOW 9 IMPRACTICAL				
	-	9 or K56 are ma ^r , U, V, W, X, Y		not applicable in the		ENTER E-SCORE HERE				
		_	Г							
K29	9:		K56:			K5: e.g 2.5				
*10.540	TH ITV	MEETSISCDA	SED ON	(Check all that apply)						
· K9 : FAU	ILII Y	MEETS LOU BA	SED ON:	(Cneck all inal apply)						
A	1			A2 X	A3		A4		A5	
	OMP. W Provi	/ITH SIONS)	(A	CCEPTABLE POC)	(WAI	VERS)	(F	SES)	(PERFORMANCE BASED DESIGN)	
FACILITY	DOES	NOT MEET LS	C:	K180: A.	X		В.		C.	
B.					SPRINKLER			SPRINKLERED areas are sprinklered)	NONE (No sprinkler system)	
				(An required	a areas are spin	iniciou)		acus are sprinkiered)	(100 sprinkter system)	

*MANDATORY

FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUM	OVIDER NUMBER FACILITY NAME							SURVEY DATE	
K1 24514	19	GOOD	SAMARITAN SOCIET	Y - AMBA	SSADOR			*K4 02/12/2016	
K6 DATE APPRO	OF PLAN)VAL		K3 : MULTIPLE CONSTRUC TOTAL NUMBER OF BUILDI NUMBER OF THIS BUILDING	INGS	2 02		A	A BUILDING B WING C FLOOR D APARTMENT UNIT	
LSC FORM IN	DICATOR				COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21				
	н	ealth Care	Form	1 I	SMALL		(16 BEDS OR	LESS)	
12			2000 EXISTING	1			1 PROMPT		
13			2000 NEW	1	K8:		2 SLOW		
	2700 R	Į		-			3 IMPRACTI	CAL	
		ASC For							
14	2,00 0		2000 EXISTING		LARGE		4 PROMPT		
15	2786 U		2000 NEW	J			5 SLOW		
ICF/MR Form			ן ר	K8:		6 IMPRACTI	CAL		
16	1		2000 EXISTING	1					
17			2000 NEW	1	APARTMEN	NT HOUSE			
	*K7 13 SELECT NUMBER OF FORM USED FROM ABOVE (Check if K29 or K56 are marked as not applicable in the				K8: 7 PROMPT 8 SLOW 9 IMPRACTICAL				
	R, T, U, V, W, X, 1				ENTER E-SCORE HERE				
K29:		K56:			K5:		e.g 2.5		
*K9 : FACIL	TY MEETS LSC B	ASED ON: (Check all that apply)						
	P. WITH DVISIONS)		A2	A3 (WAI	VERS)	A4 (FSI	ES)	A5 (PERFORMANCE BASED DESIGN)	
FACILITY D	DES NOT MEET L	SC:		X PRINKLERI areas are sprir		B PARTIALLY SF (Not all required are		C. NONE (No sprinkler system)	

*MANDATORY

S5149026

MINNESOTA DEPARTMENT OF HEALTH Division of Health Policy, Information and Compliance Monitoring 85 East Seventh Place, Suite 300, P.O. Box 64900 St. Paul, Minnesota 55164-0900

	_								
Email for Adminis	strator: Mbarta & Good-Sc	im.com							
National Provider Identifier (NPI) Number: <u>1114908878</u> One facility may have multiple NPI Numbers. Please verify the NPI number associated with the provider type for this survey, i.e. for a nursing home survey, the NPI Number will be associated with the Nursing Home.									
OWNERSHIP INFO	DRMATION AT THE TIME OF SURVEY								
Name of Facility:	GOOD SAM SOCIETY AMBASSADOR	City: <u>NEW HOPE</u>							
Name of Legal Ent	tity Operating Provider: <u>THE EVANGELICAL LUTH</u>	ERAN GOOD SAMARITAN							
SOCIETY									
Name and Addres	ss of Governing Board President:								
Name:	DAVID HORAZDOVSKY								
Address:	1112 EAST DOVE TRAIL								
City/State/Zip:	SIOUX FALLS, MAY 57108								
If legal entity or pa provide the inform	resident of the governing board is different than nation below.	what is noted above, please							
Name of Facility	/:	City:							
Name of Legal E	ntity Operating Provider:								
Name and Addro	ess of Governing Board President:								
Name:									
Address:									
City/State/	/Zip:								
SIGNATURE	$\sim \rho$								
Completed by: 💆	Mare Darba								
Title:	ADMINISTRATOR								
Date:	2-8-16								

		ID HUMAN SERVICES			FORM	APPROVED	
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE	0938-0391	
-	CORRECTION	IDENTIFICATION NUMBER:		6	COMP		
		245149	B. WING		02/	11/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	MARITAN SOCIETY - AN	IRASSADOR		8100 MEDICINE LAKE ROAD			
GOOD 3A	WARITAN SOCIETT - AW	IBASSADOR		NEW HOPE, MN 55427			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF			
		,		DEFICIENCY)			
F 000	INITIAL COMMENTS		F 00	0			
	÷ .	correction (POC) will serve					
	as your allegation of o						
		ance. Because you are ur signature is not required					
		rst page of the CMS-2567					
		submission of the POC will					
	be used as verificatio	n of compliance.					
	I Inon receipt of an ac	ceptable electronic POC, an					
		facility may be conducted to					
		ial compliance with the					
		attained in accordance with					
	your verification.						
	A standard recertifica	tion survey was conducted					
	and a complaint invest						
		of the standard survey. An					
		laint H5149028 was not					
F 225	substantiated during f	•	Гос				
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c INVESTIGATE/REPC		F 22	.5			
55-D	ALLEGATIONS/INDIV						
		employ individuals who have					
		busing, neglecting, or by a court of law; or have					
	, united and the second s	into the State nurse aide					
		buse, neglect, mistreatment					
		propriation of their property;					
		edge it has of actions by a					
	_	n employee, which would service as a nurse aide or					
		service as a nurse aide or ne State nurse aide registry					
	or licensing authoritie						
	The feet"						
	The facility must ensu involving mistreatmer	re that all alleged violations					
		וו, ווכטובטו, טו מטטטב,					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	Ξ.	TITLE	1	(X6) DATE	

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

PRINTED: 02/25/2016

		D HUMAN SERVICES MEDICAID SERVICES					FORM): 02/25/2016 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245149	B. WING				02/	11/2016
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STA	TE, ZIP CODE	-	
GOOD SA	MARITAN SOCIETY - AM	BASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 225	including injuries of un misappropriation of re- immediately to the ad to other officials in acc through established p State survey and cert The facility must have violations are thoroug prevent further potent investigation is in prog The results of all inve- to the administrator of representative and to with State law (includi certification agency) v incident, and if the all appropriate corrective This REQUIREMENT by: Based on interview a facility failed to ensure mistreatment were the reported to the state a reported to the admin (R20 and R65) whose mistreatment. Findings include: R20's quarterly Minim 12/22/15, indicated th cognitive impairment,	hknown source and esident property are reported ministrator of the facility and cordance with State law rocedures (including to the ification agency). e evidence that all alleged hly investigated, and must ial abuse while the gress. stigations must be reported r his designated other officials in accordance ing to the State survey and within 5 working days of the eged violation is verified a action must be taken.	F	225				

If continuation sheet Page 2 of 46

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/25/2016 M APPROVED D. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245149	B. WING _			02	/11/2016
NAME OF PF	OVIDER OR SUPPLIER	I		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				810	00 MEDICINE LAKE ROAD		
GOOD SAI	MARITAN SOCIETY - AN	IBASSADOR		NE	W HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	resident had a ADL server related to cerebral var A Suggestion Or Comindicated "[R20] required medical assistant/cere [NA-D] no longer be in that TMA/CNA "holler on 1/1/16 while caress Resident reports that (bed time cares) and swore at her and "muticated" (R20) reports that [NA- threatened her by stationary in the room with [NA- threatened her by station or row." Resident [NA-D] fired and wan this." The Investigat with [NA-D] and [NA- reports that he provid and that [NA-D] was to observe only. Both [In no inappropriate word [NA-D] during the time reports that [R20] inford question that she did going to "get her fired "Care Plan includes 2 room when providing history of making fals and has difficulty adjucts care plan was being fals and has difficulty adjucts accommodated. [NA-	A 2 d 4/9/15, indicated the elf care performance deficit scular accident (CVA). cern report dated 1/4/16, ests that TMA/CNA (trained tified nursing assistant) in her room. Resident states red" at her and swore at her were being provided. CNA [NA-E] provided HS that during cares [NA-D] ttered" under her breath. A-D] was "mean" to her while E] and states that she ting, "I'm taking care of you reports that she wants ts something done abut ion indicated, "Interviews E] were conducted. [NA-E] ed all HS cares for [R20] told to stand by the wall and NA-D and NA-E] report that ds or tones were used by eframe reported. [NA-E] ormed him on the day of not like [NA-D] and was 1." The resolution indicated, 2 staff members in resident's cares. Resident has a e allegations against staff usting to change. Resident's followed at the time of the quests that [NA-D] not come quest will be respected and -D] advised to have the ns to [R20] and switch with	F 2	225	DEFICIENCY)		
		for care needs. [NA-D] and e plan." Although the facility					

Facility ID: 00898

If continuation sheet Page 3 of 46

PRINTED: 02/25/2016 FORM APPROVED

OLIVIEN	S FOR MEDICARE &					O. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	L /	E SURVEY IPLETED	
		245149	B. WING		02	2/11/2016	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SA	MARITAN SOCIETY - AM	IBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 225	investigated R20's all was not reported the concern form was sig 1/5/16, one day after During interview 2/10 nurse (RN)-A stated N her room per the resident resident was to have RN-A stated R20 had accusations of staff m stated after they conf allegation did not hap needed to report it to stated the facility doe staff involved before to decision as a team to state agency, and staff	egation of mistreatment, it state agency, and the ned by the administrator on the incident. /16, at 12:14 p.m. registered NA-D does not enter R20's dents request and the two care givers in the room. a history of making false histreatment, and RN-A irmed with NA-E the open, they did not feel they the state agency. RN-A s interview the residents or	F 22	25			
	extensive assistance of daily living. R65's care plan dated had hearing and visua to allow him adequate repeat things as nece During interview on 2 stated NA-F, "Picked bed when I asked to g incident happened ap prior, but was unable R65 stated NA-F, "Hit the far side of the bed	ognitively intact and required of one to complete activities d 02/09/16, identified R65 al deficits and directed staff e time to respond, and essary. /8/16, at 5:15 p.m. R65 me up and threw me into go to bed." R65 stated this oproximately three months to provide a specific date. t my head on the metal on					

If continuation sheet Page 4 of 46

		D HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 02/25/2016 MAPPROVED O. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(2) MULTIPLE CONSTRUCTION BUILDING		E SURVEY IPLETED
		245149	B. WING		02	2/11/2016
NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
GOOD SA	MARITAN SOCIETY - AM	BASSADOR		100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 225	12/29/15, identified R assistant had, "Pick[e the bed," and this had The form identified a incident, which includ with resident who was further description of [R65] endorses feelin Resident [R65] doe deficits and severe he interviewed five other as R65 for potential a no indication the alleg reported to the state a	urse. or Concern form dated 65 had reported a nursing d] him up and threw him on l occurred, "Multiple times." facility investigation into the ed, "SW [social worker] met s unable to provide any staff member Resident g safe and denies being hurt	F 225			
F 226 SS=D	When interviewed on stated R65 had repor arms around R65's ch bed without waiting fo had been unable to id member, however, R6 the facility. SW stated identified on the conc reported to the State interviewed residents 483.13(c) DEVELOP/ ABUSE/NEGLECT, E The facility must deve policies and procedur	2/9/16, at 12:20 p.m. SW ted a staff would wrap his nest and throw him on the or other staff to assist. R65 entify a specific staff 55 reported he felt safe at d the allegation of abuse ern form had not been agency because the other all felt safe. IMPLMENT TC POLICIES elop and implement written es that prohibit , and abuse of residents	F 226			

Facility ID: 00898

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245149	B. WING			02/	11/2016
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR		-	100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 226	Continued From page	9 5	F	226			
	by: Based on interview a facility failed to ensure mistreatment were the reported to the state a reported to the admin facility abuse and neg residents (R20 and R staff mistreatment. Findings include: A facility Policy titled / 9/13, indicated "Notify immediately of any in misappropriation of re suspected abuse, and neglect, financial exp seclusion. In case ab follow the chain of con (DNS, SW, etc) Doo "Immediately," in this as possible after disco ought not to exceed the absence of a shorter requirement." The por notify the designated and to interview staff, witnesses to the incide R20's quarterly Minim 12/22/15, indicated the cognitive impairment, assistance with activity	Abuse And Neglect revised y the location administrator, agency of the administrator cidents of resident abuse, esident property, alleged or d injury of unknown origin, loitation or involuntary osence of the administrator, mmand for notification cument this notification. procedure means "as soon overy of the incident, and he end of the shift, in the state time frame olicy also directed staff to stated agency immediately, residents, or other					

Facility ID: 00898

If continuation sheet Page 6 of 46

PRINTED: 02/25/2016

CONSTRUCTION (TREET ADDRESS, CITY, STATE, ZIP CODE 100 MEDICINE LAKE ROAD EW HOPE, MN 55427 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	X3) DATE SURVEY COMPLETED 02/11/2016 (X5) COMPLETIC DATE
100 MEDICINE LAKE ROAD EW HOPE, MN 55427 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETIC
100 MEDICINE LAKE ROAD EW HOPE, MN 55427 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETIC
EW HOPE, MN 55427 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETIC
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETIC

Facility ID: 00898

If continuation sheet Page 7 of 46

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 02/25/2016 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245149	B. WING		02	/11/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AM	IBASSADOR		3100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	 1/5/16, one day after immediately according During interview 2/10, nurse (RN)-A stated N her room per the resider stated RN-A stated R20 had accusations of staff m stated after they confiallegation did not hap needed to report it to stated the facility does staff involved before the decision as a team to state agency, and state agency, and state agency prior according to the facility Although R20 made a facility investigated the the state agency, nor administrator immediated R65 was co extensive assistance of daily living. R65's care plan dated 	state agency, and the ned by the administrator on the incident, and not g to the facility policy. (16, at 12:14 p.m. registered NA-D does not enter R20's dents request and the two care givers in the room. a history of making false histreatment, and RN-A rmed with NA-E the pen, they did not feel they the state agency. RN-A s interview the residents or hey would make the report the incident to the ted she was not aware that be reported immediately to to a full investigation ty policy. an allegation of abuse the e incident, and did not notify did they notify the ately according to facility completed 11/26/15, gnitively intact and required of one to complete activities at 02/09/16, identified R65 al deficits and directed staff e time to respond, and	F 226			

Facility ID: 00898

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/25/2016 MAPPROVED D. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245149	B. WING			02/	/11/2016
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AM	BASSADOR			100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From page	8	F	226			
	stated NA-F, "Picked	/8/16, at 5:15 p.m. R65 me up and threw me into					
		o to bed." R65 stated this proximately three months					
	prior, but was unable	to provide a specific date. my head on the metal on					
	the far side of the bed	," which caused the					
		R65 stated he received a because of the incident,					
	and reported it to a nu						
	12/29/15, identified R assistant had, "Pick[e the bed," and this had The form identified a incident, which includ with resident who was further description of s [R65] endorses feelin Resident [R65] doe deficits and severe he interviewed five other as R65 for potential a no indication the alleg reported to the state a	or Concern form dated 65 had reported a nursing d] him up and threw him on l occurred, "Multiple times." facility investigation into the ed, "SW [social worker] met is unable to provide any staff member Resident g safe and denies being hurt is have severe vision earing difficult [sic]." SW residents in the same unit buse, however, there was lation of mistreatment was agency according to the e any other staff interviewed					
	stated R65 had report arms around R65's ch bed without waiting fo had been unable to id	2/9/16, at 12:20 p.m. SW ted a staff would wrap his nest and throw him on the r other staff to assist. R65 entify a specific staff					
	the facility. SW stated	65 reported he felt safe at d the allegation of abuse ern form had not been					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					PRINTED: 02/25/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		245149	B. WING		02/11/2016
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE	•
GOOD SAMARITAN SOCIETY - AMBASSADOR			8100 MEDICINE LAKE ROAD		
GOOD SA	MARITAN SOCIETT - AN	IDASSADUK		NEW HOPE, MN 55427	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO TH DEFICIENCY		VE ACTION SHOULD BE COMPLETION ED TO THE APPROPRIATE DATE
F 226	Continued From page 9		F 2	26	
	reported to the State agency according to the facility policy because the other interviewed residents all felt safe.				
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY		F 2	41	
	manner and in an env	note care for residents in a vironment that maintains or ent's dignity and respect in or her individuality.			
	by: Based on observatio review, the facility fail	is not met as evidenced n, interview, and document ed to promote dignity with of 5 residents (R163 and bileting.			
	Findings include:				
	12/21/15, indicated th	mum Data Set (MDS) dated ne resident was cognitively sive assist with toileting, and inent of urine.			
	R163's care plan date had bladder incontine	ed 10/08/15, indicated he ence and wore briefs.			
	was sitting in his recli incontinence brief wa	/10/16, at 6:51 a.m. R163 ner chair, and a soiled, white s observed from the hall or behind his wheelchair.			
	stated he was not aw was on the floor next	/16, at 6:52 a.m. R163 are the incontinence pad to him and stated, "I have t want them to see that."			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 02/25/2016 // APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE	
		245149	B. WING				02/	11/2016
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	DE		
GOOD SA	MARITAN SOCIETY - AM	IBASSADOR			8100 MEDICINE LAKE ROAD			
					NEW HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD B		(X5) COMPLETION DATE
F 241	Continued From page	9 10	F	241	1			
	nurse (RN)-E stated t	/16, at 7:00 a.m. registered he pad should not be on the e, and RN-E then entered d the pad.						
	he was cognitively int	S dated 11/12/15, indicated act, needed extensive ng, and was frequently						
		ed 9/01/15, indicated he had and preferred a urinal or .f.						
	stated at times his cal minutes, and stated, ' into the bathroom. It's to tell them I peed by me." R154 stated he	 /16, at 7:12 a.m. R154 II light was left on for over 30 'I am in bed wanting to go s embarrassing when I have pants again, please change had incontinence episodes e had to wait so long for staff at night. 						
		Documentation Survey I/16, to 2/11/16, R154 was /e times at 7:00 p.m.						
	stated the facility does however, they were n print out to see how lo being left on. RN-A w audit on 1/28/16, how hours were included, to provide any evenin	(16, at 10:58 a.m. RN-A s random call light audits, ot able to do a computerized ong R154's call light was as able to provide one call rever, only the morning and the facility was unable g audits. Resident Dignity dated						

