CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 2SXE

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

	PART I - TO BE COM	PLETED BY T	HE STAT	STATE SURVEY AGENCY Facility ID: 00019			
MEDICARE/MEDICAID PROVIDER NO. (L1) 245278 2.STATE VENDOR OR MEDICAID NO. (L2) 608716700	3. NAME AND ADI (L3) GOOD S (L4) 413 13TH (L5) HOWAR	AMARITA I AVENUE	N SOCI	ETY - HOWA	ARD LAKI 55349	3. Termination 5. Validation	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUP	PPLIER CATEGOR	Y 09 ESRD	<u>02</u> (L7)	22 CLIA	7. On-Site Visit 8. Full Survey After Com	9. Other
6. DATE OF SURVEY 12/27/2013 (L3 8. ACCREDITATION STATUS: (L10 0 Unaccredited 1 TJC 2 AOA 3 Other		06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING D	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 35 (L1): 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19:	7) B. Not in Comp	ce With quirements	n	2. Technic 3. 24 Hou	cal Personnel ar RN RN (Rural SNF) affety Code	Following Requirements:	r
35	39) (L42)	(L43)		1001 (6) (1) 01 100	or (j) (1).	(2.0)	
16. STATE SURVEY AGENCY REMARKS (IF APPLICA See Attached Remarks	BLE SHOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE Rebecca Wong, HFE NE I	Date :	12/27/2013	(L19)	18. STATE SURVE		rcement Specialist	Date:3/7/2014(L20)
PART II -	TO BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR SIN	NGLE STATI	E AGENCY	(220)
19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L.		PLIANCE WITH C	CIVIL	2. Own		al Solvency (HCFA-2572) hterest Disclosure Stmt (HCFA-	1513)
22. ORIGINAL DATE 23. LTC AGI OF PARTICIPATION BEGINE 04/01/1985 (L24) (L41)	REEMENT 2 NING DATE	4. LTC AGREEME ENDING DATE (L25)		26. TERMINATIO VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W 03-Risk of Involuntar		05-Fail to Mee	<u>RY</u> et Health/Safety
A. Suspe	ATIVE SANCTIONS nsion of Admissions: nd Suspension Date:	(L44) (L45)		04-Other Reason for		OTHER 07-Provider S 00-Active	tatus Change
28. TERMINATION DATE: (L28)	29. INTERMEDIARY/C. 00140	ARRIER NO.	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION C 12/26/2013	OF APPROVAL DA	(L33)	DETERMINAT	ION APPROV	/AL	

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Facility ID: 00019

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

Page 2

Provider Number: CCN# 24-5278 Item 16

Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective December 6, 2013, the facility is certified for 35 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245278

March 7, 2014

Ms. Laura Rindfleisch, Administrator Good Samaritan Society - Howard Lake 413 13th Avenue Howard Lake, Minnesota 55349

Dear Ms. Rindfleisch:

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 December 6, 2013, the above facility is certified for:

35 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 35 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

January 29, 2014

Ms. Laura Rindfleisch, Administrator Good Samaritan Society - Howard Lake 413 13th Avenue Howard Lake, MN 55349

Re: Enclosed Reinspection Results - Project Number S5278021

Dear Ms. Rindfleisch:

On December 27, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 1, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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.

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program

Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA /	(Y2) Multiple Construction	(Y3) Date of Revisit
	Identification Number	A. Building	12/19/2013
	00019	B. Wing	12/19/2013

Name of Facility

GOOD SAMARITAN SOCIETY - HOWARD LAKE

Street Address, City, State, Zip Code

413 13TH AVENUE HOWARD LAKE, MN 55349

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5) E	ate
ID Prefix	20265	(Correction Completed	ID Pref	ix 20 !		Correction Completed 12/06/2013		ID Prefix	20885		Correction Completed 12/06/2013
	MN Rule 4658.0085				# MN	Rule 4658.0405 Subp. 3	3			MN Rule 4658		_
•	20895 MN Rule 4658.0525	1 Subp. 2.	Correction Completed 12/06/2013	_	# MN				•	20910 MN Rule 4658		
ID Prefix Reg. # LSC	20965 MN Rule 4658.0600	1	Correction Completed 12/06/2013	ID Pref Reg. LS	# MN		Correction Completed 12/06/2013		ID Prefix Reg. # LSC	21475 MN Rule 4658	3.1005 Subp.	Correction Completed 12/06/2013
•	21942 MN St. Statute 144A	1 1 A.10 Sub	Correction Completed 12/06/2013	Reg.	#				ID Prefix Reg. # LSC			_
ID Prefix Reg. # LSC			Correction Completed	ID Pref Reg. LS	#				ID Prefix Reg. # LSC			_
Reviewed By	,	iewed By	BF/KJ	Date: 1/14/2	2014	Signature of Surve	309	951				/19/2013
	Survey Completed of 11/1/2013	3		Date:		Check for any Uncorrected	Uncorrected			a Summary of to the Facility		NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting 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 CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245278	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/19/2013
Name of Facility		Street Address, City, State, Zip Code		
GOOD SAMARITAN SOCIETY - HOWARD LAKE		AKE	413 13TH AVENUE HOWARD LAKE, MN 55349	

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

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
			Correction					Correction					Correction
ID Dester	50455		Completed		ID Dester	50050		Completed		ID D. f.	F0000		Completed
ID Prefix			12/06/2013		ID Prefix			12/06/2013		ID Prefix			12/06/2013
Reg. # LSC	483.10(b)(11)				Reg. # LSC	483.15(g)(1)					483.20(k)(3)(ii)		_
				-	LSC				┿-	LSC			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0310		12/06/2013		ID Prefix	F0314		12/06/2013		ID Prefix	F0315		12/06/2013
Reg. #	483.25(a)(1)				Reg.#	483.25(c)				•	483.25(d)		_
LSC					LSC				<u> </u>	LSC			_
			Correction					Correction					Correction
ID Prefix	F0318		Completed 12/06/2013		ID Prefix	F0325		Completed 12/06/2013		ID Prefix	F0411		Completed 12/06/2013
Rea #	483.25(e)(2)				Rea #	483.25(i)		•		Rea #	483.55(a)		_
LSC					LSC								_
									+-				
			Correction					Correction					Correction
ID Drofiv			Completed		ID Drofiv			Completed		ID Drofiv			Completed
ID Prefix													_
Reg. #					Reg. #					Reg. #			_
				-					+-		-		<u> </u>
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			_
Reg. #					Reg.#					Reg. #			_
LSC					LSC				Ш.	LSC			
Reviewed By	Revie	ewed E	By BF/KJ	Da	te: 1/14/20	Signature of	Surve	yor: 309.	51			Date:	2/19/2013
State Agency	/		DI / IX)		1/14/2	J14						1	_, 17, 2013
Reviewed By	Revie	ewed E	Ву	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed o						-				a Summary of		
	11/1/2013					Unco	rrecte	Deficiencies	(CIVI	5-256/) Sent	to the Facility?	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 2SXE

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PARTI	- TO BE COMP	LEIED DY I	HE SIA	IE SURVET AGENCT	Facility ID: 00019
MEDICARE/MEDICAID PROVIDER NO (L1) 245278		3. NAME AND AL (L3) GOOD SAM	IARITAN SOC		WARD LAKE	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO.		(L4) 413 13TH A	VENUE			3. Termination 4. CHOW
(L2) 608716700		(L5) HOWARD I	LAKE, MN		(L6) 55349	5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWNER	RSHIP	7. PROVIDER/SU	PPLIER CATEGO	ORY	<u>02</u> (L7)	
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 11/01/20	013 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FIGGAL WEAD ENDING DATE (125)
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	09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED A	S:		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of Th	e Following Requirements:
To (b):			Requirements ace Based On:		2. Technical Personnel	6. Scope of Services Limit
12.Total Facility Beds	20 (I 18)	•			3. 24 Hour RN 4. 7-Day RN (Rural SNF)	7. Medical Director
12.10tal Facility Beds	38 (L18)	1.	Acceptable POC		5. Life Safety Code	9. Beds/Room
13. Total Certified Beds	38 (L17)		mpliance with Progents and/or Applied		* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKDOWN		I			15. FACILITY MEETS	
18/19 SNF	10 CNT	ICE	Ш			(1.15)
18 SNF 38	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARKS	(IF APPLICABL	E SHOW LTC CANC	ELLATION DATE	E):		
At the time of the Standard surve health along with the facility's pl						lations. Please refer to the CMS 2567 fo
17. SURVEYOR SIGNATURE	un or correc	Date :	incution revis		18. STATE SURVEY AGENCY A	APPROVAL Date:
Jessica Sellner - HFE N	IE II		12/09/2013	(L19)	Colleen Leach -	Program Specialist 12/18/2013
PAR	T II - TO BI	E COMPLETED	BY HCFA R	` /	L OFFICE OR SINGLE STA	ATE AGENCY
19. DETERMINATION OF ELIGIBILITY		20 CON	MPLIANCE WITH	CIVIL	21. 1. Statement of Finan	cial Solvency (HCFA-2572)
			GHTS ACT:	CIVIL	Ownership/Control	I Interest Disclosure Stmt (HCFA-1513)
1. Facility is Eligible to Partici	pate				3. Both of the Above	:
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE 23	B. LTC AGREEM	ENT 2	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	ΓE	VOLUNTARY <u>00</u>	INVOLUNTARY
04/01/1985					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	nt 06-Fail to Meet Agreement
	* *	VE SANCTIONS	(===)		03-Risk of Involuntary Termination	OTHER
2. Die Eine Kolon Bille. 2.		of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
			(L44)			00-Active
(L27)	B. Rescind Sus	pension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00140				
	(L28)	00210		(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D	ATE		
	(1.32)			(L33)	DETERMINATION APPR	



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7791

November 20, 2013

Ms. Laura Rindfleisch, Administrator Good Samaritan Society - Howard Lake 413 13th Avenue Howard Lake, Minnesota 55349

RE: Project Number S5278021

Dear Ms. Rindfleisch:

On November 1, 2013, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

<u>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:

Brenda Fischer, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, Minnesota 56301

Telephone: (320) 223-7338

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 December 11, 2013, 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 December 11, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,
- Include signature of provider and date.