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		3	COMPLETED
		245149	B. WING		02/11/2016
IAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP C	CODE
GOOD SA	MARITAN SOCIETY -	AMBASSADOR		8100 MEDICINE LAKE ROAD	
				NEW HOPE, MN 55427	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COMPLETING COMPLETING DATE
F 241	Continued From pa	ae 11	F 24	11	
		icated, "The facility will			
		sidents in a manner and in an			
		aintains or enhances each			
	• • •	nd respect in full recognition of lity." The policy further			
		ng from practices demeaning			
		s keeping urinary catheter			
		fusing to comply with a			
F 282	residents request for 483 20(k)(3)(ii) SE	RVICES BY QUALIFIED	F 28	32	
SS=D	PERSONS/PER C/				
		led or arranged by the facility y qualified persons in			
		ich resident's written plan of			
	This REQUIREME	NT is not met as evidenced			
	by:				
		tion, interview, and document ailed to ensure care plan			
		followed by staff for 1 of 3			
		iewed for accidents and for 1			
	of 3 residents (R37 pressure ulcers.) reviewed for toileting and			
	Findings include:				
		inimum Data Set (MDS) dated			
		R34 had moderate cognitive ncer, anemia, and heart			
	•	indicated the resident needed			
	extensive assist of	two with transfers, toileting,			
	-	lity, was incontinent of bowel			
	and bladder, and h	ad no falls in the last month.			
	R34's care plan dat				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		245149	B. WING			02/	11/2016
NAME OF P	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
GOOD SA	MARITAN SOCIETY - AM	BASSADOR			8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	mass, was at risk for mobility, had a history mat, concave mattress care plan directed sta call light with in her re- During observation 2/ observed laying in he observed in the low p mat on the floor. During observation 2/ observed laying in be the low position, howe folded up against the tank. During interview 2/9/1 nurse (RN)-I stated the floor and the bed sho all times. RN-I entered the fall mat on the floor During observation 2/ observed laying in be low position with fall re- the fall mat on the floor During interview 2/10/ stated she didn't know the low position, and NA who was working the NA stated she tho	breast cancer with brain falls related to impaired of falls, had low bed, floor is, and a body pillow. The aff to ensure R34 had her each. 9/15, at 8:21 a.m. R34 was r bed. R34's bed was not osition, nor was there a floor 9/15, at 9:32 a.m. R34 was d dressed. The bed was in ever, the floor mat was wall behind the oxygen 16, at 11:39 a.m. registered the fall mat should be on the uid be in the low position at ed R34's room and placed or next to resident. 10/16, at 8:01 a.m. R34 was d and the bed was in the nat on the floor. However, t was observed laying on the ch. Director of nursing of the call light being out of entered the residents room	F	282			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		245149	B. WING			02	11/2016
NAME OF P	ROVIDER OR SUPPLIER		1	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AM	IBASSADOR			8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 282	including having the of the resident will use it R37's admission Mini 1/7/16, identified R37 impairment, was freque bladder and bowel, we development of press extensive assistance personal hygiene, and staff for transfers and R37's care plan dated bowel and bladder ind weakness and impair directed to offer and a hours (and as needed check/change every t while asleep. The ca assist R37 with turnin every two hours with During continuous ob 7:23 a.m. to 10:17 a.r toileting, checked/ cha repositioned for three During interview on 24 stated R37 was to be toileted every two hou in bed was not indicat repositioning, toileting	ave all the assessed according to the care plan, call light available because to call for staff assistance. mum Data Set (MDS) dated had no cognitive uently incontinent of both as at risk for the ure ulcers, required from staff for toilet use and d was totally dependent on bed mobility. d 2/2/16, identified R37 had continence related to ed mobility, and staff were assist with toileting every two d) while awake, and to wo hours (and as needed) re plan also directed staff to g and repositioning at least use of a mechanical lift. servation on 2/10/16, from n., R37 was not offered anged, or turned/ ours and 37 minutes.	F	282			

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	S FOR MEDICARE &				(VO) 5 47	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING			E SURVEY IPLETED
		245149	B. WING		02	2/11/2016
NAME OF P	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP COL	DE	
GOOD SA	MARITAN SOCIETY - A	MBASSADOR) MEDICINE LAKE ROAD N HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 282	offload her bottom, h utilize the bedpan. F planned intervention	e 14 I like to be repositioned to lave her brief changed, and RN-A stated R37's care s for repositioning and owed during the above	F 282			
F 309 SS=D	indicated, "Residents the necessary care a highest practicable w the comprehensive a will have an individua care that will include timetables directed to maintaining the resion nursing physical, fun psychosocial and ed use of departmental Assessment Instrum physician's orders, a concerns identified w 483.25 PROVIDE CA HIGHEST WELL BE	lent's optimal medical, ctional, spiritual, emotional, ucational needs. Through assessments, the Resident ent and review of the ny problems, needs and vill be addressed." ARE/SERVICES FOR ING	F 309			
	provide the necessa or maintain the higher mental, and psychos accordance with the and plan of care.	comprehensive assessment				
	by:	T is not met as evidenced				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/25/2016 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		245149	B. WING			02/	11/2016
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR			8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
				l .			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	 were in place to reliev (R154) with pain. Findings include: R154's quarterly Minii 11/12/15, indicated he was on a scheduled p (as needed) pain med occasional to modera R154's care plan date chronic pain/discomfo gout, and neuropathy medications. The car staff to, "Report to Nu activity attendance pa activities related to s/s c/o (complaints of) pa health care provider in unsuccessful or if cur significant change fro of pain." A Care Area Assessm 5/25/15, indicated he worsening right hip pa indicated the pain affe R154 Pain Data Colle indicated R154 had p 	ure adequate interventions ve pain for 1 of 1 residents mum Data Set (MDS) dated e was cognitively intact and bain regimen, received prn dications, and had te pain. ed 5/28/15, indicated he had ort related to osteoarthritis, which was managed with re plan further instructed urse any change in usual atterns or refusal to attend s (signs and symptoms) or in or discomfort. Notify f interventions are rent complaint is a m residents past experience hent (CAA) Worksheet dated had osteoarthritis with ain, rated his pain as 7, and ected his sleep and mood. ection form dated 11/28/15, ain in the last 5 days that		309			
	The form indicated th 6 (on a scale from 1- pain) and had vocal c expressions of pain d was stabbing, pain m	 is back and whole leg. e resident rated his pain at a 10, with 10 being the worst complaints and facial aily. In addition, the pain eds relieved the pain, pain nent, the pain did not disrupt 					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 02/25/2016 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	
		245149	B. WING		-	02/	11/2016
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AM	BASSADOR		100 MEDICINE LAKE ROA NEW HOPE, MN 55427	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 309	had no changes in ap on a scheduled pain r Resident/Family Educ c/o increased pain (no Goal is tolerable pain needed." A Pain Data Collection R154 had pain in his extremity, rated his pa body movements or p day-to-day activities b interest pursuits, and The Pain Data Collec not received PRN pai "Current Treatment pl pain". R154's current physic 2016, indicated he rea (hydrochloride) 5 milli analgesic used for mo tablet three times a da indicated the start dat 8/14/15. R154 also h HCL 5 mg every four do not exceed six tab of 6/26/15. R154 also 325 mg two tablets by needed for headache 5/31/15. R154's medication ad dated 2/1/16, to 2/10/ R154 did not receive medications.	mit his day to day activities, petite/eating ability, and was nedication regimen. Under cation indicated, "Resident othing new) over a few days. . PRN's to be offered as In dated 2/7/16, indicated entire back and right lower ain at a 5, made protective iostures due to pain, limited because of pain, decreased had irritability and anger. tion also indicated he had in medication and the, an addresses resident's ian orders dated February ceived Oxycodone HCL grams (mg) (a narcotic oderate to severe pain) one ay for pain. The orders e of the medication was ad an order for Oxycodone hours as needed for pain; lets per day with a start date o had an order for Tylenol i mouth every 4 hours as pain with a start date of ministration record (MAR) 16, at 2:31 p.m. indicated	F 309				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/25/2016 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245149	B. WING			02	/11/2016
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AM	IBASSADOR			8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	 physician had increase used for gout) and ad used for gout), and he morephine (a pain me however, his morphin to sedation and needie effects of opioid). A HealthPartners Sulindicated R154 used his "Mobility limited by pain." A Park Nicollet Senior Visit Note dated 2/3/1 Park Nicollet team, ar syndrome and had be years and was received day as well as prn. T current pain regimen During interview on 2 he felt his leg pain wa his pain medications if the nurses he wanted however, "I get no an say they will contact the heard back and I ask The nurse practioner rarely. I haven't had at the pain, she doesn't pain. They are doing stated his pain was at During a follow up interp.m. R154 stated he but it didn't help, so heard and the pain set the set of the	out in his knee and the sed allopurinol (a medication ded cholchicine (medication e had been receiving edication for severe pain), e tablets were stopped due ing narcan (reverses the besequent visit dated 1/4/16, a scooter for mobility and y chronic right lower ext r Services Nursing Home 6, indicated he was new to nd R154 had chronic pain een on narcotics for several ing oxycodone three times a here was no indication if the was effective. /8/16, 6:43 p.m. R154 stated is getting worse, he wanted increased, and he had told more pain medication, swer and they [the nurses] he nurse practioner. I never again and never hear back. comes and see's me but a chance to talk to her about come and ask me about my nothing for me." R154	F	309			

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 02/25/2016 RM APPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245149	B. WING		0;	2/11/2016
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR		100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	level of 5. During interview 2/10, assistant (NA)-B state and he has a lot of pa back, and because of to transfer or ambulat stay in bed because of During observation 2/ was observed to trans NA-C situated a chain the bed and placed a in front of R154 with t briefly repositioned hi an audible sigh and v noted. NA-C asked "/ today?Where?" R18 my legs." Once all se "Take your time" seve first attempt to stand. on his legs and feet h quickly returned to a s wheelchair. He was the heavily, and then beg transfer, and again wa heavily with his mouth closed, as he took ste bed. With contact gus wheelchair and place The NA repeated seve do you want me to ge declined for the aide to seated on the bed, R	 that he is very rarely at a (16, at 1:01 p.m. nursing ed she worked with R154 in in his right leg and his the pain R154 would refuse e, and at times would just of the pain. 10/16, at 2:27 p.m. NA-C sfer R154 in his room. 10/16, at 2:27 p.m. NA-C sfer R154 in his room. 10/16, at 2:27 p.m. NA-C sfer R154 in his room. 10/16, at 2:27 p.m. NA-C sfer R154 in his room. 10/16, at 2:27 p.m. NA-C sfer R154 in his room. 10/16, at 2:27 p.m. NA-C sfer R154 in his room. 10/16, at 2:27 p.m. NA-C sfer R154 in his room. 10/16, at 2:27 p.m. NA-C sfer R154 in his room. 10/16, at 2:27 p.m. NA-C sfer R154 in his room. 10/16, at 2:27 p.m. NA-C sfer R154 in his room. 10/16, at 2:27 p.m. NA-C sfer R154 in his room. 10/16, at 2:27 p.m. NA-C sfer R154 in his room. 10/16, at 2:27 p.m. NA-C sfer R154 in his room. 10/16, at 2:27 p.m. NA-C sfer R154 in his room. 10/16, at 2:27 p.m. NA-C set a 45 degree angle from four wheeled walker (4WW) he brakes applied. R154 mself in his wheelchair and ocalization of "Ah" were Are you hurting 54 stated "Yes my hands, at up to transfer, NA-C said eral times as R154 made his As he began to bear weight e yelled out "Ow" and seated position back in his oreathing quickly and gan the 2nd attempt to 	F 309			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		245149	B. WING _			02	/11/2016
NAME OF P	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR			100 MEDICINE LAKE ROAD EW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	9 19	F3	309			
	the following: -On 2/3/16, 4:26 p.m. Physician Note Text: NP (nurse practioner) (Transcutaneous Elec which is predominate pain conditions) unit f knee if that was possi Awaiting return call." -A physician order wa days after the reques evaluate right knee patters evaluate right knee patters evaluate right knee patters con 2/4/16, at 3:00 p. resident but he refuse -On 2/5/16, at 8:58 p. -On 2/9/16, at 10:00 p dinner. He wheeled f wheelchair. -On 2/10/16, at 3:24 p with Physician Note T residents c/o pain in the continues to c/o "shard denied that it is radiated requested PRN pain p Continue to monitor at - On 2/10/16, at 10:00° shower, "Stating have meds were administed During interview on 2	m. resident refused to walk. o.m. patient did not walk to nimself out in his electric o.m. Communication/Visit fext: NP updated on bilateral hands. Resident rp pain" in his hands. He ting from anywhere. He has pills this shift, with little relief. and update NP.					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 02/25/2016 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE	
		245149	B. WING				02/	11/2016
NAME OF PI	ROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AM	IBASSADOR			100 MEDICINE LAKE ROAI NEW HOPE, MN 55427	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 309	having increased pair today and had been a medication. During interview on 2/ registered nurse (RN) manager for R154's u was having pain. RN- switched to a new doo practioner and physic to additional pain medication RI aware a request for a she would call the NP During interview on 2/ stated she worked the had a pain rating of 7/ resident has had increase During interview on 2/ p.m. NA-C stated R15 morning and afternoo his pain medication m three weeks R154's p Although R154 report refusing to ambulate, the pain, the facility di if any further intervent to decrease the reside A facility policy titled F Assistance policy issu indicated the purpose assistance in pain ma residents will receive consultations on assis	h and he asked for a PRN asking more for his pain (10/16, at 2:30 p.m.)-A stated she was the unit and was not aware R154 -A stated he had recently ctor and his previous nurse bian were not very receptive dication requests from the N-A stated she was not tens unit was made and P and re-request the order. (11/16, at 9:31 a.m. RN-F e day shift and R154 usually (10, and recently the eased complaints of pain. (11/16, at approximelty 1:50 54 complained of pain in the ms and had been requesting hore often, and felt in the last bain has been increasing. (11/16, at approximelty 1:50 54 complained of pain in the ms and had been requesting hore often, and felt in the last bain has been increasing. (11/16, at approximelty 1:50 54 complained of pain in the ms and had been requesting hore often, and felt in the last bain has been increasing. (11/16, at approximelty 1:50 54 complained of pain in the ms and had been requesting hore often, and felt in the last bain has been increasing. (11/16, at approximelty 1:50 54 complained of pain in the ms and had been requesting hore often, and felt in the last bain has been increasing. (11/16, at approximelty 1:50 54 complained of pain in the ms and was observed to be in id not reassess to determine tions could be implemented ents pain. (11/16, at approximelty 1:50 54 complained pain, was and was observed to be in id not reassess to determine tions could be implemented ents pain.	F	309				

Facility ID: 00898

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		MEDICAID SERVICES				<u>NO. 0938-03</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	· · · ·	TE SURVEY MPLETED
		245149	B. WING		0	2/11/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 309	Continued From page	21	F 3	09		
	will assess current pa	in levels and develop with				
	the physician and inte					
		y be non-pharmacological as cal. The registered nurse				
		to medication interventions				
		the physician to assist in				
	the individualized pair	-				
F 314			F 3	14		
SS=D	PREVENT/HEAL PRI	ESSURE SURES				
	resident, the facility m who enters the facility does not develop pre- individual's clinical co they were unavoidabl pressure sores receiv	thensive assessment of a nust ensure that a resident without pressure sores ssure sores unless the indition demonstrates that e; and a resident having we necessary treatment and healing, prevent infection and ow developing.				
	This REQUIREMENT	is not met as evidenced				
	Based on observatio review, the facility fail repositioning were co prevent pressure ulce	n, interview, and document ed to ensure toileting and mpleted as assessed to ers for 1 of 3 residents (R37) entified at risk for pressure				
	Findings include:					
	1/7/16, identified R37 impairment, was freque bladder and bowel, we development of press	uently incontinent of both as at risk for the				

Facility ID: 00898

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		D HUMAN SERVICES MEDICAID SERVICES			FC	TED: 02/25/2016 DRM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		245149	B. WING			02/11/2016
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, Z		
GOOD SA	MARITAN SOCIETY - AN	BASSADOR	8	100 MEDICINE LAKE ROAD		
			N	NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 314	Continued From page	22	F 314			
	personal hygiene, and staff for transfers and	d was totally dependent on bed mobility.				
	fracture, was weak, d non-weight bearing of The CAA identified a from skin breakdown use of an incontinenc R37's Positioning Ass 1/3/16, identified R37	 37 had a prosthetic knee e-conditioned, and h her right, lower extremity. goal for R37 to remain free related to incontinence and e brief. essment & Evaluation dated required total assistance I directed staff to offer 				
	bowel and bladder ind weakness and impain directed to offer and a hours (and as needed check/change every t while asleep. The ca assist R37 with turnin every two hours with R37's Braden Scale for Risk dated 2/6/16, ind identifying R37 was a development of press During a telephone in p.m. family member (get assisted with toile	ed mobility, and staff were assist with toileting every two d) while awake, and to wo hours (and as needed) re plan also directed staff to g and repositioning at least use of a mechanical lift. or Predicting Pressure Sore licated a score of 16/18, t mild risk for the ure ulcers. terview on 2/8/16, at 7:36 FM)-A stated R37 did not ting timely, and stated she nstance where R37 had to er meal for her soiled				
		servation on 2/10/16, from				

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						IO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	E SURVEY IPLETED	
		245149	B. WING		02/11/2016		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 314	Continued From page	e 23	F 31	4			
		m., R37 was not offered					
	toileting, checked/ ch						
	repositioned for two hours and 37 minutes.						
	Observations include						
		s lying in bed and nursing					
		s present in the room.					
		hecked/ changed R37's before assisting R37 to sit in					
		a mechanical lift and two					
	staff to transfer.						
	At 7:45 a.m., NA-G b	rought R37 to the dining					
	room for the breakfas						
		s moved from the dining					
		to an alcove/ day room area					
	watched television wi	ng room), where the resident					
	At 9:20 a.m., R37 rer						
		room area and R37 stated,					
		et?" The resident stated she					
		her morning medications,					
		sisted with her exercises,					
		audibly sighed several times. ted the surveyor to find a					
		behalf and registered nurse					
		assist R37. R37 stated to					
		o get back to my room."					
		o her resident room, handed					
		exited the room. RN-G did					
	•	ecking/ changing or turning/					
	repositioning to R37.						
		ntered R37's room and nto bed. R37 accepted and					
		aff member to assist with					
	transferring R37 into						
	At 10:07 a.m., NA-G	and licensed practical nurse					
		hanical lift to transfer R37 to					
	-	o change R37's incontinence					
		and 37 minutes between					
	changes. NA-G cont	irmed R37's incontinence				1	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/25/201 FORM APPROVE OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245149	B. WING		02/11/2016
NAME OF PI	ROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP COD	
GOOD SA	MARITAN SOCIETY - AM	MBASSADOR		00 MEDICINE LAKE ROAD	
				W HOPE, MN 55427	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 314	brief contained a sma R37 was not observe herself during this ob At 10:17 a.m., NA-G checked/ changed, a every two hours. Progress Notes from	all void of urine. ed to offload or reposition	F 314		
	repositioning and che incontinence product During a continuous 8:23 a.m. to 11:29 a. toileting, checked/ ch repositioned for three Observations include	observation on 2/11/16, from m., R37 was not offered anged, or turned/ e hours and five minutes.			
	the day room area. F brought her to her roo medication and then room. RN-H did not change, or reposition	If-propelled her wheelchair to RN-H approached her, om, administered eye drop returned R37 to the day offer to toilet or check/			
	if she wanted to lay of down, however, NA-/ check/ change her br offload R37. No encourse was provided to prev At 10:31 a.m., an act attend an exercise gr and remained seated	lown. R37 declined to lay A did not offer to toilet, rief, or offer to reposition or ouragement or education			
	R37 was to be check	was interviewed and stated ed/ changed and turned/ /o hours, using a mechanical			

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 02/25/20 RM APPROVE NO. 0938-039
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DA	ATE SURVEY MPLETED
		245149	B. WING				02/11/2016
NAME OF P	ROVIDER OR SUPPLIER	1		STR	EET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD SA	MARITAN SOCIETY - A	MBASSADOR			MEDICINE LAKE ROAD		
	1			NE\	W HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 314	Continued From pag	e 25	F.	314			
	1 3	b bed. NA-A stated R37 was					
		ed and turned/ repositioned					
	-	tated she had approached					
		ed her if she wanted to lay					
		nt declined to lay down.					
	refusal to be checked	rpreted R37's response as a					
		stated she attempted to					
		two hours and ask if she					
	-	and if the resident agreed to					
		check and change her.					
		d with assisting other nad still not been offered to					
		I/ changed or turned/					
	repositioned.						
	At 11:05 a.m., the su	rveyor asked NA-A when					
		offer toileting, checking/					
	000	g/ repositioning to R37, at					
		proached R37 and asked if her room to check her					
		R37 accepted and NA-A					
		to her room, and asked					
	-	A and RN-H proceeded with					
	-	er bed and checked and					
	-	nence brief, with three hours					
	and five minutes bet	ttom was observed as					
	slightly pink, but blar						
	confirmed.	,					
		stated when changing R37's					
		I bowel movement and a					
	small void of urine in	her incontinence brief.					
	During interview on t	2/11/16, at 2:25 p.m. RN-H					
		e repositioned and toileted					
		was usually incontinent.					
	RN-H stated she felt	NA-A's offer for R37 to lay					
	down did constitute a						
	repositioning and toil	leting or checking/ changing,					

Facility ID: 00898

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CENTER	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIPI F	CONSTRUCTION		IO. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:			· · · ·	IPLETED	
		245149	B. WING		0	2/11/2016	
NAME OF PI	ROVIDER OR SUPPLIER	1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SA	MARITAN SOCIETY - AN	MBASSADOR		100 MEDICINE LAKE ROAD EW HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 314			F 314				
	and stated if R37's de considered a refusal repositioning.	ecline to lay down, that was for toileting and					
	stated R37 was to be toileted every two ho in bed was not indica repositioning, toileting R37's declining to lay refusals for these car staff should have spe have liked to be repo bottom, have her brie bedpan. RN-A stated interventions for repo not followed during the The facility's policy the Pressure Ulcer Preve Requirements dated who are unable to repo	ositioning and toileting were ne above observations. tled Skin Assessment, ention, and Documentation 12/15, directed, "Residents position themselves					
F 315 SS=D	directed by the care 483.25(d) NO CATH	ETER, PREVENT UTI,	F 315				
	resident who enters t indwelling catheter is resident's clinical cor catheterization was n who is incontinent of treatment and service	lity must ensure that a the facility without an a not catheterized unless the adition demonstrates that necessary; and a resident bladder receives appropriate es to prevent urinary tract ore as much normal bladder					

Facility ID: 00898

If continuation sheet Page 27 of 46

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		245149	B. WING			02/	11/2016
NAME OF PF	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AM	IBASSADOR			100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID PREFIX TAG					PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 315	by: Based on observation review, the facility fail in accordance with as maintain as much urin 1 of 3 residents (R37) incontinence. Findings include: R37's admission Minin 1/7/16, identified R37' frequently incontinent was not on a toileting extensive assistance personal hygiene, and staff for transfers and R37's Care Area Asse 1/12/16, indicated R3 fracture, was non-wei lower extremity, and r assistance from two s identified R37 require toileting, had function increased risk for urin infection due to a prev had increased urinary use of diuretic medica R37's care plan dated bowel and bladder ind weakness and impain	T is not met as evidenced n, interview, and document ed to ensure timely toileting asessed needs, in order to hary function as possible, for reviewed for urinary mum Data Set (MDS) dated 's cognition was intact, was of both bladder and bowel, program, required from staff for toilet use and d was totally dependent on bed mobility. essment (CAA) dated 7 had a prosthetic knee ght bearing on her right, required a total lift with taff to transfer. The CAA d maximum assistance with al incontinence, was at an ary incontinence and vious UTI, and may have requency secondary to her ations. 1 2/2/16, identified R37 had	F	315			
	•	l as needed) while awake, every two hours (and as					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		245149	B. WING			02/	11/2016
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE		
					8100 MEDICINE LAKE ROAD		
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR			NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			3E	(X5) COMPLETION DATE
F 315	Continued From page	28	F	315	5		
	p.m. family member (assist R37 with toiletii at least one instance through the supper m incontinence product During a continuous of 7:23 a.m. to 10:17 a.r toileting or checked/ of 37 minutes. Observa At 7:23 a.m., R37 was nursing assistant (NA room. At 7:30 a.m., NA-G cl incontinence product sit in her wheelchair, two staff to transfer he At 7:45 a.m., NA-G bi room for the breakfas At 9:00 a.m., R37 was room, to an alcove/ di the dining room), whe with two of her peers. At 9:20 a.m., R37 ren wheelchair in the day how late they get?" F received her morning been assisted with he sighing as she was ta At 9:40 a.m. R37 state get back to my room.	to be changed. bbservation on 2/10/16, from m., R37 was not offered changed for two hours and tions included the following: s lying in her bed and)-G was present in the hecked/ changed R37's before she was assisted to using a mechanical lift and er. rought R37 to the dining t meal. s moved from the dining ay room area (across from ere she watched television hained seated in her room area and stated, "See R37 stated she had not yet medications, nor had she er exercises, and was					
		ne check/ change R37.					

Facility ID: 00898

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		ID HUMAN SERVICES				FORM	02/25/2016 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	
		245149	B. WING		_	02/	11/2016
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
			8	100 MEDICINE LAKE RO	AD		
GOOD SA	MARITAN SOCIETY - AM	IBASSADOR	1	NEW HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 315	At 9:57 a.m., NA-G er offered to assist her in NA-G sought another the transfer. At 10:05 a.m., while N of the room to find an stated staff did not off commode or bedpan did not believe she co commode because of non-weight bearing st At 10:07 a.m., NA-G a (LPN)-G used a mech bed, and NA-G then p R37's incontinence br minutes between cha use of a toilet or bedp At 10:17 a.m., NA-G s checked/ changed ev use a bedpan or toilet incontinent, and NA-G incontinence brief cor Progress Notes from were reviewed and lar refusing or declining of of a bedpan and check incontinence product. During a continuous of 8:23 a.m. to 11:29 a.m toileting or checked/ of five minutes. Observa- following: At 8:23 a.m., R37 was table waiting for break At 9:06 a.m., R37 self the day room area. R	htered R37's room and hto bed. R37 accepted and staff person to assist with NA-G had again stepped out other staff person, R37 fer her use of the toilet, for toileting, and stated she buld use the toilet or f her leg injury and tatus. and licensed practical nurse hanical lift to transfer R37 to proceeded with changing rief, with two hours and 37 nges. R37 was not offered han. stated R37 was to be ery two hours and did not t because she was always G confirmed R37's htained a small void of urine. 12/31/15, through 2/10/16, cked evidence of R37 cares, including toileting/ use cking/ changing her beservation on 2/11/16, from n., R37 was not offered changed for three hours and ations included the s seated at the dining room kfast. f-propelled her wheelchair to	F 315				

Facility ID: 00898

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							10. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	L 1	TE SURVEY MPLETED	
		245149	B. WING _			0	2/11/2016	
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 315	Continued From page	e 30	F 3	315				
		and then returned R37 to						
		did not offer to toilet or						
	check/ change R37.							
		approached R37 and asked						
	-	own. R37 declined this						
		did not offer to toilet or						
	check/ change R37.	ivition staff invited D27 to						
		ivities staff invited R37 to oup, which R37 declined						
	-	in her wheelchair in the day						
	room.							
	At 10:46 a.m., NA-A	was interviewed and stated						
		ed/ changed every two						
	-	anical lift to transfer her into						
	bed. NA-A stated R3							
	changed at 8:00 a.m.	ier and asked her if she						
		out the resident declined.						
		preted R37's response as a						
		/ changed, and typically she						
		every two hours and ask if						
		wn, which is when she would						
		37. NA-A stated R37 did not						
		ode because she required a or transfers, and stated R37						
	did not use a bedpan							
		ting other residents and R37						
		ered to toilet or be checked/						
	changed.							
		rveyor asked NA-A when						
		I toileting again, and NA-A						
		asked if she could take her her incontinence brief. R37						
		prought her to her room						
	-	ond staff person to help with						
	-	turned and RN-H entered						
		h transferring R37 to bed						
		ng her incontinence brief,						
	with three hours and	five minutes between					1	

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 02/25/2016 APPROVED 0: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	
		245149	B. WING			02 / [,]	11/2016
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STAT	E, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AM	IBASSADOR		100 MEDICINE LAKE ROAD)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 315	bowel movement and incontinence brief. The observed offering R33 this observation, NA-// bedpan and R37 decl During interview on 2// stated R37 was to be and was usually incor she and NA-A did offer the above noted obser RN-H stated that she lay down did constitut checking/ changing, a offer equated a refusa During interview on 2// confirmed R37 was to bedpan every two hou offered a bedpan des bowel in her incontine offer to lay down in be offer for toileting or ch R37's declining to lay refusal for toileting. F have specifically aske have her brief change staff were not followin interventions for toilet The facility's Bowel an Evaluation and Retraid directed staff to ensur or bladder incontinent	tated R37 had a small a small void of urine in her hough staff were not 7 the use of a bedpan during A stated she did offer the ined. (11/16, at 2:25 p.m. RN-H toileted every two hours national. RN-H stated that er a bedpan to R37 during ervation, but R37 declined. felt NA-A's offer for R37 to be an offer for toileting or and R37's decline to this al. (11/16, at 3:01 p.m. RN-A b be offered the use of a urs, and should have been pite identification of urine or ence brief. RN-A stated an ed was not indicative of an ecking/ changing, and down did not equate a RN-A stated staff should ed if she would have liked to ed and use the bedpan, and ig R37's care planned ing.	F 315				

Facility ID: 00898

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/25/2016 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		245149	B. WING		_	02/	11/2016
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AM	BASSADOR		100 MEDICINE LAKE ROANE NOT NEW HOPE, MN 55427	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323 SS=D	483.25(h) FREE OF A HAZARDS/SUPERVI		F 323				
	as is possible; and ea	as free of accident hazards					
	by: Based on observation review the facility faile assess and implement	is not met as evidenced n, interview, and document ed to comprehensively nt interventions to reduce the residents (R34) reviewed for					
	Findings include:						
	1/13/16, indicated R3 impairment, had cance failure. The MDS indi- extensive assist of two dressing, bed mobility and bladder, and had R34's Care Area Asse 1/13/16, indicated the with transfers, received	mum Data Set (MDS) dated 4 had moderate cognitive eer, anemia, and heart dicated the resident needed o with transfers, toileting, v, was incontinent of bowel no falls in the last month. essment (CAA) dated e resident was not steady ed an antidepressant, had palance, and had impaired					
	balance during transit falls would be address goal of preventing fall R34's care plan dated	tions. The CAA indicated sed in the care plan with a s. 1 1/14/16, indicated the					
	resident had metastic	breast cancer with brain					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/25/2016 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		245149	B. WING		_	02/	11/2016
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
GOOD SA	MARITAN SOCIETY - AN	BASSADOR		100 MEDICINE LAKE ROA IEW HOPE, MN 55427	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	mobility, had a history mat, concave mattress care plan directed sta call light with in her re- An Incident Report da indicated, "Writer was answer a light, when help. Resident [R34] side on the floor by he indicated she receiver wrist, and an air overl and a low bed and co provided to resident. An Incident Report da indicated, "Resident [floor in resident's roor stomach at foot of be place and time. She The report indicated she nose and the cem raised area on the low head. The report also slippers on and a floo floor near her bed. During observation 02 observed laying in he observed laying in be the low position, how	falls related to impaired of falls, had low bed, floor is, and a body pillow. The aff to ensure R34 had her each. ated 1/20/16, at 3:49 a.m. is walking down the hall to I heard a resident yelling for was found lying on her left er bed." The report d a skin tear on her left ay mattress was removed	F 323				
	observed laying in he observed in the low p mat on the floor. During observation 02 observed laying in be the low position, how folded up against the	r bed. R34's bed was not osition, nor was there a floor 2/9/15, at 9:32 a.m. R34 was d dressed. The bed was in ever, the floor mat was					

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	MENT OF HEALTH AN S FOR MEDICARE &		-					PRINTED FORM OMB NC	APPR	ROVED
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		· ,		DNSTRUCTION		(X3) DATE COMP	SURVE) LETED	ſ
		245149	9	B. WING _			_	02/	11/201	6
NAME OF PI	ROVIDER OR SUPPLIER				STRE	EET ADDRESS, CITY, ST	ATE, ZIP CODE			
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR				MEDICINE LAKE ROA V HOPE, MN 55427	AD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	YFULL	ID PREFIX TAG		PROVIDER'S (EACH CORREC	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI		COMPL	(5) LETION ATE
						[DEFICIENCY)			
F 323	Continued From page	e 34		F ?	323					
	During interview 02/9		gistered		020					
	nurse (RN)-I stated th									
	floor and the bed sho all times. RN-I entered									
	the fall mat on the floo									
	During observation 2	/10/16 at 9:01 a m	B24 was							
	During observation 2/ observed laying in be									
	low position with fall r	mat on the floor. How	wever,							
	the residents call light floor out of R34's read	-	-							
	(DON) was informed		•							
	R34's reach, and she		ts room							
	and gave her the call	light.								
	During interview 2/10	/16, at 12:31 p.m. R	N-A							
	stated she didn't know the low position, and	2								
	NA who was working									
	the NA stated she tho	ought during a physic	cian visit							
	he had left the bed up fall risk and should ha									
	interventions in place									
	light available becaus		se it to							
	call for staff assistance	æ.								
	A facility Fall Preventi	-								
	issued July 2015, indi Approach-requires ide									
	and taking steps to pr									
	again. In a fall prever	ntion program, a rea	ctive							
	approach will include determine the cause									
	analysis), identifying i									
	(interventions) to prev again."	vent the fall from hap	opening							
F 325	483.25(i) MAINTAIN I	NUTRITION STATU	S	F3	325					
SS=D	UNLESS UNAVOIDA									
FORM CMS-256	7(02-99) Previous Versions Obs	solete	Event ID: 096L11		Facility	/ ID: 00898	If continu	uation shee	t Page 3	35 of 46