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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 February 1, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 1, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

> Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

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

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 11/19/2013 FORM APPROVED RECEIVEDOMB NO. 0938-0391

STATEMENT OF DEFICIE AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NGDEC 0 2 2013	(X3) DATE SURVEY COMPLETED	
		245278	B. WING _		11/	01/2013
GOOD SAMARITA		- HOWARD LAKE		STREET ADDRESS, CITY, MATERIPOROPE Ith 413 13TH AVENUE St.Cloud HOWARD LAKE, MN 55349		
PRÉFIX (EAC	H DEFICIENC	ITEMENT 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
The factor as your as to be used. Upon recrevisit of validate regulation your veriful. 483.10(b) (INJURY) A facility consult with known, recreating the residual consequents of the facility and interventing the residual consequents of the facility and, if known interventing the residual consequents of the facility and, if known interventing the residual consequents of the facility and, if known interventing the facility and interve	allegation of the first pass verificated as verificated as verificated as verificated as verificated as verificated as the substants has been fication. (a)(11) NOTI (b)(11) NOTI (c)(11)	of correction (POC) will serve of compliance upon the otance. Your signature at the page of the CMS-2567 form will gion of compliance. Cacceptable POC an on-site of may be conducted to nital compliance with the en attained in accordance with the resident's legal representative en accommende a new form of ision to transfer or discharge to a facility as specified in the promptly notify the resident endent's legal representative member when there is a commate assignment as 5(e)(2); or a change in	F 15	General Disclaimer 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	nent by s the n of uted e w. For at the ince an of ance	

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:2SXE11

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245278	B. WING		11/0	1/2013	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- HOWARD LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 413 13TH AVENUE HOWARD LAKE, MN 55349	decement of the later	20.10	
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	resident rights und regulations as specthis section. The facility must rethe address and phagal representative. This REQUIREME by: Based on interview facility failed to notion resident (R21) reviscondition when he findings include: R21's medical record left femur. The addition when the extensive assistant daily living (ADL's), developing pressure. R21's Daily Skilled 10/25/13- "Noted of what appears to be placed in treatment until resolved." 10/26/13- "What appears in the resolved."	er Federal or State law or cified in paragraph (b)(1) of ecord and periodically update none number of the resident's eror interested family member. NT is not met as evidenced and document review, the fy the physician for 1 of 1 ewed, who had a change in developed a pressure ulcer. ard identified diagnosis fracture admission Minimum Data Set 13, identified R21 had impairment, needed the with with most activities of and was at high risk for	F 157	F 157 Physician Notifications 1. Resident's primary physician was notified of blood blister on right greatoe. Resident was discharged to has 11/15/13. 2. All residents currently at risk for pressure ulcers were reviewed to skin integrity. Physician notification been completed for all residents was currently have pressure ulcers, in to ensure implementation of adequatereatment to promote healing. 3. All newly admitted residents and residents with significant change in condition related to the developmental appressure ulcer will have prompt physician notification by the first licensed nurse to recognize the pressure ulcer. Educational in-service was provide all nursing staff on 11/27/13 regard the risk factors, identification of, an importance of prompt notification to physician related to ensuring adequate treatment of pressure ulcers.	eat nome or verify on has who order uate of ding and the to the		

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - HOWARD LAKE (XA) ID (SEAL MARKY STATEMENT OF DEFICIENCIES HOWARD LAKE, MN 55349 PREFIX TAG (SEACH DEFICIENCY MUST BE PRECEDED BIS FULL PREGULATORY OR LSC IDENTIFYING INFORMATION) F157 Continued From page 2 (10/27/13 "Blood blister remains intact on right great toe; no change noted in size." 10/28/13 "Blood blister on right great toe; no change noted in size." 10/28/13 "Blood blister on right great toe; no change noted in size." When interviewed on 10/30/13, at 12:40 p.m. licensed practical nurse (LPN)-A stated the nurses are monitoring the blood blister. LPN-A stated she could not find any where in R21's medical record that the physician had been notified of this area. When interviewed on 10/30/13, at 9:30 a.m. the occupational therapist (OT)-G stated R21 had just started wearing shoes in the last week to week and a half ago. She was not aware R21 currently had a "blood blister" on his right toe. She stated the nurses have not been measuring it and verified it would be difficult to know if it was healing related to the lack of monitoring, RN-A was unsure where the blister on his toe came from but stated she did not billed to the lack of monitoring, RN-A was unsure where the blister on his toe came from but stated she did not billed the recovery and the province of the case of th		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE 413 13TH AVENUE HOWARD LAKE, MN 55349 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 157 Continued From page 2 10/27/13 "Blood blister remains intact on right great toe; no change in size." 10/28/13 "Blood blister on right great toe; no change noted in size." When interviewed on 10/30/13, at 12-40 p.m. licensed practical nurse (LPN)-A stated the nurses are monitoring the blood blister. LPN-A stated she could not find any where in R21's medical record that the physician had been notified of this area. When interviewed on 10/30/13, at 9:30 a.m. the occupational therapist (OT)-G stated R21 had just started wearing shoes in the last week to week and a half ago. She was not aware R21 currently had a "blood blister" on his right toe, and had not notified the physician. When interviewed on 10/31/13, at 9:45 a.m. RN-A stated she had been monitoring R21's "blood blister" on his right toe. She stated the nurses have not been measuring it and verified it would be difficult to know if it was healing related to the blister on his toe came from but stated she did			245278	B. WING		11/0	1/2013
FineFix TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F157 Continued From page 2 10/27/13- "Blood blister remains intact on right great toe; no change in size." 10/28/13- "Blood blister intact on right great toe; no change noted in size." 10/29/13- "Blood blister rom right great toe intact." 10/30/13- Blood blister rom right great toe intact." When interviewed on 10/30/13, at 12:40 p.m. licensed practical nurse (LPN)-A stated the nurses are monitoring the blood blister. LPN-A stated she could not find any where in R21's medical record that the physician had been notified of this area. When interviewed on 10/30/13, at 9:30 a.m. the occupational therapist (OT)-G stated R21 had just started wearing shoes in the last week to week and a half ago. She was not aware R21 currently had a "blood blister" on his right toe. She stated the nurses have not been measuring it and verified it would be difficult to know if it was healing related to the lack of monitoring. RN-A was unsure where the blister on his toe came from but stated she did			- HOWARD LAKE		413 13TH AVENUE		
10/27/13. "Blood blister remains intact on right great toe; no change in size." 10/28/13. "Blood blister intact on right great toe; no change noted in size." 10/29/13. "Blood blister on right great toe intact." 10/30/13. Blood blister on right great toe intact." When interviewed on 10/30/13, at 12:40 p.m. licensed practical nurse (LPN)-A stated the nurses are monitoring the blood blister. LPN-A stated she could not find any where in R21's medical record that the physician had been notified of this area. When interviewed on 10/30/13, at 9:30 a.m. the occupational therapist (OT)-G stated R21 had just started wearing shoes in the last week to week and a half ago. She was not aware R21 currently had a "blood blister" on his right toe. She stated the nurses have not been measuring it and verified it would be difficult to know if it was healing related to the lack of monitoring. RN-A was unsure where the blister on his toe came from but stated she did	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	O BE	
"Doesn't wear shoes." RN-A verified the physician had not been notified and the nurse discovering the blood blister should have notified the physician. When interviewed on 10/31/13, at 10:35 a.m. director of nursing (DON) stated she was just	F 157	10/27/13- "Blood b great toe; no chang 10/28/13- "Blood b no change noted ir 10/29/13- "Blood bli 10/30/13- Blood bli When interviewed licensed practical r nurses are monitor stated she could not medical record that notified of this area." When interviewed occupational therapiust started wearing week and a half ag currently had a "blo had not notified the When interviewed A stated she had be blister" on his right have not been means be difficult to know lack of monitoring. blister on his toe canot think it was pre "Doesn't wear shoe physician had not be discovering the blothe physician.	lister remains intact on right ge in size." lister intact on right great toe; a size." lister on right great toe intact." ster on right great toe intact." on 10/30/13, at 12:40 p.m. aurse (LPN)-A stated the ing the blood blister. LPN-A of find any where in R21's the physician had been at the physician. on 10/30/13, at 9:30 a.m. the physician had been at the physician had been at the physician. on 10/31/13, at 9:45 a.m. RN-been monitoring R21's "blood toe. She stated the nurses assuring it and verified it would if it was healing related to the RN-A was unsure where the ame from but stated she did assure related because R21, as." RN-A verified the been notified and the nurse od blister should have notified	F 15	4. DNS / Designee will do randon audits of the 24 hr communication report to ensure that all reported pressure ulcer development has I reported timely to the physician a communication of all resident-relainformation. These audits will be weekly x 8 with results to QA for frecommendation. 5. Completion Date:	n been nd ated done	