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245149	B. WING			02	/11/2016
NAME OF PI	ROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR			3100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	Continued From page	35	F	325			
	resident - (1) Maintains accepta status, such as body unless the resident's demonstrates that thi	ity must ensure that a ble parameters of nutritional weight and protein levels, clinical condition					
	by: Based on observatio review the facility faile reassess nutritional n loss for 1 of 4 residen nutritional needs and Findings include: R72's quarterly Minim 12/08/15, indicated th impairment, felt depre dementia and heart fa with eating, and had n R72's care plan dated resident had obesity n exceeding needs, lim high calorie foods at n plan goal was for the weight of 278 lbs (por 2-4 lbs a month. The	num Data Set (MDS) dated be resident had no cognitive essed and tired, had ailure, needed set up help no swallowing problems. d 2/14/14, indicated the related to energy intakes ited mobility, and choosing meals/snacks. The care resident to maintain a unds); or a gradual loss of care plan indicated R72					
		er lower extremity, flux disease, (a chronic damage caused by stomach					

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	S FOR MEDICARE &					NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
		245149	B. WING		0	2/11/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SA	MARITAN SOCIETY - AM	IBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 325	Continued From page	e 36	F 32	25			
		the stomach) and heart		-			
	failure.						
	A Dietary Profile date received a regular die	d 12/07/15, indicated R72					
	supplements, and ha						
		sessment dated 12/07/15,					
		decrease in her food intake					
and had weight loss greater than lbs).		greater than 3 kilograms (6.6					
		dated 1/4/16, indicated					
		ion risk, and her oral intake					
	-	d 11 meal refusals with in the					
		te further indicated the					
	facility would continue preferences, offer sul	bstitutions for meals, and					
		phitor her oral intake and					
	weight.						
		rs dated 2/11/16, indicated					
		Lasix (diuretic to remove ng) twice a day for edema.					
		m. R72 was observed eating					
		n, salad, and apple crisp.					
		neal. R72 was sitting in her					
		a sticker taped to the back icating the foot pedals					
	weighed 51.8 lbs.	icalling the loot pedals					
		p.m. R72 was observed					
		i and a baked potato, and					
	she ate 75% of her m	neal. Of Meal Eaten form dated					
		indicated R72 refused 19					
	meals.						
	R72's Vital Results id weights:	lentified the following					
	12/2/15 - 260 lbs	81-260 lbs weight gain of 21					
	12/23/15 - 281 lbs (2 lbs, no documentation 12/30/15 - 283 lbs						

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 02/25/2016 RM APPROVED NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245149	B. WING)2/11/2016	
NAME OF P	ROVIDER OR SUPPLIER	1		STR	EET ADDRESS, CITY, STATE, ZIP CODE			
	MARITAN SOCIETY - AN	IBASSADOR		810	0 MEDICINE LAKE ROAD			
				NE\	W HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 325	22 lbs, no documenta 2/11/16 - 245 lbs (263 no documentation as Although R72's weigh 5.8 % weight loss fro- was no indication the determine why there changes. During interview on 2 registered nurse (RN Lasix, however, after stated it looked as if t inconsistency with the wouldn't loose 20 lbs she would have staff follow-up interview at was weighed and the RN-A stated she felt t be from R72 not havi however, RN-A weigh which weighed 4.4 lb During interview 2/11 dietician (RD) stated and felt the weights w 280's were inaccurate the weight from 12/2/ accurate for R72. Th working with staff to a accurate weights, ar reweigh the resident lbs. RD stated R72 h	25 to 263 lbs weight loss of ation as to why). 3- 245 weight loss of 18 lbs, to why). This fluctuated and R72 had a m 12/02/15, to 2/11/16, there facility reassessed R72 to were significant weight 7/10/16, at 12:22 p.m.)-A stated R72 was on reviewing the weights she there was some e weights because, "You in one week," and stated reweigh the resident. In a 2:22 p.m. RN-A stated R72 e weight was 242.6 lbs. the weight fluctuation could ng her prosthetic leg on, ned R72's prosthetic leg os. 7/16, at 1:27 p.m. registered R72 had a decline in health which were recorded in the e. The RD stated she felt 15, which was 260 lbs was e RD stated she had been ensure they obtained and RD stated she had staff and she now weighed 243	F3	325				

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	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING			E SURVEY IPLETED	
		245149	B. WING		0:	2/11/2016	
AME OF P	ROVIDER OR SUPPLIER	•	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	Ē		
GOOD SA	MARITAN SOCIETY - A	MBASSADOR		MEDICINE LAKE ROAD V HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 325	Continued From pag been eating meals ir	e 38 i her room more often. RD	F 325				
	had further intervent	ave been reassessed and ons put into place when the s initially noted, from January					
	During interview 2/11/6, director of nursing (DON) stated R72 had been refusing to get out of bed more often and seemed to be more confused. The DON stated the nuses used to do weights on paper so they could see a weight loss, however, the weights are now entered electronically and staff are not able to see the previous weight.						
F 412	revised 2/16, indicate with notify the dietand by sending an alert s gain or loss, 3 pound one month, 7.5 perce percent in six months indicated the director designee will review more often to identify weight loss or gain of refers to a gradual un weight loss or gain of	of dietary services (DDS) or resident weights monthly or residents with significant r insidious weigh loss or gain hintended, progressive	F 412				
SS=D	SERVICES IN NFS	nust provide or obtain from	1 712				
	§483.75(h) of this pa covered under the S dental services to me	rt, routine (to the extent tate plan); and emergency set the needs of each sessary, assist the resident in					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/25/2016 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		245149	B. WING			02/	11/2016
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD SA	MARITAN SOCIETY - AM	IBASSADOR			100 MEDICINE LAKE ROAD EW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 412	must promptly refer re damaged dentures to This REQUIREMENT by: Based on observation review the facility faile appointments were co (R15) reviewed for de Findings include: R15's significant char (MDS) dated 1/6/16, i moderate cognitive in extensive assistance daily living. R15's care plan dated provide resident with dressing and groomin performed oral care in	from the dentist's office; and esidents with lost or a dentist. T is not met as evidenced in, interview, and document ed to ensure dental follow up ompleted for 1 of 3 residents ental services. Age Minimum Data Set indicated the resident had inpairment and need for to complete activities of a 2/10/16, directed staff to assistance to complete ig, and the resident independently.	F 4'	112	DEFICIENCY)		
	stated he had missing side of his mouth and evaluation by the den teeth and discomfort of jaw. R15 stated he has be a follow up appoin	/9/16, at 10:42 a.m. R15 g teeth on the upper right had been seen for tist because of the missing on the right side of his upper ad understood there was to tment, however, he had ng this since his last visit					
	was observed eating problems chewing. D	n 2/10/16, at 1:03 p.m. R15 his meal with no visible puring interview at this time, ued to have discomfort on					

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		D HUMAN SERVICES MEDICAID SERVICES			F	NTED: 02/25/2016 ORM APPROVED NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		245149	B. WING			02/11/2016
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE,	ZIP CODE	
GOOD SA	MARITAN SOCIETY - AM	BASSADOR		100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 412 F 441	the upper right side of and again stated he h supposed to follow up dentist], and I haven't Review of the Apple T note dated 9/10/15, in that date for a recall e indicated, "Diagnosis High;rampant decay. #12 and 13 had bucca non-restorable, Recor Several no [sic] cavitie Treatment recommen fillings and extractions prophylaxis treatment Review of R15's medi resident had no furthe appointments, nor we appointments schedu During interview on 2/ registered nurse (RN) dental recommendatio because when a follor appointments is comp "Noted," on the form. indicated there had be communication with A since R15's visit of 9/ A review of the policy Services and Assessr 2012, indicated the pu assessments was for as necessary.	i his mouth with chewing, ad broken teeth and, "I was be a long time ago [with the heard anything." Tree Coon Rapids progress dicated (R15) was seen on exam. The progress note /Assessment: Caries risk: See oral exam form. Tooth al cusps have fractured off; mmend extractions " es noted since last exam." dations were made for s, in addition to follow up for every three months. cal records indicated the er follow up dental re there any follow up dental led. (11/16, at 1:55 p.m. -A stated it appeared the ons were not processed w up of recommendation of oleted, the nurse will write, A review of R15's record een no follow up or opple Tree dental services 10/15. titled Dental/Oral Health ments, issued September urpose of dental treatment to begin as early	F 412			

Facility ID: 00898

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 02/25/2016 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE	
		245149	B. WING				02/	11/2016
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE,	ZIP CODE		
GOOD SA	MARITAN SOCIETY - AM	BASSADOR			100 MEDICINE LAKE ROAD IEW HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BI TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 441 SS=D	Continued From page SPREAD, LINENS	e 41	F	441				
	safe, sanitary and cor	ram designed to provide a nfortable environment and evelopment and transmission						
	Program under which (1) Investigates, contr in the facility; (2) Decides what proc should be applied to a	blish an Infection Control it - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective						
	prevent the spread of isolate the resident. (2) The facility must p communicable diseas from direct contact wi direct contact will tran (3) The facility must re hands after each direct hand washing is indic professional practice. (c) Linens Personnel must hand	a Control Program ident needs isolation to infection, the facility must rohibit employees with a se or infected skin lesions th residents or their food, if smit the disease. equire staff to wash their ct resident contact for which ated by accepted						

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 02/25/201 RM APPROVE IO. 0938-039
TATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		245149	B. WING		0	2/11/2016
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	MARITAN SOCIETY - A	MDASSADOD		8100 MEDICINE LAKE ROAD		
GOOD SA	MARITAN SOCIETT - A	MBASSADOR		NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	Continued From pag	je 42	F 44	11		
	by: Based on observation review the facility fait disinfecting procedur blood glucose monite (R42 and R90) who glucometer on the S Findings include: R42 was observed for 2/10/16 at 8:23 a.m. who pierced R42's fit placed a large drop of of the glucometer to After disposing of the strip, the glucometer alcohol prep pads are the tote. At 8:30 a.m. blood glucose on R9 used for R42. Upon testing, the glucome	T is not met as evidenced on, interview, and document led to ensure proper re of the glucometer after oring for 2 of 3 residents utilized the facility community unny Ridges unit. or a blood glucose testing on by registered nurse (RN)-B nger using a lancet and of blood on the collection strip measure the glucose level. e lancet and blood collection r was then wiped down with nd placed on a paper tissue in n., RN-B proceeded to test 00 with the same glucometer completion of blood glucose ter, was cleaned with alcohol n a clean paper tissue in the				
	RN-B stated that the with alcohol wipes be of Sunny Ridges use On 2/11/16, registere R42, R90, and R20 a blood glucose monite On 2/11/16 at 9:29 a residents have their term care units. The	wed to air dry. on 2/10/16 at 8:35 a.m., e glucometer is wiped down etween residents. Residents e a community glucose meter. ed nurse (RN)-C identified all had orders for routine oring on Sunny Ridges unit. , RN-D stated that the own glucometer on the short long term care units, pe wiped with sani cloth plus				

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		D HUMAN SERVICES			FC	ED: 02/25/2016 RM APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) D/	NO. 0938-0391 ATE SURVEY MPLETED
		245149	B. WING			02/11/2016
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP	CODE	
GOOD SA	MARITAN SOCIETY - AM	BASSADOR		100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE
F 441	Continued From page wipes before and after the surfaces for rema- minutes. RN-D state wipe glucometer with The facility policy of B Disinfecting, and Clea 2012, was reviewed a to disinfectant the me one of two ways, either dilute 1 ml of house b achieve a 1;10 dilution paper towel to wipe d attention to the time th The other option that germicidal disposable Society's preferred ver meter should be left a it is dry. 483.70(c)(2) ESSENT OPERATING CONDIT The facility must main mechanical, electrical equipment in safe ope This REQUIREMENT by: Based on observation review the facility failed the walk-in cooler to e temperatures were main	 443 r use, taking time to assure ined visibly wet for 3 d "It is not our procedure to alcohol wipes." Blood Glucose Monitoring, aning, issued September and indicates the process ter may be completed in er with a process of using a leach in 9 ml of water to n, using a lint-free cloth or own the meter, paying he meter must remain wet. may be used is the use of a wipe supplied by the endor. After disinfecting, the few minutes to ensure that TIAL EQUIPMENT, SAFE TION tatin all essential , and patient care erating condition. is not met as evidenced n, interview, and document ed to ensure timely repair of 	F 441			
	⊢ınaıngs ınclude:					

Facility ID: 00898

If continuation sheet Page 44 of 46

		MEDICAID SERVICES				IO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		· · · ·	E SURVEY IPLETED	
		245149	B. WING		02/11/2016		
NAME OF P	ROVIDER OR SUPPLIER	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR		100 MEDICINE LAKE ROAD IEW HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 456	On 2/8/16, at 1:12 p.r facility's kitchen was dietary manager (CD walk-in cooler was of and was not sealed s no longer automatica pressed shut after ea informed the mainten issue. On 2/11/16, at 1:23 p conducted with CDM again observed to be sealed shut. CDM st maintenance of the d approximately two we facility had experienc maintenance personn departments respons requests may have b result. CDM was un documentation regard repair, and stated he request but just spoke department. During t entered and exited th press the door shut b to rest slightly opened noticed and pressed During interview on 2 environmental service he had started workin approximately three w was not aware of the not sealing. He state maintenance log whe	m. an initial tour of the conducted with certified M), and the door of the pserved resting slightly open hut. CDM stated the door Ily sealed and had to be ch entry, and he had already ance department of this .m. a follow-up tour was and the walk-in cooler was resting slightly open/ not ated again he had informed oor/seal needing repair eeks prior, however, the ed a turn-over of nel and he suspected the e time to maintenance een somewhat delayed as a able to provide any ding the request for the did not document the e to the maintence his follow-up tour, cook-A e walk-in cooler, but failed to ehind him, leaving the door d/ unsealed, until CDM the door closed. /11/16, at 4:13 p.m. the es director (ESD) reported ng at the facility weeks prior. He stated he facility's walk-in cooler door	F 456				

Facility ID: 00898

If continuation sheet Page 45 of 46

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/25/2016 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245149	B. WING			02/	/11/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR			100 MEDICINE LAKE ROAD EW HOPE, MN 55427		
		ATEMENT OF DEFICIENCIES	15	<u> </u>	PROVIDER'S PLAN OF CORRECTION	1	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 456	facility's process. ES preventative maintena back logged, he was maintenance/ repair r had known about the repaired it immediated The facility's Food Sto directed the CDM was refrigerator temperatu	D stated though some of the ance tasks were slightly on schedule with equests, and stated if he issue, he would have	F	456			

Facility ID: 00898

If continuation sheet Page 46 of 46

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	CONSTRUCTION 1 - MAIN BUILDING 01		TE SURVEY MPLETED
		245149	B. WING		0	2/12/2016
NAME OF PI	ROVIDER OR SUPPLIER		S ⁻	IREET ADDRESS, CITY, STATE, ZIP CODE	1 0	2/12/2010
	MARITAN SOCIETY - AN	IBASSADOP	81	100 MEDICINE LAKE ROAD		
000D 3A		IBASSADON	N	EW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	3	K 000			
	FIRE SAFETY					
	ALLEGATION OF CO DEPARTMENTS ACO SIGNATURE AT THE PAGE OF THE CMS	C WILL SERVE AS YOUR DMPLIANCE UPON THE CEPTANCE. YOUR BOTTOM OF THE FIRST -2567 FORM WILL BE TION OF COMPLIANCE.				
	ONSITE REVISIT OF CONDUCTED TO VA SUBSTANTIAL COM REGULATIONS HAS	AN ACCEPTABLE POC, AN FYOUR FACILITY MAY BE ALIDATE THAT IPLIANCE WITH THE BEEN ATTAINED IN HYOUR VERIFICATION.				
	Minnesota Departme Fire Marshal Division the time of this surve Ambassador was fou compliance with the r in Medicare/Medicaic 483.70(a), Life Safety edition of National Fin	requirements for participation I at 42 CFR, Subpart y from Fire, and the 2000 re Protection Association I, Life Safety Code (LSC),				
	PLEASE RETURN T CORRECTION FOR DEFICIENCIES (K-T	THE FIRE SAFETY				
	Healthcare Fire Inspe State Fire Marshal Di 445 Minnesota St., S St. Paul, MN 55101-8	ivision uite 145				

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/25/2016 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 5 01 - MAIN BUILDING 01	1 Y /	E SURVEY PLETED
		245149	B. WING			02	/12/2016
	ROVIDER OR SUPPLIER MARITAN SOCIETY - AN	IBASSADOR	1		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427	1 04	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUST FOLLOWING INFOR 1. A description of wh to correct the deficien 2. The actual, or prop 3. The name and/or t responsible for correct prevent a reoccurrent Good Samaritan Soc building with a partial constructed at 3 diffe building was construct determined to be of T 1996, an addition was determined to be of T 2010, an addition was determined to be of T There is a 2-hour fire addition and the rest the facility is surveyed CMS-2786R forms us The building is autom throughout. The facili with smoke detection open to the corridors automatic fire departs	te.mn.us State.mn.us RECTION FOR EACH INCLUDE ALL OF THE MATION: The thas been, or will be, done ncy. The the second of the person ction and monitoring to ce of the deficiency. The building was rent times. The original cted in 1963 and was type II (000) construction. In the constructed and was type II (000) construction. In the construction. In the sconstructed and was type V (111) construction. Wall between the 2010 of the building. Therefore, d as two buildings with two sed. The corridors and spaces that is monitored for ment notification. The facility beds and had a census of 68	K	000			

Facility ID: 00898

If continuation sheet Page 2 of 5

	<u>S FOR MEDICARE</u> &	MEDICAID SERVICES			OMB N	O. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING 01 -	DNSTRUCTION Main Building 01	(X3) DAT	E SURVEY PLETED
		245149	B. WING		02	2/12/2016
NAME OF P	ROVIDER OR SUPPLIER	•	STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR) MEDICINE LAKE ROAD N HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	Continued From page	e 2 2 CFR, Subpart 483.70(a) is	K 000			
K 012	NOT MET as evidend		K 012			
SS=F		type and height meets one	1012			
	of the following: 19.1.6.2, 19.1.6.3, 19 This STANDARD is r Based on observatio building does not med	0.1.6.4, 19.3.5.1 not met as evidenced by: n and staff interview, this et the requirements for multiple construction types.				
	Findings include:					
	1:30 PM on February revealed that the 2-ho fiberglass insulation a the large penetrations the 1997 building and	acility between 9:30 AM and 12, 2016, observation our fire separation had and no fire caulking around s through the wall between d the 2010 building. are separation cannot be				
K 050 SS=C	This deficient practice administrator at the ti NFPA 101 LIFE SAFE		K 050			
	signal and simulation conditions. Fire drills times under varying c on each shift. The sta and is aware that drill routine. Responsibility conducting drills is as	are held at unexpected conditions, at least quarterly aff is familiar with procedures is are part of established				

Facility ID: 00898

If continuation sheet Page 3 of 5

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/25/2016 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE	
		245149	B. WING			02/	12/2016
NAME OF P	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR			100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
K 050 K 143 SS=E	Where drills are cond 6:00 AM a coded ann instead of audible ala 18.7.1.2, 19.7.1.2 This STANDARD is r Based on documenta interview, the facility of documentation that fil once per shift per qua varying times and cor NFPA 101, Section 19 practice could affect a Findings include: On facility tour betwee February 12, 2016, th documentation for the that a fire drill was no evening shift during th This deficient practice Director of Environme discovery. NFPA 101 LIFE SAFE Transferring of liquid to another shall be ac specifically designate as follows: (a) separated from ar wherein patients are housed, examiner of a fire barrier of 1-ho construction; and	ucted between 9:00 PM and ouncement may be used rms. not met as evidenced by: ation review and staff could not provide re drills were conducted arter for all staff under nditions as required by 2000 9.7.1.2. This deficient all 68 residents. en 9:30 AM and 1:30 PM on re review of the fire drill e past 12 months revealed t documented for the ne second quarter. e was confirmed by the ental Services at the time of ETY CODE STANDARD oxygen from one container complished at a location d for the transferring that is any portion of a facility d, or treated by a separation		143			

Facility ID: 00898

If continuation sheet Page 4 of 5

CENTER	S FOR MEDICARE 8	ND HUMAN SERVICES				ORM APPROVE NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		DATE SURVEY OMPLETED
		245149	B. WING			02/12/2016
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		
	MARITAN SOCIETY - A	MRASSADOP		8100 MEDICINE LAKE ROAD		
GOOD SA	MARTAN SOCIETT - A			NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
K 143	Continued From page	ne 4	K 1	43		
	sprinklered, and has	s ceramic or concrete flooring;				
	and	posted with signs indicating				
		ccurring, and that smoking in				
	the immediate area	is not permitted in				
	accordance with NF Association.	PA 99 and Compressed Gas				
	8-6.2.5.2 (NFPA 99)					
		not met as evidenced by:				
		on and staff interview, this				
	-	eet the requirements for the of room intended for the				
		oxygen from one container to				
	another per NFPA 9 practice could affect	9 8-6.2.5.2. This deficient all 44 residents.				
	Findings include:					
	1:30 PM on Februar	facility between 9:30 AM and y 12, 2016, observation ygen transfilling room in 1963 oor tiles.				
		ce was verified by the time of the inspection.				
		•				

Facility ID: 00898

If continuation sheet Page 5 of 5

		ID HUMAN SERVICES				FOF	RM APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION • NEW ADDITION	(X3) DAT	O. 0938-0391 E SURVEY IPLETED
		245149	B. WING			0	2/12/2016
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	• •	
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR			0 MEDICINE LAKE ROAD W HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		К 0	00			
	FIRE SAFETY						
	ALLEGATION OF CO DEPARTMENTS ACC SIGNATURE AT THE PAGE OF THE CMS-	C WILL SERVE AS YOUR MPLIANCE UPON THE CEPTANCE. YOUR BOTTOM OF THE FIRST 2567 FORM WILL BE FION OF COMPLIANCE.					
	ONSITE REVISIT OF CONDUCTED TO VA SUBSTANTIAL COM REGULATIONS HAS	PLIANCE WITH THE					
	Minnesota Departmen Fire Marshal Division the time of this survey Ambassador was fou compliance with the r in Medicare/Medicaid 483.70(a), Life Safety edition of National Fir	equirements for participation at 42 CFR, Subpart from Fire, and the 2000 e Protection Association , Life Safety Code (LSC),					
	PLEASE RETURN TI CORRECTION FOR DEFICIENCIES (K-T/	THE FIRE SAFETY AGS) TO:					
	Healthcare Fire Inspe State Fire Marshal Di 445 Minnesota St., Si St. Paul, MN 55101-5	vision uite 145					
ABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATU	RF		TITLE		(X6) DATE

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

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/25/2016 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - NEW ADDITION	(X3) DATE	
		245149	B. WING			02/	12/2016
NAME OF P	ROVIDER OR SUPPLIER	L	I	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR			8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
К 000	By email to: Marian.Whitney@stat Angela.Kappenman@ THE PLAN OF CORF DEFICIENCY MUST FOLLOWING INFOR 1. A description of whito correct the deficient 2. The actual, or prop 3. The name and/or the responsible for correct prevent a reoccurrent Good Samaritan Soci building with a partial constructed at 3 differ building was construct determined to be of T 1996, an addition was determined to be of T 2010, an addition was determined to be of T There is a 2-hour fire addition and the rest the facility is surveyed CMS-2786R forms us The building is autom throughout. The facility with smoke detection open to the corridors automatic fire departr	te.mn.us Destate.mn.us RECTION FOR EACH INCLUDE ALL OF THE MATION: at has been, or will be, done rcy. osed, completion date. the of the person ction and monitoring to be of the deficiency. ety Ambassador is a 1-story basement. The building was rent times. The original ted in 1963 and was ype II (000) construction. In a constructed and was ype V (111) construction. In a constructed and was ype V (111) construction. wall between the 2010 of the building. Therefore, d as two buildings with two sed.	K	000			

Facility ID: 00898

If continuation sheet Page 2 of 5

<u>CENTER</u>	S FOR MEDICARE &	MEDICAID SERVICES				M APPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING 02 -		(X3) DATE	E SURVEY PLETED
		245149	B. WING		02	/12/2016
NAME OF P	ROVIDER OR SUPPLIER	•	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - AN	IBASSADOR) MEDICINE LAKE ROAD N HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP! DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	Continued From page		K 000			
	NOT MET as evidence	2 CFR, Subpart 483.70(a) is ced by:				
K 012 SS=F	NFPA 101 LIFE SAFE	ETY CODE STANDARD	K 012			
	of the following: 18.1.6.2, 18.1.6.3, 18 This STANDARD is r Based on observatio building does not me	not met as evidenced by: n and staff interview, this et the requirements for multiple construction types.				
	Findings include:					
	1:30 PM on February revealed that the 2-he fiberglass insulation a the large penetrations the 1997 building and	acility between 9:30 AM and 12, 2016, observation our fire separation had and no fire caulking around s through the wall between d the 2010 building. are separation cannot be				
K 050 SS=C	This deficient practice administrator at the ti NFPA 101 LIFE SAFE		K 050			
	signal and simulation conditions. Fire drills times under varying c on each shift. The sta and is aware that drill routine. Responsibilit conducting drills is as	are held at unexpected conditions, at least quarterly aff is familiar with procedures is are part of established				

Facility ID: 00898

If continuation sheet Page 3 of 5

					FOR	D: 02/25/2016 MAPPROVED D. 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
	245149	B. WING			02	12/2016
ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
MARITAN SOCIETY - AN	IBASSADOR					
			N	EW HOPE, MN 55427		1
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		x	(EACH CORRECTIVE ACTION SHOULD I	3E	(X5) COMPLETION DATE
Where drills are cond 6:00 AM a coded ann instead of audible ala 18.7.1.2, 19.7.1.2 This STANDARD is r Based on documenta interview, the facility of documentation that fin once per shift per qua varying times and cor NFPA 101, Section 18	ucted between 9:00 PM and ouncement may be used rms. not met as evidenced by: ation review and staff could not provide re drills were conducted arter for all staff under nditions as required by 2000 3.7.1.2. This deficient	K	050			
February 12, 2016, the documentation for the that a fire drill was no evening shift during the This deficient practice Director of Environme discovery. NFPA 101 LIFE SAFE Transferring of liquid of to another shall be ac specifically designate as follows: (a) separated from an wherein patients are here treated by a separation	e review of the fire drill e past 12 months revealed t documented for the ne second quarter. e was confirmed by the ental Services at the time of ETY CODE STANDARD oxygen from one container complished at a location d for the transferring that is ny portion of a facility noused, examined, or on of a fire barrier of 1-hour	к	143			
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER MARITAN SOCIETY - AN SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page Where drills are cond 6:00 AM a coded anni instead of audible ala 18.7.1.2, 19.7.1.2 This STANDARD is r Based on documenta interview, the facility of documentation that file once per shift per qua varying times and cor NFPA 101, Section 18 practice could affect a Findings include: On facility tour betwee February 12, 2016, the documentation for the that a fire drill was no evening shift during the This deficient practice Director of Environmenta discovery. NFPA 101 LIFE SAFE Transferring of liquid a to another shall be act specifically designate as follows: (a) separated from an wherein patients are between the treated by a separation	CORRECTION IDENTIFICATION NUMBER: 10ENTIFICATION NUMBER: 245149 ROVIDER OR SUPPLIER MARITAN SOCIETY - AMBASSADOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 18.7.1.2. This deficient practice could affect all 68 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on February 12, 2016, the review of the fire drill documentation for the past 12 months revealed that a fire drill was not documented for the evening shift during the second quarter. This deficient practice was confirmed by the Director of Environmental Services at the time of discovery. NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 245149 B. WING ROVIDER OR SUPPLIER MARITAN SOCIETY - AMBASSADOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFI TAG Continued From page 3 K (Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. K (18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 18.7.1.2. This deficient practice could affect all 68 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on February 12, 2016, the review of the fire drill documentation for the past 12 months revealed that a fire drill was not documented for the evening shift during the second quarter. K if Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: K if (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour K if	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING 0: 245149 B. WING ROVIDER OR SUPPLIER MARITAN SOCIETY - AMBASSADOR ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 3 Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. K 050 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 18.7.1.2. This deficient practice could affect all 68 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on February 12, 2016, the review of the fire drill documentation for the past 12 months revealed that a fire drill was not documented for the evening shift during the second quarter. K 143 This deficient practice was confirmed by the Director of Environmental Services at the time of discovery. K 143 Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: K 143	S FOR MEDICARE & MEDICAID SERVICES 0F DEFICIENCIES (X1) PROVIDERUPPLIERCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 02 - NEW ADDITION A BUILDING 02 - NEW ADDITION A BUILDING 02 - NEW ADDITION B WIND CONDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE MARITAN SOCIETY - AMBASSADOR STREET ADDRESS, CITY, STATE, 2P CODE SUMMARY STATEMENT OF DEFICIENCES (EACH CORRECTIVE ADDRESS PLAN OF CORRECTION REQUILATORY ON LISC IDENTIFYING INFORMATION) ID PREFX PREFX PREFX Continued From page 3 K 050 Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. K 050 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 18.7.1.2. This deficient practice could affect all 68 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on February 12, 2016, the review of the fire drill documentation for the past 12 months revealed that a fire drill was not documented for the evening shift during the second quarter. K 143 This deficient practice was confirmed by the Director of Environmental Services at the time of discovery. K 143 T	MENT OF HEALTH AND HUMAN SERVICES FORM SPCOR MEDICARE & MEDICALOB SERVICES OMB NC CORRECTION (x1) PROVIDERUSHIPHERICUA IDENTIFICATION NUMBER (x2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW ADDITION (x3) DATE ROWDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE (x3) DATE RARTAN SOCIETY - AMBASSADOR STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE (x4) DATE SUMMARY STATEMENT OF DEFICIENCES (PACH DEPICIENCY NUST BE PRECIDEND BY YILL REQULATORY OR LSC IDENTIFINIS INFORMATION) ID PRETIX PROVERSING PLAN OF CORRECTION (EXCH CORRECTIVE ACTION SUMMARY STATEMENT OF DEFICIENCES (ROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) Continued From page 3 K 050 Where drills are conducted between 9:00 PM and 6:00 AM a code announcement may be used instead of audible alarms. K 050 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drill swere conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFFA 101, Section 13.7.1.2. This deficient practice could affect all 68 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on February 12, 2016, the review of the fire drill documentation for the past 12 months revealed that a fire drill was not documented for the evening shift during the second quarter. K 143 Transferring file udia xygen from one container to anoth

Facility ID: 00898

If continuation sheet Page 4 of 5

AND PLAN OI	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION - NEW ADDITION	(X3) DAT	O. 0938-039 E SURVEY IPLETED
		245149	B. WING		0	2/12/2016
NAME OF P	ROVIDER OR SUPPLIER	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	• •	
GOOD SA	MARITAN SOCIETY - A	MBASSADOR		00 MEDICINE LAKE ROAD EW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
K 143	and (c) in an area that is that transferring is of the immediate area is accordance with NFI Association. 8-6.2.5.2 (NFPA 99) This STANDARD is Based on observation building does not me proper arrangement transferring of liquid another per NFPA 99 practice could affect Findings include: During a tour of the f 1:30 PM on Februar revealed that the oxy building had vinyl flo	 ceramic or concrete flooring; posted with signs indicating ccurring, and that smoking in is not permitted in PA 99 and Compressed Gas not met as evidenced by: on and staff interview, this the requirements for the of room intended for the oxygen from one container to 9 8-6.2.5.2. This deficient all 24 residents. 	K 143			

Facility ID: 00898

If continuation sheet Page 5 of 5

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			MET	NOT MET	N/A REMARKS
	PART I - LSC REQUIREMENTS - Items in italics relate to the	ms in italics relate to the FSES			K12-
<u> </u>	BUILDING CONSTRUCTION	TRUCTION			1-story building with a partial basement. The building was
	If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1½ hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2	ith a nonconforming building, /ing at least a two hour fire erials as required for the occur only in corridors and closing fire doors with at !.1.4.1, 19.1.1.4.2	٢	0	 constructed at 3 different times. The constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II (000) construction. In 1996, an addition was constructed and was determined to be of Type II(000) constructed and was constructed and was determined to be of Type V (111)
K10	2000 FXISTING				construction. There is a z-riour life wall between the zuro
	Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	It meets one of the following:	0	•	Therefore, the facility is surveyed as two buildings with two CMS-2786R forms used.
-	1 🔘 I (443), I (332), II (222)	Any Height			The building is automotic fire ancientler erected
	2 0 (111)	One story only (non-sprinklered).			the building is automatic me spiritiker protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to
	3	Not over three stories with complete automatic sprinkler system.			the corridors that is monitored for automatic fire department notification.
Ч	4 🔘 III (211)				1. It was observed that the two hour separation had
(1)	5 💽 V (111)	Not over two stories with			fiberglass insulation and no fire caulking
	6 Oiv (2нн)	sprinkler system.			building and the 2010 building.
					I neretore, a z-nour tire separation cannot be contirmed.
ω	8 🔘 III (200)	Not over one story with			
	9 Ov (000)	sprinkler system.			
	Building contains fire treated wood. Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as propriete	d. of the construction, the its, floors on which patients barriers and dates of small floor plan of the			
orm CMS	Form CMS-2786R (02/2013)				Page 2