	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 157	had not had time to verified the nurses assessment to dete documenting size, physician. DON st been done. She all beginning to wear I of the blood blister pressure of his should be the facility provide Nursing Coverage 2/2012. The policy documentation to his service should include the service should include the service should include assessment to determine the service as s	blood blister two days ago but blook at the area. The DON should have done an ermine the cause, should be and should have notified the ated none of the above had so verified the timing of R21 his shoes and the development was probably related to the bes. d a policy entitled Skilled and Documentation dated instructed, "Nursing help support a skilled nursing ude assessments, nursing in contacts and documentation	F 157				
F 250 SS=D	a pressure area, the residents physician was in place to proof the National Pressure underlike area of displaced area of	sure Ulcer Advisory Panel lcer's, "Purple or maroon scolored intact skin or due to damage of underlying essure and or shear," as ssue injury." /ISION OF MEDICALLY	F 250				

	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245278	B. WING		11/0	01/2013	
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F 250	Continued From pa well-being of each i		F 250				
	by: Based on observation review, the social secondinate discharge agency for 1 of 1 redesired to discharge. R3's medical recorded quadriplegia (paralyloss of upper and lost of pressure ulcers of Minimum Data Set identified R3 was concepted and had an active of return to the community whe and "social worker/resident/ family with However, added to Currently long termineeds in ADL's."	ion, interview, and document ervice department failed to ge services with an outside esidents (R3) reviewed who e to the community. d indicated a diagnoses of vsis resulting in partial or total ower limb use) and had history or 10 years. The annual (MDS) dated 9/25/13, cognitively intact, needed with all activities of daily of eating, had pressure ulcers, discharge plan in place to unity. R3's care plan dated "Will consider placement in n open areas have healed," interdisciplinary team to assist a discharge planning." this was, "Discharge plan: care related to level of care		F 250 Social Services 1. ADON reviewed discharge plans R3 again on 11/27/13. R3 states "Sas I tell you every time; I want a grhome in Howard Lake or Cokato because this is where my family livand since nothing like that currentleven exists, I am staying here until does." R3 also states that he has bin contact with his county (Wright) worker, Konnie Laudenback. Documentation from Konnie Laudenback on the date of 5/15/13 does indicate a face-to-face visit ar screening for alternative placement Message was once again left for K Laudenback on 11/27/13 reiterating request that facility DON or ADON kept informed of progress related to discharge planning. DON / designed continue to search for alternative placement that meet resident preferences quarterly, as well as or as-needed or per-request basis.	Same oup res, y I it been social dt. onnie g the be oue will		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		E SURVEY MPLETED
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F 250	about 10 years, but closer to family. R3 at the facility as he common with the "cunable to find anoth family. He stated la county social works months ago and the trying to find more a in a facility with people buring observation was in his room eat 12:25 p.m. R3 was room. On 10/29/13 observed in his election of the facility and go and smoking a cigal interacting with other	moved to the facility to be stated he does not do much does not have much in older people," but he was her place to live close to his lest he had spoke with the er about discharge was several export case worker was appropriate placement for him ple more his age. on 10/28/13, at 5:45 p.m. R3 ing supper. On 10/29/13, at observed eating lunch in his at 12:55 p.m. R3 was ctric wheelchair going outside bing to the end of the driveway rette. R3 was not seen	F 2	appropriateness of discharge deemed that discharge is app facility will coordinate with an agency in order to facilitate the discharge process. 3. All discharge planning and coordination duties are now do to DON / ADON, and will be reconferences. Education is preall new admissions, and was to all nursing staff on 11/27/13 regarding resident's rights to where he/she lives as well as importance of notifying discharge can be provided.	e If it is ropriate, outside e esignated eviewed evided to provided to choose the rge	
	4/17/13- "Care team met with resident present. Social service reports resident is stable resident will be meeting with his social worker in May. She will be presenting [R3] with a list of housing options." No further social work notes were found in R3's medical record. 7/10/13- "Quarterly care conference. Nursing reports chronic wounds are maintained by treatment orderResident declined attendance at care conference and has no concerns except locating alternate placement. Has been working with his social worker on this."			 DNS/designee will do randor of quarterly care conferences will weeks, then monthly x 3 months are discharge planning is be reviewed during care conference coordinated with outside agency indicated. Results will be forward QA for further recommendation. Completion Date: December 6th, 2013 	eekly x ths to eing es and ies if rded to	

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F 250	county social worked meeting she had we approximately 5-6 in wanted to find more others, "closer to he area so he counces." I stated she living facility's in Mathem or they had a CSW-J was unable regarding what facilities R3 in weified R3 had no was the resident plalso stated she had the facility regarding does not give the facility's R3 had be further went on to so "heard" R3 was not his wounds heal.	on 10/30/13, at 11:14 a.m. er (CSW)-J stated the last with R3 was in May 2013, months ago. CSW-J stated R3 er appropriate placement with its age," but wanted to stay in ld be close to his family. It had looked at several different ay for R3 but either R3 rejected willong waiting list." However, er to provide information dilities were considered and rejected going to. CSW-J active plans for discharge, nor acced on any waiting lists. She do not spoken with anyone from grad discharging and she accility information regarding the en spoken to about. CSW-J say that she thought she transport to this solutions.	F 2	250		
	director of nursing worker had retired DON stated there was regarding R3 dischaddressed discharge county social worker Furthermore, she had social worker to vein place. DON veri	on 10/30/13, at 12:33 p.m. The (DON) stated the facility social several months ago. The was no further information arging and stated, "I never ge" with R3 as she thought the er was working on discharge. nad not spoken to the county rify if any discharge plan was fied there was no plan arging from the facility, and the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
		245278	B. WING		11/01/2013
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F 250	county social work	age 7 rdinated with the resident er to ensure R3 was e appropriate placement.	F 250		
F 282 SS=D	facility. 483.20(k)(3)(ii) SEI PERSONS/PER Co The services provided by	RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility by qualified persons in ach resident's written plan of	F 282	F 282 Qualified Persons 1. Care plans for R2, R19, and R3 were reviewed by Restorative RN they have been referred to therap	, and
	by: Based on interview facility failed to ens for 3 of 4 residents	NT is not met as evidenced v and document review the ure the care plan was followed (R19 and R36 and R2) assessed as needing services.		evaluation of current level of funct abilities to ensure appropriateness current restorative programs. Restorative RN is working with therapies to develop comprehensi plans of care based on identified and care plans will be followed.	ional s of ve
	R19's quarterly Mir 9/12/13, included a and rheumatoid art was cognitively inta	e restorative nursing services care plan. nimum Data Set (MDS) dated diagnosis of schizophrenia hritis. The MDS indicated he let, did not reject cares, had s in range of motion of upper		2. All residents with restorative programs were reviewed to ensure resident-appropriateness and programe being done according to the coplan and documented and if refuse communicated to the Restorative	grams are ed,

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F 282	extremities, but did nursing program. R19's care plan darestorative nursing directed staff to ass Restorator (an exeminutes, dowel exeminutes, and the dated 8/9/13, includeveloped a new refeels he can tolerate frequently which he Patient will use arm extremity Restorate planes." R19's Care Plan Appeared to the storative nursing weeks, on 8/26/13 and include why R13 restorative programs the care plan. When interviewed on ursing assistant (Not assist residents to programs. She is controlled to the afternoon to dowe the staff of th	ted 9/18/13, included a program twice a week, and sist R19 with use of a rcise machine) for five ercises moving side to side and a forward and backwards and	F 2	3. Education was staff on 11/27/1 importance of for programs as list care plan, crucing refusals and/or what to do in the restorative programs as is completed, regard More specific, in will be provided nursing assistant meeting will be Administrator, ERN, and all primiting the purpose of the purpose of the puring this meeting the necessity of consistent and a and how to doc	bllowing the restorated in each individual documentation of completion, as well e event that reside the reason is not getting ardless of the reason dividualized educate and with the DON, ADON/Restoraty restorative aid restructure and the overall program. It is on 12/4/13, where the overall program. It is on the compliance, accurate document are under a communication of the communicati	ative ual of I as on. ation orative en a rative es for view tation, ate	

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NAME OF		245278	B. WING			11/	01/2013
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F 282	a full day restorative was cut back to jus 2013. NA-B stated everyone with their of this, there is not morning person," all program in the mor dining duties. NA-E to provide R19 with anyone. When interviewed of stated he always us nursing program in restorative aide. All quit asking him to gwould offer his program in restorative program would go. When interviewed of assistant director of though she is response was not aware directed by his care this to her.	e nursing assistant, but this tour hours a day in April she is unable to assist restorative programs because enough time. R19 "is a not will only do the restorative nings, when she is assigned a had not reported her inability the restorative program to on 10/30/13, at 1:03 p.m. R19 to go for his restorative the morning with the pout six months ago the staff to to the program. If they ram in the mornings, he on 10/30/13, at 11:22 a.m. the nursing (ADON) stated even nsible for reviewing the sfor each resident monthly, R19 was not attending as plan. No one had reported	F 2	282	4. Audits of all CNA documentation care plan approaches, including dintakes, ADLs, and all FMP/restoral program attempts) will be completed the DNS and Designee (s) at the eleach shift x 7 days, and random waudits x 5 weeks thereafter. These random weekly audits regarding completion and documentation of pertinent care plan approaches will occur x 3 months to ensure compliand that all refusals are being communicated to the appropriate designated person. 5. Completion Date: December 6th, 2013	aily ative ed by end of eekly	
	diagnoses of diabet indicated he was co	S dated 9/4/13, included es and depression. The MDS gnitively intact and torative nursing program for					

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F 282	Continued From pa active range of mot the assessment we	ion (ROM) two times during	F 2	282			
	attend a restorative week. This would i minutes and/or up a	ted 9/4/13, indicated he was to e nursing program twice a nclude, Restorator for ten and down the stairs twice, s with three pounds for 15					
	to 10/30/13, indicat program 14 times of was no documenta	oproaches report from 7/30/13 ed he received his restorative during these 13 weeks. There tion to indicated why R36 had ogram twice a week as					
	NA-B stated R36 de restorative nursing	on 10/31/13, at 10:22 a.m. oes not refuse to come to his program, but she does not o assist him with it. She had anyone.					
	ADON stated she he program monthly, b	on 10/31/13, at 12:30 p.m. the had reviewed R36's restorative but was not aware it was not rected by the care plan. No his to her.					
,	R2 did not receive to program as directed	the restorative nursing d by the care plan.					