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	meets one of the following:	Any height with complete automatic sprinkler system	Not over three stories with complete automatic sprinkler system		Not over one story with complete automatic	sprinkler system.		Not Dormittad		S, of the construction, the nts, floors on which patients barriers and dates of small floor plan of the	gs of Type I or Type I or limited-combustible ing listed fire retardant earing one-hour rated
	2000 NEW Building construction type and height meets one of the 1 18.1.6.2, 18.1.6.3, 18.3.5.1.	1 1 (443), 1 (332), 11 (222)	2 II (111)	3 III (211)	4 V (111)	5 IV (2HH)	6 II (000)	7 III (200)	8 V (000)	□ Building contains fire treated wood. Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.	Interior walls and partitions in buildings of Type I or Type Il construction shall be noncombustible or limited-combustible materials. 18.1.6.3, 19.1.6.3 (Indicate N/A for existing buildings using listed fire retardant treated wood studs within non-load bearing one-hour rated partitions.)
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	INTERIOR FINISH	2000 EXISTING Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than ½s inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 Indicate flame spread rating/s A	2000 NEW Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower half of corridor walls, not exceeding 4ft in height, may have a Class C flame spread rating. 10.2, 18.3.3.1, 18.3.3.2, NFPA TIA 00-2 Indicate flame spread rating/s	2000 EXISTING Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2 Indicate flame spread rating/s <u>A</u>	2000 NEW Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2. <i>Indicate flame spread rating/s</i>
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ID PREFIX	K18 2000 EXISTING 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 1 ³ / 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. 19.3.6.3	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.	2000 NEW	Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. 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 positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited.	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.	 K19 Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) In other than smoke compartments containing patient bedrooms, miscellaneous opening are permitted in vision panels or doors provided the aggregate area of the opening per room does not exceed 20 in.² and the opening is installed in bottom half of the wall (80 in.² in fully sprinklered buildings). 18.3.6.5, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5

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XI	VERTICAL OPENINGS	2000 EXISTING Stairways elevator shafts light and ventilation shafts chirtes	and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 <i>If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.</i>	If enclosures are less than required, give a brief description and specific location in REMARKS.	2000 NEW	Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.2.5.6, 8.2.5, 18.3.1.1.	If enclosures are less than required, give a brief description and specific location in REMARKS.	Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms	doors are kept closed.
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	Describe method used in REMARKS	SMOKE COMPARTMENTATION AND CONTROL	2000 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2	2000 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2	The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1	Detail in REMARKS zone dimensions including length of zones and dead end corridors.	2000 EXISTING	Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5	2000 NEW	Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5	Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.4, 19.3.7.4
D ID PREFIX			K23		K24		K25				K26

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K27	2000 EXISTING 2000 EXISTING Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1 ³ / ₄ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic- closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	have at least a 2 inch thick solid t tes that do not e: re permitted. Hoi oors shall be self oors shall be self tith 19.2.2.2.6. Sw gress and positiv	20 minute fire protection bonded core wood. xceed 48 inches from rizontal sliding doors -closing or automatic- winging doors are not /e latching is not	۲	Ŏ	0	
	2000 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1 ³ / ₄ inch thick solid bonded core wood. Non- rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8	ave at least a 20 nch thick solid bor tt do not exceed 4 Horizontal sliding shall be arranged boors shall be self quired at the mee 3.3.7.5, 18.3.7.6,	minute fire protection nded core wood. Non- 48 inches from the bottom g doors comply with I so that each door swings f-closing and rabbets, eting edges. Positive 18.3.7.8				
K28	2000 EXISTING Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7	. barriers shall pr m) for swinging c	ovide a minimum clear or horizontal doors.	•	Õ	0	
	2000 NEW Door openings in smoke barriers are installed as swinging or	barriers are inst	talled as swinging or	1 5 1 1 1 1 1 1 1 1 1	1 1 1 1 1 1 1 1		
	horizontal doors shall provide a minimum clear width Provider Type Swinging Doors Horizontal S	ovide a minimum Swinging Doors	1 clear width as follows: Horizontal Sliding Doors				
	Hospitals and Nursing Facilities	41.5 inches (105 cm)	83 inches (211 cm)				
	Psychiatric Hospitals and Limited Care Facilities	32 inches (81 cm)	64 inches (163 cm)				
	18.3.7.7						

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	Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5	Describe any mechanical smoke control system in REMARKS.	HAZARDOUS AREAS	2000 EXISTING Che hour fire rated construction (with % 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 shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be 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 And And And Field Heater Rooms the bottom of the door are permitted. 19.3.2.1 And And Field Heater Rooms the bottom of the door are permitted. 19.3.2.1 And And Field Heater Rooms the bottom of the door are permitted. 19.3.2.1 And Combine (greater than 100 sq feel) Compared to the construction of the door are built and the field heater from the bottom of the door are permitted. 19.3.2.1 And Combine (greater than 100 sq feel) Compared to the field heater from the bottom of the door are branches from the bottom of the door are built and the field heater from the bottom of the door are built as severe the field as field as the field as the field as the field
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	2000 NEW Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 34 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1. Automatic Sprinkler Sparation N/A accordance and Fuel-Fired Heater Rooms accordance and Paint Stops <u>e. Laundries (greater than 100 sq feet)</u> <u>e. Laundries (greater than 100 sq feet)</u> <u>e. Laundries (fi classified a Sovier Hazard - see K31)</u> <u>e. Laundries (fi classified a Sovier Hazard - see K31)</u> <u>e. Combustible Storage Rooms/Spaces (over 100 sq feet)</u> <u>e. Combustible Storage Rooms/Spaces (over 100 sq feet)</u> <u>e. Solied Linen Rooms</u> <u>m.Combustible Storage Rooms/Spaces (over 100 sq feet)</u>	are deficient in REMARKS. Gift shops shall be protected as hazardous areas when used for storage or display of combustibles in quantities considered hazardous. Non-rated walls may separate gift shops that are not considered hazardous, have separate protected storage and that are completely sprinkled. Gift shops may be open to the corridor if they are not considered hazardous, have separate protected storage, are completely sprinklered and do not exceed 500 square feet. 18.3.2.5, 19.3.2.5 Area Automatic Sprinkler Separation NA L. Gift Shop storing hazardous quantities duromatic Sprinkler Separation NA of combustibles
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× Merr Nhere Alcohol Based Hand Rub (ABHR) dispensers are Where Alcohol Based Hand Rub (ABHR) dispensers are writistaled. Merr Inte anskinum individual fluid dispenser capacity shall be I 1.2 liters (2 liters (2 liters in suites of rooms) acch other Merr Inte dispensers shall have a minimum spacing of 4 ft from each other Inte dispensers shall have a minimum spacing of a ft from each other Inte dispensers in suites of rooms) Inte dispensers shall have a minimum spacing of a ft from each other Inte dispensers in suites of rooms) Inte from is carpeted, the building is fully sprinklered. Inte floor is carpeted, the building is fully sprinklered. Int fit fit fit from is carpeted, the building is fully sprinklered. Is 3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623 Access to exits shall be marked by approved, readily usible signs in all cases where the exit or way to reach exit is not reach floor of the soulding. Not less than one exit have a sign designating "No Exit". 7.10, 18.2.10.1 Not less than two exits. 7.10, 18.2.10.1 Not less than two exits, remote from each other, are provided for reach floor of the soulding. Not less than one exit trans are not of the soulding. Not less than one exit to mach floor of the soulding. Not less than one exit to mach floor of the soulding. Not less than one exit to mach floor of the soulding of at least one hour, 1.2.2.4.1, 18.2.4.1, 18.2.4.1, 13.2.4.1, 1.3.2.8.2.8.2.5.8.2.5.1 ZOOD EXISTING Exit enclosure from other parts of the building. 7.1.3.2.8.2.2.5.8.2.1, 19.3.1, 1.1.3.2.8.2.2.2.1, 19.2.1, 1, 1.1.3.2.8.2.2.1, 19.2.1, 1, 1.1.3.2.	N/A	0		0		0	
× MeT Where Alcohol Based Hand Rub (ABHR) dispensers are Where Alcohol Based Hand Rub (ABHR) dispensers are mastalled. MeT The installed. In the orridor is at least 6 feet wide In the maximum individual fluid dispenser capacity shall be the maximum individual fluid dispenser capacity shall be acch other In the dispensers shall have a minimum spacing of 4 ft from each other In the dispensers shall have a minimum spacing of a thit from each other In the dispenser capinet, accomparities of rooms) In the floor is carpeted, the building is fully sprinklered. Is 3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623 Source. Source. EXTS AND EGRESS Access to exits shall be marked by approved, reading visible signs in all cases where the exit or way to read point an exit have a sign designating "No Exit". 7.10, 19.2.10.1, 19.2.10.1 Not less than two exits, remote from each other, are provided for reach floor of fire section shall be a door less than one exit to meach floor of fire section shall be a door less than one exit to meach floor of fire section shall be a door less than one exit to meach floor of fire section shall be a door less than for stair, smoke proof enclosure, ramp, or exit passages or stainways that are not of the soution of the building. 2000 EXISTING Exit enclosures (such as stainways) are enclosed with construction painst fire or smoke from other parts of the building. 2000 EXISTING Exit enclosures (such as stainways) are enclosed with construction against fire or smoke from other parts of the build		Õ		Ō	0	Õ	
 ★ Where Alcohol Based Hand Rub (ABHR) dispensers a installed: The corridor is at least 6 feet wide The corridor is at least 6 feet wide The corridor is at least 6 feet wide The aximum individual fluid dispenser capacity shows are used in a single smole compartment outside a storage cabinet. Not more than 10 gallons are used in a single smole compartment outside a storage cabinet. Dispensers are not installed over or adjacent to an source. Dispensers are not installed over or adjacent to an source. Source. If the floor is carpeted, the building is fully sprinkler tables active a source. Access to exits shall be marked by approved, readily signs in all cases where the exit or way to reach exit is singles in all cases where the exit. Access to exits shall be marked by approved, readily signs in all cases where the exit. Access to exits shall be marked by approved, readily signs in all cases where the exit. Access to exits shall be marked by approved, readily signs in all cases where the exit. Access to exits shall be a door leading sidn, signs in all cases than two exits. ramp, or exit passagew or that are not a way of exit. Access than two exits. ramp, or exit passage or that are not a way or exit passagew, or each floor or fire section shall be a door leading stalr, smoke-proof enclosure, ramp, or exit passagew, or exit massagem, or each floor or fire section shall be a door leading stalr, smoke-proof enclosure, ramp, or exit passagew, or exit massagew, or exit mastate a more of these two exits may be a horizontal exit. Eg		۲		\bullet	$\overline{\bullet}$	\overline{ullet}	
K33 K32 K22 K22 K23		e Alcohol Based Hand Rub (ABHR) dispensers are led: a corridor is at least 6 feet wide a maximum individual fluid dispenser capacity shall be liters (2 liters in suites of rooms) a dispensers shall have a minimum spacing of 4 ft from the other the more than 10 gallons are used in a single smoke npartment outside a storage cabinet. pensers are not installed over or adjacent to an ignition rce. 2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623	EXITS AND EGRESS	ess to exits shall be marked by approved, readily visible is in all cases where the exit or way to reach exit is not dily apparent to the occupants. Doors, passages or stairways are not a way of exit that are likely to be mistaken for an exit e a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1	less than two exits, remote from each other, are provided for h floor or fire section of the building. Not less than one exit n each floor or fire section shall be a door leading outside, r, smoke-proof enclosure, ramp, or exit passageway. Only of these two exits may be a horizontal exit. Egress shall not rn through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 2.4.2	0 EXISTING enclosures (such as stairways) are enclosed with struction having a fire resistance rating of at least one hour, arranged to provide a continuous path of escape, and provide tection against fire or smoke from other parts of the building. 3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 <i>I vertical openings are properly enclosed with construction</i> <i>viding at least a two hour fire resistance rating, also check</i> <i>box.</i> □	nclosures are less than required, give a brief description and cific location in REMARKS.

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REMARKS									
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MET		($oldsymbol{O}$	$oldsymbol{O}$	$\textcircled{\bullet}$			\bigcirc	\bullet
	2000 NEW Exit enclosures (such as stairways) in buildings four stories or more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous path of escape, and provide a protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 7.1.3.2, 8.2.5.2, 8.2.5.4, 18.3.1.1, 18.2.2.3	specific location in REMARKS.	stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4	The capacity of required mean of egress is based on its width, in accordance with 7.3.	Travel distance (exit access) to exits are measured in accordance with 7.6. • Room door to exit ≤ 100 ft (≤ 150 ft sprinklered) • Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered) • Point in room to room door ≤ 50 ft • Point in suite to suite door ≤ 100 ft 18.2.6, 19.2.6	2000 EXISTING Existing dead-end corridors shall be permitted to be continued to be used if it is impractical and unfeasible to alter them so that exists are accessible in not less than two different directions from all points in aisles, passageways, and corridors. 19.2.5.10	2000 NEW Every exit and exit access shall be arranged so that no corridor, aisle or passageway has a pocket or dead-end exceeding 30 feet. 18.2.5.10	Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1	2000 EXISTING Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3
ID PREFIX		r c x	K34	K35	K36	K37		K38	K39

Name	Name of Facility				2000 CODE
ID PREFIX		MET	NOT MET	A/A	REMARKS
	2000 NEW Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4				
K40	2000 EXISTING Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. An exception is provided for existing 34-inch doors in existing occupancies. 19.2.3.5	•	\bigcirc		
	2000 NEW				
	Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 41.5 inches in clear width. Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In psychiatric hospitals or limited care facilities (e.g.,ICF/MD providing medical treatment) doors are at least 32 inches wide. 18.2.3.5				
K41	All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1 <i>If doors lead directly to grade from each room, check this box.</i>	$\overline{\bullet}$	\bigcirc		
K42	Any patient sleeping room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2	$\overline{\bullet}$	\bigcirc		
K43	Patient room doors are arranged such that the patients can open the door from inside without using a key. Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5, 19.2.2.2.4, 19.2.2.2.5	$\overline{\bullet}$	$\overline{\bigcirc}$	\bigcirc	
	If door locking arrangement without delay egress is used indicate in REMARKS 18.2.2.2, 19.2.2.2.2	\tilde{O}	\bigcirc		
K44	Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5	$\overline{\mathbf{O}}$	\bigcirc	\bigcirc	
K47	Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1	$\overline{\bullet}$	$\overline{\bigcirc}$	\bigcirc	
	(Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)				

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Name of Facility

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ID PREFIX		MET NOT	T N/A	REMARKS
K72	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1	\bigcirc		
	ILLUMINATION			
K45	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8	\bigcirc		
K46	Emergency lighting of at least 1½ hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.	\bigcirc	\bigcirc	
K105	2000 NEW (INDICATE N/A FOR EXISTING)			
	Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the Life Safety Branch of the electrical system described in NFPA 99. 18.2.9.2., 18.2.10.2 (Indicate N/A if life support equipment is for emergency purposes only).			
	EMERGENCY PLAN AND FIRE DRILLS			
K48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1	\bigcirc	0	
K50	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2		<u> </u>	K50- It was observed during document review that a fire drill was not documented for the evening shift during the second quarter.
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Definition MeT MoT	Name	Name of Facility				2000 CODE
FIRE ALARM SYSTEMS FIRE ALARM SYSTEMS A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wing of fire in any part of the building. Fire alarm system warning or other transmission paths are monitored for integrity. Initiation of the fire alarm system alarm, detection device, or detection system Manual alarm boxes are provided at all nurse's stations. Cocupant officiation is provided by any required exit. Manual alarm boxes in patient boxes are located at all nurse's stations. Cocupant officiation is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of tinctions. System records are maintained and readily available. A fire alarm system required for life safety shall be, tested, and maintenance and NFPA 70 National Electric Code and readily available. A fire alarm system submatically control tunctions. System has an advisual signals. A fire alarm system shall now the analytication is provided by the system shall now the value of or tunctions. Statem and the string available. A fire alarm system shall now the aution alter of the state of the string available. A fire alarm system is out of service for more trainanded in accordance with NFPA 70 National Electric Code and resolity available. A fire alarm system shall now the result of the string available. A fire alarm system is out of service for more trainading availabl	ID PREFIX				N/A	REMARKS
A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National system wining or other transmission patrs are monitored for integrity. Initiation of the fire alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required exit. Manual alarm boxes are provided by audible and visual signals. In critical care areas, visual alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically to notify and and readily available. 18.34, 19.34, 9.6 The system records are maintained and readily available. 18.34, 19.3.4, 9.6 A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. 70 and 72.9.6.1.7, Where a required for life safety shall be, tested, and testing program complying with applicable requirement of NFPA 70 and 72.9.6.1.4, 9.6.1.7, Where a required for the alarm system has been returned to service. 9.6.1.8 and bubble for an approved maintenance and testing program complying with applicable requirement of NFPA 70 SPRINKLERED NURSING HOMES) in an existing nursing home, not fully sprinklered, the resident available. The spate shall be provided for all parties left and specied or an approved fire watch shall be provided for all parties left and specied or an approved fire watch shall be notified, and the shufdown until the fire alarm system has been returned to service. 9.6.1.8 and testing nursing home, not fully sprinklered, the resident available. The system set in approved fire watch shall be provided for all parties left and the shufdown until the fire alarm sys			1			
A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70	K51	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6	$\textcircled{\bullet}$	0		
Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70	K52	A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,		0		
	K155	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8	•	\bigcirc	0	
-	K53	2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70	Õ	Õ	\bigcirc	

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_	B. Show who provided the service. SUMMIT				
_	C. Note the source of water supply for the automatic sprinkler system. CITY WATER	1 1 1 1			
_	(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)	 			
K61	Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72	•	$\overline{\bigcirc}$		
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	$\overline{\bullet}$	$\overline{\bigcirc}$		
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13	\bigcirc	\bigcirc		
K64	Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6	$\underbrace{\bullet}$	\bigcirc		
_	SMOKING REGULATIONS				
K66	 Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99) (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 	$\underbrace{\bullet}$	\bigcirc		
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DEFINA MET NAT Net T NAT PRETIX (2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision. (a) Ashtrays of noncombustible material and safe design shall be prohibited, except when under direct supervision. (b) Ashtrays of noncombustible material and safe design shall (c) Ashtrays of noncombustible material and safe design shall (c) Ashtrays of noncombustible material and safe design shall (c) Ashtrays and succontainers with self-closing cover devices into which ashtrays can be empled shall be readily available to all areas where smoking is permitted. (d) Metal containers with self-closing cover devices into which ashtrays can be installed. (d) Metal containers with the manufacturer's properting the installed of the accordance with the manufacturer's and shall be installed in accordance with the manufacturer's properting install. (d)	REMARKS										
 (2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be installed in accordance with the manufacturer's specifications. BULDING SERVICE EQUIPMENT BULDING SERVICE EQUIPMENT BULLDING SERVICE EQUIPMENT BUS.2.2, 19.5.2.2. Cooking facilities shall be protected in accordance with 9.2.3. 18.5.2.1, 19.5.2.1, 9.5.2.2. Cooking facilities shall be protected in accordance with 9.2.3. 18.5.2.1, 19.5.2.2. Cooking facilities shall be protected in accordance with 9.2.3. 18.5.2.1, 19.5.2.2. Cooking facilities shall be protected in accordance with 9.2.3. 18.5.2.1, 19.5.2.2. Cooking facilities shall be protected in accordance with 9.2.3. 18.5.2.1, 19.5.4, 9.5. 8.4, NFPA 96 Portable space heating devices shall be provided in all heatth consciletations is taken from and discharged to the outside air. 18.5.4, 19.5.4, 9.5. 8.4, NFPA 82 Rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with after door assembly having a fire protection rating of 1 hour. All new chrites shall comply with 9.5. (2) Any trash chute shall	NOT MET		0 0 0			○○	0 0 0	○ ○ ●		○ ○ ●	
		Smoking by patients classified as not responsible prohibited, except when under direct supervision.		BUILDING SERVICE EQUIPMENT	Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 18.7.8, 19.7.8	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82	Any existing linen and trash chute, including pneur rubbish and linen systems, that opens directly onto corridor shall be sealed by fire resistive constructic prevent further use or shall be provided with a fire assembly having a fire protection rating of 1 hour. chutes shall comply with 9.5.	

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	 (4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use. 		Ō	O	
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	for Existing Elevators & Escalators. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. 9.4.2, 9.4.3, 19.5.3	•	Č	\supset	
	(includes tirerighters service phase I key recall and smoke detector automatic recall, firefighters service phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
	2000 NEW				
	Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record.				
	New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter's Service Requirements. 9.4.2, 9.4.3, 18.5.3				
	(Includes firefighters service phase I key recall and smoke detector automatic recall, firefighters service phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
K161					
	Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.	Č	C	lacksquare	
	All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, <i>Safety Code for</i> <i>Existing Elevators and Escalators</i> . 19.5.3, 9.4.2.2)))	

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	matic skirt istway door ar is being	ith the	A17.1, 2.1	NS	ey are of fire 5.4	er loosely orations pt for ains are 18.7.5.1,	e char d in 10.3.3,	lgth and ance 5.3,	es means	eed 32 er capacity). A
ID PREFIX	(Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.)	2000 NEW Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.	All escalators and conveyors comply with ASME/ANSI A17.1 Safety Code for Elevators and Escalators. 18.5.3, 9.4.2.1	FURNISHINGS AND DECORATIONS	Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4	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	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.	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	Newly introduced upholstered furniture and mattresses means purchased since March, 2003.	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft ² (20.4 L/m ²). A

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REMARKS							
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	Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code, 4-3 (NFPA 99), 10-7.2.1 (NFPA 99)	MEDICAL GASES AND ANESTHETIZING AREAS	 Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 	Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4.	 Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or great than 35% 4-3.1.2.3(n) and 5-4.1.1 (NFPA 99), 18.3.2.3, 19.3.2.3 	 Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities. (a) Master alarm panels are in two separate locations and have audible and visible signals. (b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2 (c) Where a level 2 gas system is used, one alarm panel that complies with 4-3.1.2.2(b)3a,b,c,d and with 4-3.1.2.2(c)2,5 shall be permitted. 4-4.1 (NFPA 99) exception No. 4. 4-3.1.2.2 (NFPA 99) 	Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUSION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99)
ID PREFIX			K76	K77	K78	K140	K141

Nam	Name of Facility				2000 CODE
D PREFIX		MET	NOT MET	A/A	REMARKS
K142	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	Õ	\bigcirc		
K143	Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99)	0		0	K143- It was observed that the oxygen transfilling room had vinyl floor tiles.
	ELECTRICAL AND EMERGENCY POWER				
K106	Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99)	Ō	Ō	\bullet	
K107	Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1	$\overline{\bullet}$	Ο		
K108	2000 NEW (INDICATE N/A FOR EXISTING) Power for Alarms, emergency communication systems, and illumination of generator set locations are in accordance with essential electrical system of NFPA 99. 18.5.1.2				
K144	Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)		0	0	
K145	The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99)	0	Ō	\bigcirc	
Form Cl	Form CMS-2786R (02/2013)	-			Page 25

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	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source 3-6. (NFPA 99)	Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1	Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.
ID PREFIX	K146 TI ha fr 11	K147 E	К130 Бедер Ц. М

Name of Facility		2000 CODE
PART IV REC	PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS	CODE PROVISIONS
For each item of the Life Safety code recol specific provisions of the code, if rigidly ap adversely affect the health and safety of th	For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).	te the reason for the conclusion that: (a) the ne waiver of such unmet provisions will not
PROVISION NUMBER(S)	JUSTIFICATION	
K84		
Surveyor (Signature)	Title Office	Date
Fire Authority Official (Signature)	Title Office	Date
Form CMS-2786R (02/2013)		Page 27

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES	JMAN SERVICES ICAID SERVICES	E5	8				2000 CODE	Form Approved OMB Exempt
FIRE SAFETY SURVEY REPORT 2000 CODE Medicare – Medicaid	VEY REPORT 2000 CC Medicare – Medicaid	T 2000 COI Medicaid	DE - HEALTH CARE		A) PROVIDER NUN 245149		1. (B) MEDICAID I.D. NO. K2	
		P.	PART I — Life Safety Code, New and Existing PART IV — Waiver Recommendation Form	Code, New al Recommendat	nd Existing tion Form			
Identifying information as shown in applicable records. 2. NAME OF FACILITY	wn in applicable		anges, if any, al JCTION (BLDGS)	longside each 2. (B) ADDRESS	item, giving date	ongside each item, giving date of change. 2. (B) ADDRESS OF FACILITY (STREET. CITY. STATE. ZIP CODE) A(Fully Sprinklered
GOOD SAMARITAN SOCIETY AMBASSADOR		A. BUILDING B. WING C. FLOOR		8100 MEI NEW HOU	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427	ROAD 7	OOO_{a}	(All required areas are sprinklered) Partially Sprinklered (Not all required areas are sprinklered) None (No sprinkler system)
3. SURVEY FOR	4. DA	4. DATE OF SURVEY		DATE OF PLAN APPROVAL	APPROVAL	SURVEY UNDER	<u>,</u>	
		02/1	02/12/2016	K6		5. 2000 EXISTING K7	3 6 🗸 2000 NEW	M
5. SURVEY FOR CERTIFICATION OF 1 HOSPITAL 2. SH	ON OF	i FACILITY	4. OCF/MR UN	ICF/MR UNDER HEALTH CARE	ARE 50	HOSPICE		
IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW 1. OENTIRE FACILITY 2. OISTINCT PART OF (SPECIFY)	CHECK APPROPRIATE ITEM(S) DISTINCT PART OF (SPECIFY)	ATE ITEM(S) BEL (SPECIFY)	LOW			NCT PART OF HOSPIT. 'ES boo	F DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?	EDITED?
6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY 77 C	 b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE 		C. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE	22	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID	ILLED BEDS MEDICAID 77	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID	ICF/MR BEDS EDICAID
7. A THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE 1. COMPLIANCE WITH ALL PROVISIONS 2 CACCEPTANCE	ASED UPON (CHECI ALL PROVISIONS	K ALL APPROPRIATE	AIATE BOXES) ANCE OF A PLAN OF CORRECTION	RRECTION 3.	CECOMMENDED WAIVERS	Q	FSES 5 PERFORMA	PERFORMANCE BASED DESIGN
(9 C)		TITI F		OFFICE			DATE	
WILLIAM ABDERHALDEN		Deputy State	ate Fire Marshal	State	State Fire Marshal		02/12/2016	2016
FIRE AUTHORITY OFFICIAL (Signature)	turpe)	TITLE Fire Safet	пть Fire Safety Supervisor	OFFICE State	DFFICE State Fire Marshal		DATE 02-18-2016	016
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		is in italics relate to the FSES	RUCTION	h a nonconforming building, ng at least a two hour fire rials as required for the ccur only in corridors and losing fire doors with at 1.4.1, 19.1.1.4.2		meets one of the following:	Any Height	One story only (non-sprinklered).	Not over three stories with complete automatic sprinkler system.		Not over two stories with	sprinkler system.		Not over one story with	-complete automatic sprinkler system.	-	of the construction, the	barriers and dates of	small floor plan of the	
		PART I - LSC REQUIREMENTS - Items in italics relate t	BUILDING CONSTRUCTION	If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1½ hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2	2000 EXISTING	Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	I (443), I (332), II (222)	II (111)	II (111)	III (211)	V (111)	IV (2HH)	(000) II	III (200)	V (000)	Building contains fire treated wood.	Give a brief description, in REMARKS, of the construction, the number of stories including basements floors on which patients	are located, location of smoke or fire barriers and dates of	approval. Complete sketch or attach small floor plan building as appropriate.	Form CMS-2786R (02/2013)
		PA		If the the c resis addit shall least 18.1.	2000	Build 19.1.	-	2	ო	4	2	9	7	8	6	Bu	Give .	are lo	appro	1S-278
	ID PREFIX			K11	K12											L	J			Form CN

Nam	Name of Facility			2000 CODE
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K12	2000 NEW Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.3.5.1.	meets one of the following:	0 0 0	K12- 1_etory building with a partial basement. The building was
	1 I (443), I (332), II (222)	Any height with complete automatic sprinkler system		constructed at 3 different times. The purchase of the constructed at 3 different times. The constructed at 3 different times. The constructed in 1963 and was determined to be of Type II (000) construction. In 1996, an addition was constructed
	2 Oll (111)	Not over three stories with complete automatic sprinkler system		and was determined to be of 1 ype II(000) construction. In 2010, an addition was constructed and was determined to be of Type V (111)
	3OIII (211)			construction. There is a 2-hour fire wall between the 2010 addition and the rest of the building.
	4 (111) V (111)	Not over one story with complete automatic		Therefore, the facility is surveyed as two buildings with two CMS-2786R forms used.
	5O IV (2HH)	sprinkler system.		The building is automatic fire sprinkler protected
	6 O II (000)			throughout. The facility has a fire alarm system
	7 O III (200)	Not Dormittod		with stricke detection in the contigors and spaces open to the corridors that is monitored for
	8 V (000)			automatic fire department notification.
	☐ Building contains fire treated wood. Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patien are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.	S, of the construction, the nts, floors on which patients barriers and dates of small floor plan of the		 It was observed that the two hour separation had fiberglass insulation and no fire caulking around the penetrations through the wall between the 1997 building and the 2010 building. Therefore, a 2-hour fire separation cannot be confirmed.
K103	Interior walls and partitions in buildings of Type I or Type II construction shall be noncombustible or limited-combustible materials. 18.1.6.3, 19.1.6.3 (Indicate N/A for existing buildings using listed fire retardant treated wood studs within non-load bearing one-hour rated partitions.)	gs of Type I or Type II or limited-combustible ing listed fire retardant earing one-hour rated		
Form C	Form CMS-2786R (02/2013)			Page 3

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K14	2000 EXISTING			
	Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than ½ ⁸⁸ inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 <i>Indicate flame spread rating/s</i>			
	2000 NEW			
	Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower half of corridor walls, not exceeding 4ft in height, may have a Class C flame spread rating. 10.2, 18.3.3.1, 18.3.3.2, NFPA TIA 00-2 A <i>Indicate flame spread rating</i> .	•	\bigcirc	
K15	2000 EXISTING			
	Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2 <i>Indicate flame spread ratings</i> .			
	2000 NEW			
	Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2. Indicate flame spread rating/A	$\overline{\mathbf{O}}$	\bigcirc	
Form C	Form CMS-2786R (02/2013)			Page 4

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×	2000 EXISTING Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 19.3.3.3	In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, no interior floor finish requirements shall apply.	CORRIDOR WALLS AND DOORS	2000 EXISTING	Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 <i>If the walls terminate at the underside of a ceiling, give a brief</i> <i>description in REMARKS, of the ceiling, describing the ceiling</i> <i>throughout the floor</i> area.	2000 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.4, 18.3.6.5
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	ler than required hazardous areas shall structed of 1 ³ / ₄ inch ssisting fire for at least of door and floor covering rinklered smoke the passage of smoke. the poors. Hold open shed or pulled are to means suitable for seting 19.3.6.3.6 are and made of steel or 2.1. Roller latches are th care facilities. 19.3.6.3	ch as fire protection	e constructed to resist n bottom of door and ere is no impediment to es that release when I. Doors shall be Dutch doors meeting all be prohibited.	h as fire protection	all be fixed window prinklered smoke the area and fire han smoke is, miscellaneous doors provided the toes not exceed 20 in. ² of the wall (80 in. ² in
ID PREFIX	2000 EXISTING 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 1 ³ / 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 by CMS regulations in all health care facilities. 19.3.6.3	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.	2000 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. 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 positive latching hardware. Dutch doors meeting 18.3.6.3 are permitted. Roller latches shall be prohibited.	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.	Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) In other than smoke compartments containing patient bedrooms, miscellaneous opening are permitted in vision panels or doors provided the aggregate area of the opening per room does not exceed 20 in. ² and the opening is installed in bottom half of the wall (80 in. ² in fully sprinklered buildings). 18.3.6.5, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5

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MET MET Not 2000 EXISTING VERTICAL OPENINGS MET NoT 2000 action haring a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box. Met Met 2000 NEW Stainways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating, also check this, and other vertical openings between floors are enclosed with construction having a fire resistance rating, also check this, and other vertical openings are properly enclosed with construction having a fire resistance rating, also check this, and other vertical openings are properly enclosed with construction having a fire resistance rating of at least two hours concerting four stories or more. (One hour for resingle story building and buildings up to three stories in height). An athum may be used in accordance with 8.2.5, 8.2.5, 1.1.1. 2000 NEW Stainways, elevator stories on the flastory bours concerting four stores or more. (One hour for single	REMARKS						
WE O	A/A				\bullet		0
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VERTICAL OPENINGS VERTICAL OPENINGS Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fine resistance rating of at least one hour. An atrium may be used in accordance with 8.25, 8.2.56, 19.3.1.1 fi all vertical openings are properly enclosed with construction fire least a two hour fire resistance rating, also check this box. □ If enclosures are less than required, give a brief description and specific location in REMARS. 2000 NEW Zainways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and buildings and buildings up three are less than required, give a brief description and specific location in REMARKS. Door NEW Stainways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and building and buildings are less than required, give a brief description and specific location in REMARKS. Doors in an exit passageway, stainway enclosure, horizontal exit, smoke barner or hazardous area enclosure, horizontal exit, smoke barner or hazardous a	MET				0		$\overline{\bullet}$
K21 K21 K20 K20 K20 K20 K21	C I I I X I I	2000 EXISTING	-	If enclosures are less than required, give a brief description and specific location in REMARKS.	2000 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.2.5.6, 8.2.5, 18.3.1.1.	uired, give a	

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		ID CONTROL	two smoke ore than 30	t two smoke for sleeping or oad of 50 or s shall also be ed. 18.3.7.1,	3 square feet and n a door in the 18.3.7.1, 19.3.7.1	ength of zones		least a one accordance ninate at an ted glazing or 7.3, 19.3.7.5	east a one rdance with e at an atrium ing or by wired .3.7.5	rriers to pants in
	Describe method used in REMARKS	SMOKE COMPARTMENTATION AND CONTROL	2000 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2	2000 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2	The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1	Detail in REMARKS zone dimensions including length and dead end corridors.	2000 EXISTING	Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing of by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5	2000 NEW Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5	Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.4, 19.3.7.4

Form CMS-2786R (02/2013)

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	20 minute fire protection bonded core wood. xceed 48 inches from rizontal sliding doors -closing or automatic- vinging doors are not e latching is not	2000 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1 ³ / ₄ inch thick solid bonded core wood. Non- rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8	ovide a minimum clear or horizontal doors.	alled as swinging or r clear width as follows:	Horizontal Sliding Doors 83 inches (211 cm)	64 inches (163 cm)	
	have at least a 2 inch thick solid t tes that do not e: re permitted. Hoi oors shall be self th 19.2.2.2.6. Sv gress and positiv 7.6, 19.3.7.7	ave at least a 20 nch thick solid bor tt do not exceed 4 Horizontal sliding shall be arranged boors shall be self quired at the mee 3.3.7.5, 18.3.7.6,	. barriers shall pr m) for swinging c	barriers are inst ovide a minimum	Swinging Doors 41.5 inches (105 cm)	32 inches (81 cm)	
	2000 EXISTING Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1% inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic- closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not	2000 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1 ³ / ₄ inch thick solid bonded core wood. Non- rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8	2000 EXISTING Door openings in smoke barriers shall provide a minimum o width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7	2000 NEW Door openings in smoke barriers are installed as swinging or horizontal doors shall provide a minimum clear width as follows:	Provider Type Hospitals and Nursing Facilities	Psychiatric Hospitals and Limited Care Facilities	18.3.7.7
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where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5	0	
Describe any mechanical smoke control system in REMARKS.		
HAZARDOUS AREAS		
2000 EXISTING		
One hour fire rated construction (with ¾ 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 shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be 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		
Area Automatic Sprinkler Separation N/A		
a. Boiler and Fuel-Fired Heater Rooms		
c. Laundries (greater than 100 sq feet)		
d. Repair Shops and Paint Shops		
e. Laboratories (if classified a Severe Hazard - see K31)		
f. Combustible Storage Rooms/Spaces (over 50 sq feet)		
g. Trash Collection Rooms		
i. Soiled Linen Rooms		