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		245278	B. WING		11.	/01/2013	
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F 282	R2's diagnosis inc The quarterly MD moderate cognitive extensive assistated received a restorate	page 11 cluded adult failure to thrive. S dated 10/21/13, included re impairment, required nce with ambulation, and ative nursing program to include me in the assessment week.	F2	82			
	assist with a restor include ambulation walker to and from addition, the care the use of the Restanding alternate with upper extrem wooden box of six exercises 20 rependinutes and red particular and red	ted 11/28/12, directed staff to prative nursing program to in with one assist and rolling in all meals as tolerated. In plan directed staff to assist with storator as tolerated and/or in marches 20 repetitions total inity use on walker. Step up onto it inches, and/or 3 pound seated in the point of the program of the point of the program of the point of the program					
	Summary dated 5 therapy (PT) had 5/10/13, due to a and out of bed. T staff to continue h "Current Level of able to ambulate wheeled walker, v	erapist Progress & Discharge i/10/13, included physical worked with R2 4/15/13 through decline in ability to transfer in the summary directed nursing her ambulation program. The Function," concluded R2 was 60 to 100 feet with a front with minimum assistance to hold the wheel chair behind.			·		
	through 10/31/13, to ambulate to an care plan 655 time	oproaches Report from 5/1/13 showed R2 had the opportunity d from meals as directed by the es. The documentation showed ambulated to and from meals					

PRINTED: 11/19/2013 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245278 11/01/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 413 13TH AVENUE **GOOD SAMARITAN SOCIETY - HOWARD LAKE HOWARD LAKE, MN 55349** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PRFFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 282 Continued From page 12 F 282 103 times. R2 had refused 113 times. There was no evidence R2 had been offered assistance to ambulate to and from meals 439 times during this time frame. R2's Care Plan Approaches Report from 7/1/13 through 10/31/13 showed R2 had not participated in the other restorative nursing program with the Restorator, standing marches, pulleys or pegs exercises at all. This was should have occurred 123 times in this time frame. When interviewed on 10/31/13, at 1:31 p.m. R2 stated she use to walk to and from all the meals. She had to get help from staff to do this. R2 stated staff just stopped asking her to walk, and just automatically take her in her wheel chair to meals. R2 had never been offered any other exercise program. When interviewed on 10/31/13, at 1:42 p.m. NA-A stated she started working in the facility in June 2013, she had never seen R2 ambulate to and from meals. NA-A was unaware R2's care plan directed staff to assist her to ambulate to and from meals. NA-A was not aware of any other exercise program R2 was to participate in either. When interviewed on 11/1/13, at 10:05 a.m. the ADON was unaware R2 was not participating with the restorative nursing program as directed by the care plan, even though she reviews each residents restorative nursing program monthly.

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F 282	at times. No one had ambulation and exe	ge 13 e R2 would refuse to ambulate ad reported to her the ercise program were not being ted by the care plan.	F 282		*	
	Director of Nursing restorative aid who hired staff to compl	11/1/13, at 10:33 a.m., the (DON) stated they had a quit in January 2013, they had ete the restorative programs they weren't receiving them				
F 310 SS=G	facility.	sted, but not provided by the DO NOT DECLINE UNLESS	F 310			
	resident, the facility abilities in activities unless circumstanc condition demonstrunavoidable. This is to bathe, dress, and ambulate; toilet; ear	rehensive assessment of a must ensure that a resident's of daily living do not diminish es of the individual's clinical ate that diminution was ncludes the resident's ability d groom; transfer and t; and use speech, language, communication systems.				
	by: Based on observate review, the facility factories was provided with a recommended, and ability declined for ambulation services.	ion, interview, and document ailed to ensure each resident ambulation services when assessed when ambulation of 3 residents (R2) reviewed ices. This practice resulted in when she experienced an				

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F 310	Findings include: R2's diagnoses includering Minimum 10/21/13, included impairment, require transfers and amburestorative nursing ambulation one day R2's care plan date assist with a restorative include ambulation, walker, to and from addition, the care parendly exercise programment in the care parendly exercise programment in the care parendly exercise programment in the care parendly exercises programment	uded osteoarthritis. The Data Set (MDS) dated moderate cognitive of extensive assistance for alation, and received a program which included of during the assessment week. d 11/28/12, directed staff to ative nursing program to with one assist and rolling all meals as tolerated. In lan directed staff to assist with gram to include: the use of a cise machine] as tolerated ernate marches 20 repetitions remity use on walker. Step up if six inches, and/or 3 pound 0 repetitions bilateral. Pulleys ed pegs and putty. apist Progress & Discharge 0/13, included physical orked with R2 4/15/13 et oa decline in ability to of bed. The summary directed tinue her ambulation program. of Function," concluded R2 to 60 to 100 feet, with a front in inimum assistance to ull the wheel chair behind. roaches Report from May 1, per 31, 2013, showed R2 had	F 310	1. R2 was referred to physical ther (PT) for evaluation of ambulation a functional ability of lower extremitie and treatment, if warranted per PT 11/1/13. Per PT, R2 was "evaluationly", completed on 11/14/13, rela "patient concerns about ambulating consistent basis, but still wanting to have it offered", and a revised ambulation FMP was initiated at the time. The revised FMP indicates the staff should continue to offer ambudaily after lunch, as well as an alternative offer of standing at rail is refuses to ambulate. On 11/26/13, was referred again to PT and OT for review of current PT/OT FMPs as in order to ensure that these progressin order to ensure that these progressin appropriate for this residen. 2. All ambulation programs have be reviewed for appropriateness, and now being followed according to caplan. Additionally, staff is offering a when needed, documenting refuse ambulation programs on a consistent basis. These refusals will be communicated to the Restorative Fourther evaluation.	apy and es on on ted to g on a of at lation are are and, als of ent	
A TO DA A distribution and the sec	2013 through Octob			rurther evaluation.	-	

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F 310	documentation shot ambulated to and frequency and the refused 113 times. had been offered as from meals the other frame. There was a why R2 had not am R2's Care Plan App 2013 through Octobrot participated in the Restorator, standing exercises at all. Rights program daily for period. There was why it was missed from 10/28/13, at 5:0 dining room in her was propelled out on the chair by an unknown R2 was observed in wheelchair watching. When interviewed on ursing assistant (Not dining aide in the more than the facility use to have aide, but that had contain the chair was care planning that may be not reported that was care planning and not been instructive.	e plan 655 times. The wed R2 only actually from meals 103 times. R2 had There was no evidence R2 sistance to ambulate to and er 439 times during this time no documentation to indicate bulated these 439 times. Froaches Report from July 1, per 31, 2013 showed R2 had he exercise program with the grarches, pulleys or pegs 2 should have been offered for the 123 days in this time no documentation to indicate for all 123 days. Froaches Report from July 1, per 31, 2013 showed R2 had he exercise program with the grarches, pulleys or pegs 2 should have been offered for the 123 days in this time no documentation to indicate for all 123 days. Froaches Report from July 1, per 31, 2013 showed R2 had he exercise program. Should have been offered for the 123 days in the staff person. At 6:50 p.m. In the room sitting in her graph television. Froaches Report from July 1, per 31, 2013 showed R2 had have been offered by the exercise program. In the storative program, but verified do this to anyone. NA-B had to do her exercise program ed to occur every day. She cited to do so.	F 310	3. Education was provided to all nurstaff on 11/27/13 regarding the importance of following the restorat programs as listed in each individual plan, crucial documentation of refus and/or completion, as well as what in the event that residents restorative program is not getting completed, regardless of the reason. More speindividualized education will be proto all primary restorative nursing assistants on 12/4/13, when a meewill be held with the Administrator, ADON/Restorative RN, and all primarestorative aides for the purpose of restructure and restoration of the or program. During this meeting we wave review the necessity of CP compliance consistent and accurate documentation and how to document / communication referrals to the appropriate person.	ive al care cals to do ve cific, vided ting DON, ary verall ill also nce, ation, te	
	When interviewed of	on 10/31/13, at 1:31 p.m. R2				

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F 310	stated she use to wand that she require this. R2 stated that just stopped asking automatically take it chair. R2 did not knexercises, and said any. On 10/31/13, at 1:4 wheelchair in her robed. Nursing assist medication aide (Till with two person assambulated to and from that since she had so June 2013, she had and from meals. Not plan directed staff to and from meals. Not exercise program in either. On 11/1/13, at 9:19 next to the dining rousing the hallway grithe hall. R2 was ask (PT)-A if she could can't walk anymore ambulate. NA-A an with a transfer belt awas able to ambulate assistance of two malso pulling the whe stated in May 2013, to 100 feet with only	ralk to and from all the meals as assistance from staff to do about six months ago, staff her to walk and now they just her to meals in her wheel now about doing any she had not been offered 2 p.m. R2 was sitting in her nom. R2 requested to lie in ant (NA)-A and trained MA)-A assisted R2 into bed, sist. NA-A stated R2 had not nom lunch today. NA-A stated started working in the facility in a never seen R2 ambulate to A-A was unaware R2's care to assist her to ambulate to A-A was not aware of any other as was not aware of any other as was supposed to participate a.m. R2 was in the hallway nom sitting in her wheelchair, hab bars to pull herself down and by the physical therapist watch her walk. R2 replied, "I R2 agreed to attempt to d NA-D assisted R2 to stand and front wheeled walker. R2 the 20 feet with weight bearing ursing assistants who were ell chair behind her. PT-A R2 was able to ambulate 60 one assist, for balance. It declined in her ability to ted staff needed to	F3	4. Audits of all CNA documer plan approaches, inclintakes, ADLs, and all FMI program attempts) will be the DNS and Designee (s) each shift x 7 days, and rate audits x 5 weeks thereafter andom weekly audits regard completion and documents pertinent care plan approached and that all refusals are becommunicated to the approaches ignated person, with refor further recommendations. 5. Completion Date: December 6th, 2013	luding da Prestora complete at the eardom war. These arding ation of aches will be compli- periate esults to	aily ative ed by end of eekly	

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F 310	stated R2 use to ar anymore, "it is too INA-C stated this changes to six months, but NA reported this changes tated the nursing a restorative program that duty to work or happens when staf "just short." R2's Interdisciplina Summary Quarterly "Resident has goal [ambulation] and O and physical therap AMB [ambulate] [w then [one] assist to refuses with no oth old." Will continue of the continue of	on 11/1/13, at 9:43 a.m. NA-C mbulate to meals, but could not hard for her to move her feet." hange occurred over the past -C confirmed she had not ge to anyone. NA-C further assistant assigned to do the has often gets pulled from doing in the floor indicating this f call in sick, or when they are ary Assessments and y review dated 8/7/13, included sof participation in AMB T/PT [occupational therapy by]Resident continues to ith] assist of [two] to get up AMB [ambulate]. Often er reason than "I'm 101 years goals"	F3	310			

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assistants when sh programs, but had why her Interdiscip Summary reviews program R2 had be R2's Therapy Screincluded R2 had a change required m maintenance program When interviewed Director of Nursing restorative aid who had hired staff to c programs, but was not being implement it wasn't being offenot know R2 had n program which coustrength and endur The facility's Resto Restorative Nursing revised 1/2013, ind	not. The ADON did not know linary Assessment and did not address the exercise een care planned to do. en Form dated 11/1/13, change in condition and this odification of the functional am. on 11/1/13, at 10:33 a.m., the (DON) stated they had a quit in January 2013, and they omplete the restorative not aware the programs were nted. The DON stated R2 has e at times, she was not aware red. The DON stated she did ever received the exercise old have helped with R2's ance.	F3	310			
for re-screens, doc has occurred; upor do follow-up and m necessary lack o as any increase/ de 483.25(c) TREATM PREVENT/HEAL F	ument if a functional change in comparison with last screen, ake referral to therapists as if progress and reason as well ecrease in goals." JENT/SVCS TO PRESSURE SORES Drehensive assessment of a	F3	314			
	PROVIDER OR SUPPLIER SAMARITAN SOCIETY SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa assistants when sh programs, but had why her Interdiscip Summary reviews of program R2 had be R2's Therapy Screet included R2 had a change required m maintenance program When interviewed of Director of Nursing restorative aid who had hired staff to corpograms, but was not being implement refused to ambulat it wasn't being offer not know R2 had n program which coustrength and endur The facility's Resto Restorative Nursing revised 1/2013, ind document restoratif for re-screens, doc has occurred; upor do follow-up and m necessary lack of as any increase/ de 483.25(c) TREATM PREVENT/HEAL P Based on the comp	PROVIDER OR SUPPLIER SAMARITAN SOCIETY - HOWARD LAKE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 18 assistants when she reviews the restorative programs, but had not. The ADON did not know why her Interdisciplinary Assessment and Summary reviews did not address the exercise program R2 had been care planned to do. R2's Therapy Screen Form dated 11/1/13, included R2 had a change in condition and this change required modification of the functional maintenance program. When interviewed on 11/1/13, at 10:33 a.m., the Director of Nursing (DON) stated they had a restorative aid who quit in January 2013, and they had hired staff to complete the restorative programs, but was not aware the programs were not being implemented. The DON stated R2 has refused to ambulate at times, she was not aware it wasn't being offered. The DON stated she did not know R2 had never received the exercise program which could have helped with R2's strength and endurance. The facility's Restorative Nursing Program/ Restorative Nursing Documentation policy, last revised 1/2013, indicated the purpose is to document restorative nursing appropriately. 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F 314	who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based observation, interview, and record review, the facility failed to ensure 1 of 3 residents (R21) reviewed for pressure ulcers, had the pressure area assessed, monitored, and had interventions in place to promote healing. Findings include: R21 diagnosis included a fracture of the left femur. The admission Minimum Data Set (MDS) dated 9/24/13, identified R21 had moderate cognitive impairment, needed extensive assistance with with most activities of daily living (ADL's), and was at high risk for developing pressure ulcers. R21's Daily Skilled Notes included the following: 10/25/13- "Noted on right big toe on right foot what appears to be a blood blister; nickel size placed in treatment book to monitor every shift until resolved." 10/26/13- "What appears to be a blood blister remains on right big toe, noted no change in size."		F 31	F314 Pressure Sores 1. On 10/31/13, R21's pressure area was assessed, monitoring was set up and interventions to promote healing were implemented. Upon review for the week of R21's planned discharge on 11/11/13, progress toward healing was evidenced by over a 60% decrease in size of "blister" as compared to initial assessment, and was described as "loose scab" in one of the RN's final daily skilled notes. 2. All residents currently at risk for pressure ulcers were reviewed to ensure that their comprehensive skin assessments including Braden and positioning data collection tools are complete. All care plans and treatment records were reviewed and reflect current, effective interventions for			
				Physician notification has been completed for all residents who currently have pressure ulcers i to ensure implementation of adtreatment to promote healing.			

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F 314	10/27/13- "Blood bl great toe; no change 10/28/13- "Blood bl no change noted in 10/29/13- "Blood bli 10/30/13- Blood blist R21 was observed a wheelchair prope towards his room fr wearing black sock On 10/30/13, at 12: nurse (LPN)-A obsetoe. LPN-A stated area, but not measit. LPN-A verified the regarding the cause measurements to be to the physician to being done to ensururse who initially coresponsible for ensinterventions are apphysician. During interview on occupational therapiust started wearing week and a half. Scurrently had a "blo blood blister could he shoe.	ister remains intact on right ge in size." ister intact on right great toe;	F 3	3. All newly admitted resideresidents with significant chrothe development of preswill have prompt physician by the first licensed nurse the pressure ulcer, in additing implementing individualized interventions based on a comprehensive skin assess Educational in-service was all nursing staff on 11/27/13 the risk factors, identification importance of notifying the related to ensuring adequal intervention and effective transportance of all residents with pulcers to ensure ongoing coregarding the assessment, and implementation of interpromote healing. These audone weekly x4, and month thereafter, with results to Querecommendation. 5. Completion Date: December 6th, 2013	nange related sure ulcer notification o recognize ion to d sment. provided to 3 regarding in of, and the physician te reatment of andom pressure ompliance monitoring, ventions to dits will be aly x3		
		10/31/13, at 9:45 a.m. RN- A n "monitoring" R21's "blood					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245278	B. WING			11/0	01/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - HOWARD LAKE					STREET ADDRESS, CITY, STATE, ZIP CODE 413 13TH AVENUE HOWARD LAKE, MN 55349		
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F 314	have not been mea be difficult to know lack of monitoring. blister on his toe can not think it was presured in the lack of monitoring. blister on his toe can not think it was presured in the lack of	ge 21 toe. She stated the nurses suring it and verified it would if it was healing related to the RN-A was unsure where the me from but stated she did soure related because R21 s." RN-A verified there was no entions, or notification to the d the nurse discovering the one the assessment nine what caused the area. 10/31/13, at 10:35 a.m. DON) stated she was just blood blister 2 days ago but look at the area. DON should have done an ermine the cause, should be and should have notified the ated none of the above had so verified the timing of R21 is shoes and the development was probably related to the es. DON stated she was not ad determined if R21's shoes healing of the pressure ulcer developed a "blood blister" on a facility failed to ensure an empleted to ensure monitoring ere put into place to ensure	F3	314			
	Nursing Coverage a 2/2012, instructed,	d a policy entitled Skilled and Documentation, dated 'Nursing documentation to					