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ID PREFIX	2000 NEW Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a %4 hour fire-rated door, without windows (in accordance with %4.) Doors shall be self-closing or automatic closing in 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1. Area Area a Boiler and Fuel-Fired Heater Rooms a Boiler and Fuel-Fired Heater Rooms bactor and state than 100 states) a Boiler and Fuel-Fired Heater Rooms bactor and less than 100 states) a Boiler and Fuel-Fired Heater Rooms bactor and less than 100 states) b Combustible Storage Rooms/Spaces (over 100 states) b Tash Collection Rooms controls Boong Rooms/Spaces (over 100 states) b Combustible Storage Rooms/Spaces (over 100 states) c C C Combustible Storage Rooms/Spaces (over 100 states) c C C Combustible Storage Rooms/Spaces (over 100 states) c C C C C C C C C C C C C C C C C C C C	Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.	K30 Gift shops shall be protected as hazardous areas when used for storage or display of combustibles in quantities considered hazardous. Non-rated walls may separate gift shops that are not considered hazardous, have separate protected storage and that are completely sprinklered and do not exceed 500 square feet. 18.3.2.5, 19.3.2.5 Area Automatic Sprinkler Separation NA of combustibles and the separate protected for square feet. 18.3.2.5, 19.3.2.5

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	 Where Alcohol Based Hand Rub (ABHR) dispensers are installed: The corridor is at least 6 feet wide The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) The dispensers shall have a minimum spacing of 4 ft from each other Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. Dispensers are not installed over or adjacent to an ignition source. If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623 	EXITS AND EGRESS	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2	2000 EXISTING Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box. □	If enclosures are less than required, give a brief description and specific location in REMARKS.
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	2000 NEW Exit enclosures (such as stairways) in buildings four stories or more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous path of escape, and provide a protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 7.1.3.2, 8.2.5.2, 8.2.5.4, 18.3.1.1, 18.2.2.3	If enclosures are less than required, give a brief description and specific location in REMARKS.	Stainways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4	The capacity of required mean of egress is based on its width, in accordance with 7.3.	Travel distance (exit access) to exits are measured in accordance with 7.6. • Room door to exit ≤ 100 ft (≤ 150 ft sprinklered) • Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered) • Point in room to room door ≤ 50 ft • Point in suite to suite door ≤ 100 ft 18.2.6, 19.2.6	2000 EXISTING Existing dead-end corridors shall be permitted to be continued to be used if it is impractical and unfeasible to alter them so that exists are accessible in not less than two different directions from all points in aisles, passageways, and corridors. 19.2.5.10	2000 NEW Every exit and exit access shall be arranged so that no corridor, aisle or passageway has a pocket or dead-end exceeding 30 feet. 18.2.5.10	Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1	2000 EXISTING Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3
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	2000 NEW Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4		\bigcirc	
K40	2000 EXISTING Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. An exception is provided for existing 34-inch doors in existing occupancies. 19.2.3.5			
	2000 NEW Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 41.5 inches in clear width. Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In psychiatric hospitals or limited care facilities (e.g.,ICF/MD providing medical treatment) doors are at least 32 inches wide. 18.2.3.5	$\overline{\bullet}$	\cap	
K41	All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1 <i>If doors lead directly to grade from each room, check this box.</i>	\bigcirc	\bigcirc	
K42	Any patient sleeping room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2	$\overline{\bullet}$	\bigcirc	
K43	in open es.	•		
КЛЛ	If door locking arrangement without delay egress is used indicate in REMARKS 18.2.2.2.2, 19.2.2.2.2 Horizontal evite if used are in accordance with 7.2.4	$\overline{\mathbf{O}}$		
K47	18.2.2.5, 19.2.2.5 Exit and directional signs are displayed in accordance with 7.10	•	$\frac{2}{2}$	
	with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	$\overline{\bullet}$	\bigcirc	
Form C	Form CMS-2786R (02/2013)			Page 14

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REMARKS								K50- It was observed during document review that a fire drill was not documented for the evening shift during the second quarter.
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	ad free of all the case of fire , or other objects from, or visibility 1, 19.2.1		charge, is re will not be either operation	provided	support tics) have g equipment, sty Branch of 3.2., 18.2.10.2 lency purposes	SILLS	nts and for	gnal and are held at t quarterly on l is aware that for planning t persons who e conducted ment may be
ID PREFIX	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1	ILLUMINATION	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8	Emergency lighting of at least 1½ hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.	2000 NEW (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the Life Safety Branch of the electrical system described in NFPA 99. 18.2.9.2., 18.2.10.2 (Indicate N/A if life support equipment is for emergency purposes only).	EMERGENCY PLAN AND FIRE DRILLS	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2

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	FIRE ALARM SYSTEMS	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6	A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8	2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70
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	2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES) An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3	2000 EXISTING LIMITED CARE FACILITIES (INDICATE N/A FOR HOSPITALS OR NURSING HOMES) An automatic smoke detection system is installed in all corridors with detector spacing no further apart than 30 ft on center in accordance with NFPA 72. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1	Smoke Detection System Corridors Rooms Bath	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	Give a brief description, in REMARKS of any smoke detection system which may be installed.	2000 EXISTING Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8	2000 NEW Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms
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×	intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8	Initiation of the required fire alarm systems shall be by manual fire alarm initiation, automatic detection, or extinguishing system operation. 18.3.4.2, 19.3.4.2, 9.6.2.1	AUTOMATIC SPRINKLER SYSTEMS	2000 EXISTING Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5, 1, NPFA 13	2000 NEW There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1.	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.	A. Date sprinkler system last checked and necessary maintenance provided. 10/28/2015
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_	B. Show who provided the service. SUMMIT				
_	C. Note the source of water supply for the automatic sprinkler system. CITY WATER	1 1 1 1			
_	(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)	 			
K61	Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72	•	$\overline{\bigcirc}$		
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	$\overline{\bullet}$	$\overline{\bigcirc}$		
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13	\bigcirc	\bigcirc		
K64	Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6	$\underbrace{\bigcirc}$	\bigcirc		
_	SMOKING REGULATIONS				
K66	 Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99) (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 	$\underbrace{\bullet}$	\bigcirc		
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	(2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision.	(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.	(4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	BUILDING SERVICE EQUIPMENT	Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 18.7.8, 19.7.8	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82	(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with 9.5.	(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7.	(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4.
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	(4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use.	0	\bigcirc		
K160	2000 EXISTING				
	Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record.				
	Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators & Escalators. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. 9.4.2, 9.4.3, 19.5.3				
	(Includes firefighters service phase I key recall and smoke detector automatic recall, firefighters service phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
	2000 NEW				
	Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record.	0	Ŏ		
	New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter's Service Requirements. 9.4.2, 9.4.3, 18.5.3				
	(Includes firefighters service phase I key recall and smoke detector automatic recall, firefighters service phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
K161	2000 EXISTING				
	Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.				
	All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.2.2				

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	d automatic skirt les hoistway door nere car is being	nply with the 2/ANSI A17.1, 3, 9.4.2.1	ATIONS	less they are nazard of fire , 19.7.5.4	and other loosely to r decorations of except for cal curtains are o avoid .3.5.5, 18.7.5.1,	neet the char n tested in 2) and 10.3.3, thar length and accordance . 18.7.5.3,	ttresses means	t exceed 32 tainer capacity L/m²). A
ID PREFIX	(Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.)	2000 NEW Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All escalators and conveyors comply with ASME/ANSI A17.1 Safety Code for Elevators and Escalators. 18.5.3, 9.4.2.1	FURNISHINGS AND DECORATIONS	Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4	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	 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. 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 	✓ Newly introduced upholstered furniture and mattresses means purchased since March, 2003.	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft ² (20.4 L/m ²). A

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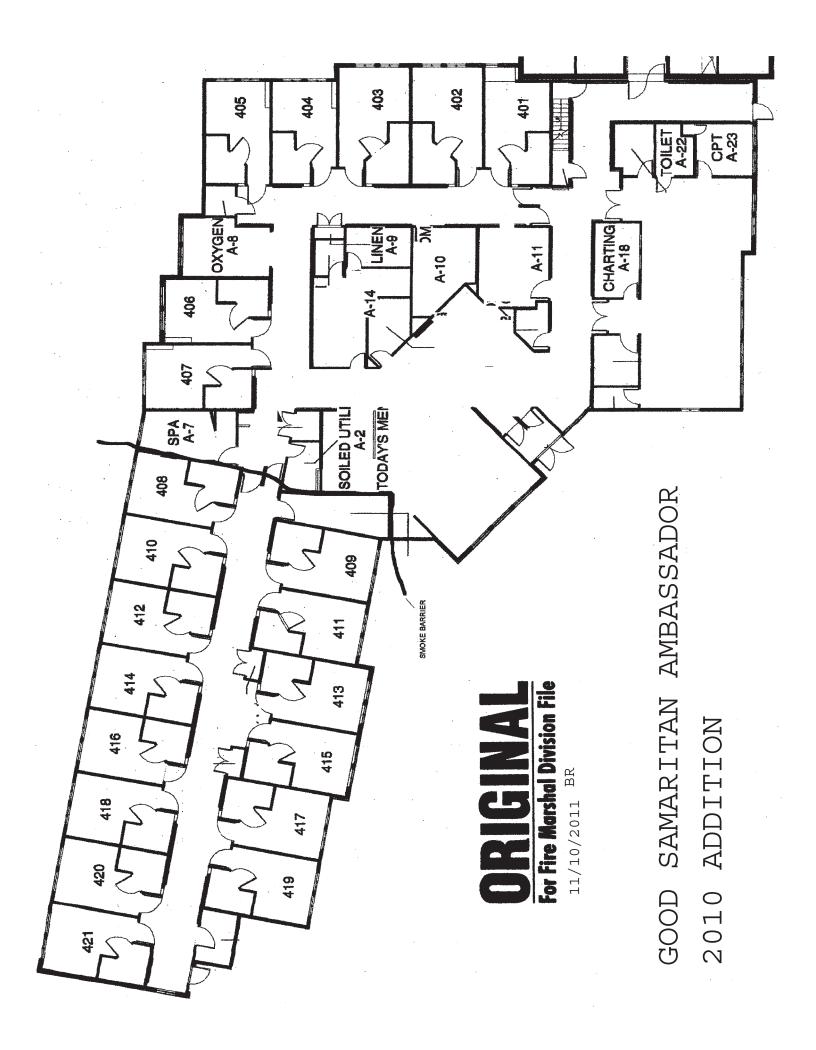
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	Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code, 4-3 (NFPA 99), 10-7.2.1 (NFPA 99)	MEDICAL GASES AND ANESTHETIZING AREAS	 Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 	Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4.	 Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or great than 35% 4-3.1.2.3(n) and 5-4.1.1 (NFPA 99), 18.3.2.3, 19.3.2.3 	 Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities. (a) Master alarm panels are in two separate locations and have audible and visible signals. (b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2 (c) Where a level 2 gas system is used, one alarm panel that complies with 4-3.1.2.2(b)3a,b,c,d and with 4-3.1.2.2(c)2,5 shall be permitted. 4-4.1 (NFPA 99) exception No. 4. 4-3.1.2.2 (NFPA 99) 	Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUSION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99)
LID PREFIX			K76	K77	K78	K140	K141

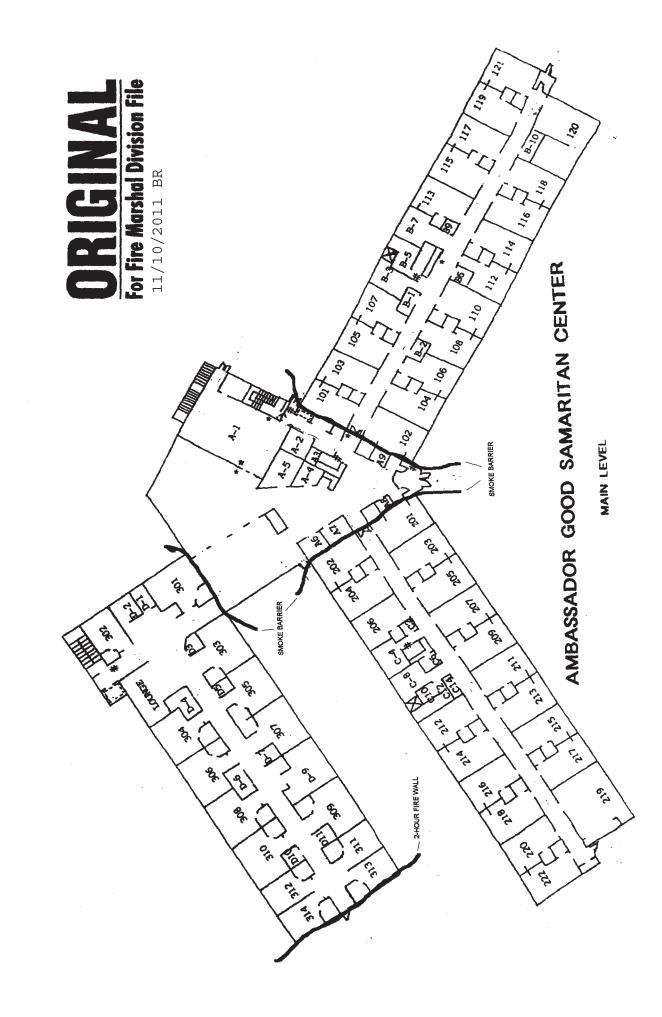
Nam	Name of Facility			2000 CODE	DE
ID PREFIX		MET	NOT N/A	REMARKS	
K142	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	Õ			
K143	Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99)	0	•	K143- It was observed that the oxygen transfilling room had vinyl floor tiles.	_
	ELECTRICAL AND EMERGENCY POWER				
K106	Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99)	Õ			
K107	Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1	$\overline{\bullet}$	\bigcirc		
K108	2000 NEW (INDICATE N/A FOR EXISTING) Power for Alarms, emergency communication systems, and illumination of generator set locations are in accordance with essential electrical system of NFPA 99. 18.5.1.2	•	$\overline{\bigcirc}$		
K144	Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)	•	$\overline{0}$		
K145	The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.3, 3-5.2.2 (NFPA 99)	0	\bigcirc		
Form CI	Form CMS-2786R (02/2013)			Page 25	le 25

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PREFIX		MET	NOT	N/A	REMARKS
K146	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source 3-6. (NFPA 99)	\bullet	0	0	
K147	Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1	$oldsymbol{O}$	Ο		
K130	Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	\bigcirc	0	\bullet	

Name of Facility		2000 CODE
PART IV REC	PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS	CODE PROVISIONS
For each item of the Life Safety code recol specific provisions of the code, if rigidly ap adversely affect the health and safety of th	For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).	e the reason for the conclusion that: (a) the e waiver of such unmet provisions will not
PROVISION NUMBER(S)	JUSTIFICATION	
K84		
Surveyor (Signature)	Title Office	Date
Fire Authority Official (Signature)	Title Office	Date
Form CMS-2786R (02/2013)		Page 27





803 AMBASSADOR GOOD SAMARITAN CENTER <mark>10</mark> 8 ŝ 007A 60 011 010 900 800 00 012 013 014 For Fire Marshal Division File RIGINAL 015 016 158 **D15A** AND NOTES ĺ

BASEMENT LEVEL

Minnesota State Fire Marshal Division-CMS Survey Draft Statement of Deficiencies Page <u>1</u> of <u>1</u>									
PROJEC	PROJECT NUMBER: PROVIDER NAME								
F51490	49025GOOD SAMARITAN AMBASSADOR02/12/2016								
Adminis	nistrator: MARIE BARTA Phone Number: 763/544-4171								
Email a	Email address: MBARTA@BOOD-SAM.COM								
State Fi	Fire Inspector: WILLIAM ABDERHALDEN 507-361-6204								
These ar	e preliminary f	findings only. A complete and final S	tatement of Defici	encies 2567 report wi	ill be provided				
by US Mail. At the time of this inspection. this facility was found to comply with the requirements of the 2000 Life Safety Code applicable to: ✓SNF/NF Hospital ICFMR ASC Facilities participating in the Medicare/Medicaid programs.									
<mark>√</mark> Th	e following fi	re/life safety deficiencies were fou	nd during this in	spection:					
K TAG S& S	🗸 Draft	Summary of Deficiency(ies)	Revisit	Clear	rance				
K12 S&S= F	It was observed that the two hour separation had fiberglass insulation and no fire caulking around the penetrations through the wall between the 1997 building and the 2010 building. Therefore, a 2-hour fire separation cannot be confirmed.								
K50 S&S= C	It was observed during document review that a fire drill was not documented for the evening shift during the second quarter.								
K143 S&S= E	It was observed that both oxygen transfilling rooms had vinyl floor tiles.								
	DRAFT								