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		245278	B. WING_		11/	01/2013
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F 314	Continued From pa	ge 22	F 3	14		
		ts, nursing concerns, and documentation of le conditions"				
	defines pressure uld or maroon localized or blood-filled bliste soft tissue from pres "Suspected deep tis 483.25(d) NO CATH	HETER, PREVENT UTI,	F 3 ⁻	F315 Urinary Incontinence		
	assessment, the factoresident who enters indwelling catheter is resident's clinical contraction was who is incontinent of treatment and service infections and to restruction as possible. This REQUIREMENT by: Based on observation review, the facility factors as the continue indwelling urinary catheters.	ent's comprehensive cility must ensure that a the facility without an s not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder of the interview, and document alled to comprehensively and need for the use of an atheter for 1 of 2 residents of had an indwelling urinary		1. See enclosed dictation from Dr. M. Schulenberg, dated 11/7/13 regarding the use of indwelling catheter for this R20. Nursing staff will continue to review the risks vs. benefits associated with long term use of an indwelling catheter with R20. On 11/29/13, trial was initiated with resident's permission and physician order to "clamp" catheter tubing for a maximum of 4 hours in order to assess whether or not R20 has any sensations of pressure or urge to void that might indicate the possibility of regaining at least some bladder control. Further trials and/or discontinuation will be dependent on these results and according to physician determination.		
	Findings include:					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 315	R20's diagnoses indand cerebrovascula admission Minimum 09/26/13, indicated and needed extens. The MDS also indicatheter. R20's Ur Indwelling Catheter dated 09/27/13, incliname brand of cath hospitalization and for ease in voiding. Needs assist with cand cares."	cluded multiple sclerosis (MS) or accident (CVA). The n Data Set (MDS) dated R20 was cognitively intact live assistance with toileting. The reaction of the re	F 3	HOWARD LAKE GOOD SAMARITAN NAME: Barbara Winter DATE OF BIRTH: 10/22/1944 DATE OF SERVICE: 11/07/2013 PROVIDER: Michael Schulenberg, MD HISTORY: This 69-year-old female is in the nursing home for CVA, complete year advanced spastic parcels of the lower extremities related to sclerosis, longstanding and progressive. The patient was discharged from the hospital to Howard Lake Cowith Foley eatheter in place for preservation of skin integrity on for patient dignity and at her request so she would not suffer epi incontinence. The State Surveyors were here recently and had concern regarding this catheter and that there was no medical in I have had previous discussions with Ms. Winter but not clearly the chart that she desires to have this catheter remain in place. It perspective, it seems reasonable to keep this catheter in place un home for prevention of skin ulceration in the perineal and ischia patient desires the catheter in at this time for preservation of her control. Therefore, I believe it is reasonable to continue with the I have had this discussion with the patient previously and the pu is for documentation. MICHAEL SCHULENBERG, MD Jan 18 18 18 18 18 18 18 18 18 18 18 18 18	multiple od Samaritan he perineum and odes of pressed a ceation for it. occumented in om a medical i discharge to area. The ignity and self oose of this note		
	R20's care plan dated 09/18/12, included, " inability to toilet self and indwelling Foley cath. Will have no urinary tract infections. Will progress towards discontinuation of catheter. Cath cares Q [every] shift. No leg bag in use when in bed."						
	"Urinary drain: you he reason for the drain toiletUrinary drain declined Foley removese, understands is	ers dated 09/18/13, included, nave a urinary drain the is inability to get to the voiding trial: Pt [patient] has oval. Prefers to keep in for infection risk. Please keep when she would agree to		- Howard Lake Good Sam FROM- EXCELIOR CLINIC	1 at:⊊t Zt-tt-&t		
	R20 was observed t [name brand] chair e	on 10/28/13, at 6:15 p.m., o be sitting in her Broda eating her supper meal in her ter bag attached to her chair		2. All residents in the building a indwelling catheters unless dee necessary per orders from primphysician.	med		

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		245278	B. WING	i		11/01/2013	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- HOWARD LAKE		4	TREET ADDRESS, CITY, STATE, ZIP CODE 413 13TH AVENUE HOWARD LAKE, MN 55349		
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F 315	When interviewed of stated she has MS for the last 10 years also stated she would control, as she did put that since admissions taff or her physicial any attempts to remove the management of the physicial and attempts to remove the physicial and attempts to remove to be catheter bag hanging. When interviewed to be catheter because should be to her recent story the physician of the catheter, and she that the physician properties of the catheter with the catheter with the catheter in place and related to this. Anticipe of the discharging has before discharging the physician properties of the place and related to this. Anticipe of the catheter in place and related to this. Anticipe of the place of the place and related to this. Anticipe of the place and place of the place of t	on 10/29/13, at 1:00 p.m. R20 and has not been able to walk while living at home. R20 ald like to get back her bladder brior to her CVA. R20 verified in to the facility on 09/18/13, in have not mentioned to her nove her urinary catheter. on 10/29/13 at 2:01 p.m., R20 lying watching TV with her no on the right side of the bed. on 10/29/13, at 2:11 p.m., IA)-C stated R20 has a ne has difficulty with mobility roke. on 10/30/13, at 11:05 a.m., the DON) stated R20 was ity with the indwelling links the doctor orders read fer when patient wants it I had not addressed removal R20. orgress note, dated 10/24/13, I continues to have Foley d has not had any issues ipate we will discontinue it ner home."	F	315	3. All residents admitted with an indwelling catheter will be assessed medical necessity and catheter will removed if placement lacks medical reason/ justification. No current reshas or will have a catheter inserted left in bladder if medically unnecess On 11/29/13, all nursing staff recededucation regarding the important avoiding indwelling catheters for the purposes of resident and/or staff convenience, and the necessity of appropriate medical justification for long-term placement of catheter. 4. DNS or designee will do random audits to ensure that a comprehent assessment has been done and the there is evidence of medical justification for all residents with indwelling catheters weekly x 3 weeks, then monthly x 2 months, and with all not admissions for the next 3 months were sults to QA for further recommendation. 5. Completion Date: December 6th, 2013	I be al sident d and ssary. ived e of ne r sive nat cation	
		ress notes dated 09/18/13 nly indicated R20 has a Foley					

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F 315	catheter and a desc the catheter bag. The	ge 25 cription of the fluid observed in ne notes did not include any regarding the removal of the	F 318				
	revised 11/09, including may require cathetes bladder distention of to a tumor or enlarg Multiple Sclerosis have documentation indwelling catheters attempts It is recognited at least to	led Catheterization (n) Insertion and Removal, ded "clinical conditions that erization include: relieve ue to: urinary obstruction due ed prostate, urine retention, The medical record must n of attempts to remove and the results of these mmended that removal be wo or three times during t can be determined that it is			7		
	prior to admission d wanted to regain bla physician ordered to did not make any at catheter during her: 483.25(e)(2) INCRE IN RANGE OF MOT Based on the compo- resident, the facility	ASE/PREVENT DECREASE TON rehensive assessment of a must ensure that a resident	F 318				
		nt and services to increase /or to prevent further					

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F 318	by: Based on observative review, the facility for recommended restrongered a change in residents (R19 & R restorative nursing) Findings include:	NT is not met as evidenced tion, interview, and document ailed to provide the orative nursing services, to a range of motion, for 2 of 3 36) reviewed who had	F 318	F 318 Range of Motion 1. R19 and R36 restorative ROM programs were reviewed by Restorative RN, and have been referred to the for evaluation of current level of functional abilities and for review current restorative ROM and FMF programs. They are being assiste Restorative RN to develop comprehensive plans of care, inclinal appropriate ROM program bases	erapy of d with uding	
	9/12/13, included a and rheumatoid arthus cognitively inta functional limitation extremities, but did nursing program. R19's care plan data restorative nursing directed staff to ass Restorator (an exerminutes, dowel exe	imum Data Set (MDS) dated diagnoses of schizophrenia hritis. The MDS indicated he ct, did not reject cares, had s in range of motion of upper not receive a restorative ed 9/18/13, included a program twice a week, and sist R19 with use of a cise machine) for five recises moving side to side and		identified need. 2. All residents with restorative/Reprograms were reviewed and are completed according to the care pensure that they are receiving the appropriate services / treatment to increase ROM and/or prevent fur	being blan to	
	Push up, two sets of R19's Physical The dated 8/9/13, include	forward and backwards and of ten. rapy discharge summary led, "Patient and therapist setorative program that patient	·			

CTATEMENT	OF DEFICIENCIES	(X4) PROVIDER/CURRUER/CUA	(X2) MULTIPLE CONSTRUCTION		7/00 140. 0300-0331		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY PLETED
		245278	B. WING			11/	01/2013
	PROVIDER OR SUPPLIER AMARITAN SOCIETY			4	TREET ADDRESS, CITY, STATE, ZIP CODE 13 13TH AVENUE IOWARD LAKE, MN 55349		
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F 318	frequently which he Patient will use arm extremity Restorato planes." R19's Care Plan Ap through 10/30/13, restorative nursing weeks, on 8/26/13 a not include why R19 restorative program the care plan. When interviewed on ursing assistant (Nodining aide in the more restorative program stated she had not be restorative program time, and also state and she is unable to programs in the more in the afternoon. facility used to have all day but that was when interviewed o stated he used to all program in the more rehab aide had retire the staff no longer and exercise program. If	ge 27 e, despite having to rest says he had to do in the past. bike for five minutes, lower or x 10 and dowel in all sproaches report from 7/30/13 evealed he had received his program only twice in these 13 and 10/23/13. The report did 9 had not received the twice a week as directed by on 10/30/13, at 11:30 a.m. IA)-B stated she works as a ornings, and does the sin the afternoons. NA-B been able to offer R19 his since she does not have d R19 is a morning person offer the restorative nursing rning. R19 does not like to do NA-B further stated the restorative aide that worked stopped in January 2013. In 10/30/13, at 1:03 p.m. R19 ways go to his restorative nursing with the rehab aide. The red about six months ago, and sked him to go to the R20 also stated if the staff ram to him in the morning he	F3		3. Education was provided to all n staff on 11/27/13 regarding the importance of following the restora programs as listed in each individuate care plan, crucial documentation or refusals and/or completion, as well what to do in the event that reside restorative program is not getting completed, regardless of the reason More specific, individualized educate will be provided to all primary restonursing assistants on 12/4/13, when meeting will be held with the Administrator, DON, ADON/Restor RN, and all primary restorative aided the purpose of restructure and restoration of the overall program. During this meeting we will also reverted the necessity of CP compliance, consistent and accurate documentate and how to document / communicate referrals. Staff was instructed that a change in range of motion is to be reported to the charge nurse on duting well as any refusals of program.	ative ual of l as on. ation orative on a ative es for view ation, te any	

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F 318	Continued From pa	ige 28	F 318				
	assistant director or reviews the restoral she was not aware program. She state attending and should the staff should infer there program. During observation was observed to be completing his restoration with no difficulties. During interview on	on 10/30/13, at 11:22 a.m. the f nursing (ADON) stated she tive programs monthly, but R19 was not attending his ed she just assumed he was ldn't have. The ADON stated orm her if someone is refusing 10/31/13, at 1:03 p.m. R19 in the therapy room orative program with NA-B 10/31/13 at 1:10 p.m., NA-B eed to complete his program		4. Audits of all CNA documentation care plan approaches, including daintakes, ADLs, and all FMP/restoral program attempts) will be complete the DNS and Designee (s) at the eleach shift x 7 days, and random wall audits x 5 weeks thereafter. These random weekly audits regarding completion and documentation of pertinent care plan approaches will occur x 3 months to ensure compliand that all refusals are being communicated to the appropriate designated person, with results to for further recommendation.	ally ative ed by nd of eekly		
	R36 did not receive program as ordered	his restorative nursing d.		5. Completion Date: December 6th, 2013	-		
	diagnoses of diabet indicated he was co extensive assistance participated in a res	S dated 9/4/13, included ses and depression. The MDS agnitively intact, required e with dressing, and storative nursing program for es during the assessment					
		ed 9/4/13, included a twice a week. The care plan					

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F 318	directed staff to ass ten minutes, and/or and/or leg exercises 15 repetitions.	ist R36 with the Restorator for up and down the stairs twice, s with three pound weights for proaches report from 7/30/13	F3	18			
	restorative program opportunities. The	documentation did not ad not received it the other 10					
	NA-B stated R36 d nursing program, bu	on 10/31/13, at 10:22 a.m. oes not refuse his restorative ut she doesn't always have st him with it. She had not one.					
	ADON stated R36 or restorative program attending the progra	on 10/31/13, at 12:30 p.m. the doesn't not refuse his , she had thought he was am as ordered. The ADON had not informed her he restorative nursing.				9	
		on 10/31/13 at 1:15 p.m., R36 therapy room receiving his					
		on 10/31/13, at 1:30 p.m. R36 had not declined in their motion (ROM).					

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F 318	When interviewed of stated R19 & R36 h there ROM. NA-C have a restorative programmer the restorative programmer them now as they as She had not reported. When interviewed of director of nursing of restorative aid who hired staff to compland had not been in completed as order.	on 11/1/13, at 9:43 a.m. NA-C had not had any declines in also stated the facility used to aide who worked all day and trams were completed then, enough time to complete are only allowed half a day. Bed this to anyone. On 11/1/13, at 10:33 a.m. the (DON) stated they had a quit in January 2013, they had ete the restorative programs aformed they were not being	F 3				
F 325 SS=D	483.25(i) MAINTAIN UNLESS UNAVOID Based on a resident assessment, the factoresident - (1) Maintains acceptatus, such as bod unless the resident' demonstrates that the (2) Receives a there nutritional problem.	t's comprehensive cility must ensure that a stable parameters of nutritional ly weight and protein levels, s clinical condition his is not possible; and apeutic diet when there is a	F3	25			

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	PROVIDER OR SUPPLIER	- HOWARD LAKE	4	TREET ADDRESS, CITY, STATE, ZIP CODE 413 13TH AVENUE HOWARD LAKE, MN 55349	oliumeeta vaa valimeele eese	
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F 325	review, the facility f (R21) reviewed who was comprehensive weight loss, and im to prevent further was remarked. R21's diagnosis incomparities include: R21's diagnosis incomparities and (MDS) dated 9/24/10 cognitive impairment assistance with with (ADL's), and had not identify that R2 fitting dentures. Review of R21's we follows: 9/17/13 (admission 9/24/13- 122 lbs.	n observation, interview, and document e facility failed to ensure 1 of 1 resident lewed who had a significant weight loss, prehensivly assessed to determine is, and implement a nutritional program to further weight loss. Include: Inc		F 325 Nutritional Status 1. A comprehensive re-assessment resident's nutritional status and welloss was completed on 11/8/13. Re R21's care plan was reviewed and 11/11/13 Resident's diet was upgrawith risks and benefits explained ar understood by resident and wife, ar were agreeable to this change. 2. The comprehensive nutritional assessment and the individual care of all current residents were reviewed the Dietary Manager and and/or Designee. All current residents are offered a diet which supplies the call and nutritional needs as determined their individual nutritional assessment addition, a process has been implemented to ensure that all full materials.	ight esident on ided ind they plans ed by being loric d by ent. In	
	10/1/13- 119 lbs. 10/9/13- 115.5 lbs. 10/20/13- 115 lbs. 10/23/13- 117 lbs. 10/26/13- 114.5 lbs. 10/30/13- 118 lbs. R21 was weighed again on 10/31/13, with a weight of 115 lbs. Nursing assistant (NA)-A stated R21 has been weighed on this same sale since admission. This was a 12.5 lbs weight loss in the 43 days since admission, almost a 10			refusals are appropriately communic to the Dietary Manager for review as investigation, as well as to ensure the resident who refused is offered and served a substitute of similar nutritive value.	nd nat the	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- HOWARD LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 413 13TH AVENUE HOWARD LAKE, MN 55349		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	stated his dentures to wear them any my while." R21 stated eat "mashed" (pure dentures not fitting go to the dentist to regular food. R21 s ground up food bed stated he was losin. The Physical Nursin indicated R21 had a (swelling), weight wand lower dentures him?" R21 had been refer to increased coughing of speech therapy of speech therapy of speech therapy of the speech to participate to participate to participate to participate to dentures stayed to chew without his unable to keep dental states.	on 10/28/13, at 6:15 p.m. R21 didn't fit, and he was unable nore. They had not fit for "a did the facility required him to need) food related to his properly, and he would like to get them fixed so he can eat stated he did not like the cause it had no taste and g weight because "I don't eat!" and Data completed on 9/17/13, no upper or lower edema ras 127.5 lbs., and had upper documented as "not with ared to speech therapy related ing noted by nursing. Review notes included the following: as dentures but states he complains of not liking ground on why need to wear ate in trails of upgrade food." herapy trialed R21's dentures tom denture came loose but if fixed. Patient feels it is easier dentures inpatient unwilling/tures in due to discomfort"	F 325	3. Upon admission Dietary Manage designee will interview Resident by using the Initial Interdisciplinary Data Collection Tool / Nutrition Data. The Nutrition Data will be completed with Resident and family or Guardian to obtain pertinent information related any issues with Nutritional status. Speech therapy will communicate concerns, progress and intervention related to residents' nutritional state the center's weekly Medicare meet to the Dietary Manager, throughout course of therapy. Education will be provided on 12/2/13 to all Therapis Nursing and Dietary Staff to inform of the Signs/Symptoms that may indicate a decline in nutritional state the importance of accurate and consistent documentation of weigh and the new process that has been implemented in order to ensure the full meal refusals have been communicated to the appropriate person and documented.	y ata ane the the the the the the the the the th	
	On 10/10/13 Speec	h therapy wrote an				

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X3) MI	ITIDI	LE CONSTRUCTION	1	. 0938-0391
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	Interdisciplinary Rel "[R21] needs to be a dentures refit. Ever adherant paste] his gums and without d of progressing him to signed and reviewed A Physician Note da "Appetite is made a with his dentures fitt R21's Nutrition Data indicated, "No dentu Also indicated R21 to preferred to "nibble a was completed by th and R21's family me The Consultant Dieti 10/16/13, included, " nutritional risk team loss and decreased a two [pureed] diet; pla calorie nutritional sup times a day] for weig speech to evaluate for 2 diet may be impact consuming less then weight 10/15/13 116, 122. Weight loss rel hospital stay Will al monitoring with mont	nab Round note indicating, seen by the dentist to have his a with Fixodent [a denture dentures do not adhere to his entures there is no possibility to a regular diet." This was do by registered nurse (RN)-B. Ited 10/10/13, included, little bit difficult by difficulty ing at this time." Completed on 9/18/13, ures worn; does not wear." was a "meat man" and all day." This assessment he director of dietary services ember. Cian Note written on [R21] discussed with meeting secondary to weight appetite. He receives a level anned extras of NDS [a high oplement] 6 oz TID [three ht maintenance. He sees or proper diet texture. (Leveling intakes). He is 25-75% of meals; current admit weight (9/26/13) was ated to fluid losses from lso add to nutritional risk	F	325	4. Dietary Manager will review and the current weights for all residents are at risk for weight loss weekly to identify and implement immediate interventions for any resident who been conformed as having a weight of 3 or more pounds in one week. Audits of all CNA documentation of plan approaches, including daily intakes, weights and / or weight los will be completed by the Dietary Manager, and/or Designee(s) at the of each shift x 7 days, and random weekly audits x 5 weeks thereafter. These random weekly audits regar completion and documentation of pertinent care plan approaches will occur x 3 months to ensure complicated that all refusals are being documented and communicated to appropriate designated person, with results to QA for further recommendation. 5. Completion Date: December 6th, 2013	has at loss f care ss, e end ding ance the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
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F 325	by the dentist. RN-residents come in to facility usually "does of the family usually "does of the family told her to appointment made, also brought up the care conference and resident could eat a didn't need to wear documentation regarded to the family member of the order to be upgraded therapy recomment. During interview on family member (FM) had been getting restarting last week, food before at home dentures, and she coneeded to be fixed him to eat "regular" her he didn't like the taste and he does ref. FM-F stated she have garding R21's deidoes not recall being the state of the s	aware R21 needed to be seen A stated usually when of the facility for short term, the send to dental appointments." 10/31/13, at 10:35 a.m. (DON) stated the medical deshe called R21's family but they did not want a dental. The DON stated she had dentures during the initial destance of the anything without dentures and them. However, there was not arding any conversation with arding being offered a dental need to have dentures fit in the deto a regular diet per speech dations. 10/31/13, at 1:25 p.m. R21's gular food (not pureed) FM-F stated R21 ate regular ewithout wearing his did not realize his dentures in order for the facility to allow food. FM-F stated R21 told be ground up food and it had no not want to eat it anymore. It is despoken to the facility intures not fitting, however, she ag offered a dental	F3	,		1	
		ng informed R21 could not eat s dentures were fixed.					

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - HOWARD LAKE K(4) ID REPREY REPORT OF STATE OF THE APPROPRIATE OF THE AP		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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FREETY TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 325 Continued From page 35 During interview on 10/31/13, at 12:20 p.m. dietary manager (DM) stated she had completed the initial nutritional assessment on R21 and was told the resident had a poor appetite. DM stated she was not aware R21 was not eating because he didn't like the ground food. DM was unaware if R21 had dentures or not but she had been told the resident did not want to go to the dentist and dietary could not upgrade to regular food without the resident wearing dentures. R21 was not able to recall who had told her he did not want to go to the dentist. During interview on 11/1/13, at 9:35 a.m. speech therapist (ST)-A stated she made recommendations to the facility regarding R21 needing to be seen by the dentist to get his dentures to fit. ST-A stated she had never spoke directly to the resident or family about making a dental appointment. She had referred that to the facility and thought they were "taking care of it." During interview on 11/1/13, at 11:15 a.m. registered dietician (RD)-A stated she had not spoken to R21 and had only spoken to the facility at the nutrition risk meeting regarding the resident was on nutritional supplements and was seeing speech, but she was not aware of the recommendations regarding the resident needing to see the dentist. RD-A stated if R21 is losing weight related to not liking the pureed food, the facility should be working with the family regarding the feet of the family regarding the resident the early regarding the resident the family regarding the resident to ensure the			- HOWARD LAKE		4	13 13TH AVENUE		
During interview on 10/31/13, at 12:20 p.m. dietary manager (DM) stated she had completed the initial nutritional assessment on R21 and was told the resident had a poor appetite. DM stated she was not aware R21 was not eating because he didn't like the ground food. DM was unaware if R21 had dentures or not but she had been told the resident did not want to go to the dentist and dietary could not upgrade to regular food without the resident wearing dentures. R21 was not able to recall who had told her he did not want to go to the dentist. During interview on 11/1/13, at 9:35 a.m. speech therapist (ST)-A stated she made recommendations to the facility regarding R21 needing to be seen by the dentist to get his dentures to fit. ST-A stated she had never spoke directly to the resident or family about making a dental appointment. She had referred that to the facility and thought they were "taking care of it." During interview on 11/1/13, at 11:15 a.m. registered dietician (RD)-A stated she had not spoken to R21 and had only spoken to the facility at the nutrition risk meeting regarding the residents weight loss. She stated the resident was on nutritional supplements and was seeing speech, but she was not aware of the recommendations regarding the residents. RD-A stated if R21 is losing weight related to not liking the pureed food, the facility should be working with the family regarding upgrading the field to ensure the	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE .	COMPLETION
The facility policy entitled Dental/ Oral Health	F 325	During interview or dietary manager (E) the initial nutritional told the resident has she was not aware he didn't like the grif R21 had denture the resident did not dietary could not up the resident wearing to recall who had to the dentist. During interview or therapist (ST)-A starecommendations needing to be seen dentures to fit. ST directly to the residental appointment facility and thought. During interview or registered dietician spoken to R21 and at the nutrition risk residents weight lowas on nutritional speech, but she was recommendations to see the dentist. weight related to not facility should be was regarding upgrading resident receives the dentist of the sident receives the sident receives the dentist of the sident receives	in 10/31/13, at 12:20 p.m. OM) stated she had completed I assessment on R21 and was ad a poor appetite. DM stated R21 was not eating because ound food. DM was unaware is or not but she had been told it want to go to the dentist and ograde to regular food without ing dentures. R21 was not able old her he did not want to go to in 11/1/13, at 9:35 a.m. speech ated she made to the facility regarding R21 in by the dentist to get his in A stated she had never spoke the interval of the state of the they were "taking care of it." In 11/1/13, at 11:15 a.m. In (RD)-A stated she had not I had only spoken to the facility meeting regarding the iss. She stated the resident supplements and was seeing as not aware of the regarding the resident needing RD-A stated if R21 is losing out liking the pureed food, the rorking with the family ing the diet to ensure the he adequate nutrition.	F3	325			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
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F 325	Services and Asserinstructed, "The coan outside source dental services the and principles. Renecessary, in make appointments, array referral to a dentist denturesReferrated specialized care a given in obtaining appliances." 483.55(a) ROUTIN SERVICES IN SN The facility must prover resource, in accompart, routine and emergencessary, assist appointments; and to and from the deresidents with lost dentist. This REQUIREMED by: Based on observatives for instruction of the facility fental services for an outside the facility fental services for an outside for the facility fental services for an outside for the facility fental services for the facility f	essments dated 1/2009 enter will provide or obtain from routine and 24 hour emergency at meet professional standards esidents will be assisted, when ing routine and annual anging transportation and t in case of lost or damaged I will be made to appropriate s needed, as well as assistance appropriately fitting NE/EMERGENCY DENTAL	F 41		ved to /or poor res	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
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F 411	dysphasia (difficulty Minimum Data Set R21 had moderate extensive assistance daily living (ADL's), MDS did not identify loose fitting denture During observation was laying in bed wwas a set of denture a denture cup. On at 9:05 a.m. in the composition of the co	rd identifed diagnosis of speaking). The admission (MDS) dated 9/2/13, identified cognitive impairment, needed with with most activities of and had no natural teeth. The y that R21 had any broken or	F	411	3. All residents receive a compreher oral/dental assessment by a license nurse within 24 hours of admission, needed, as well as on a quarterly ba Good Samaritan Society - Howard L currently has a contract with Distinct Dental Services of Howard Lake, Ml order to provide on-site routine dentexams and cleanings annually, and referrals to see an orthodontist or or surgeon, if needed, are made at that as well as on an "as-needed", or emergency basis by the nursing staff throughout the year. On 11/27/13, an nursing staff received education registed importance of thorough oral care assessments, and the necessity of making an immediate referral if/when needed.	d as asis. ake ive N in al at time, f ll arding es,	
	stated his dentures to wear them anymer for "a while." R21 sto eat "mashed" (pudentures not fitting go to the dentist to able to recall the last dentist and he had a facility offering to as appointment. R21 sto wait until he was see a dentist.	do not fit him and he is unable ore. He stated they had not fit tated the facility required him ureed) food related to his properly, and he would like to get them fixed. R21 was not st time he had been to the not recalled anyone at the sist him in obtaining a dental stated he would probably have discharged from the facility to			 4. DNS / Designee will do random audits of all residents with denture ensure ongoing compliance regard proper fitting and related nutritionarisks. These audits will be done we x4 with results to QA for further recommendation. 5. Completion Date: December 6th, 2013 	ling I	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
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F 411		licated R21 had no natural and lower dentures and	F 41	11	9	
	R21, "Had no dent The information or	form dated 9/20/13, indicated ures worn, does not wear." I this form was obtained from the resident was documented				
		dated 10/10/13, included, a little bit difficult by difficulty itting at this time."			,	
	related to pureed of dysphasia. On 10, a Interdisciplinary "[R21] needs to be dentures refit. Eve adherent paste] his gums and without of progressing him	aluated by speech therapy diet and for a diagnoses of /10/13, Speech therapy wrote Rehab Round note indicating, seen by the dentist to have his en with Fixodent [a denture is dentures do not adhere to his dentures there is no possibility to a regular diet." This was stered nurse (RN)-B.				
	stated she was no by the dentist. RN	n 10/31/13 at 8:50 a.m. RN-A t aware R21 needed to be seen l-A stated usually when to the facility for short term the bes not do dental			n	
		n 10/31/13, at 10:35 a.m. the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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F 411	but the family told appointment made also brought up the care conference at resident could eat didn't need to weat documentation reg R21 or his wife reg appointment or the fit to be upgraded therapy recomment. During interview or family member (FN had been getting restarting last week. food at home with she did not realize fixed in order for the "regular" food. FM like the ground up does not want to e had spoken to the dentures not fitting being offered a deriver the care of the c	d she had called R21's family her they did not want a dental e. The DON stated she had e dentures during the initial and R21's wife stated the anything without dentures and rethem. However, there was no larding any conversation with larding being offered a dental e need to have dentures which to a regular diet per speech adations. In 10/31/13, at 1:25 p.m. R21's M)-F stated she thought R21 egular food (not pureed) FM-F stated R21 ate regular out wearing his dentures, and his dentures needed to be the facility to allow him to eat large food and it had no taste and he at it anymore. FM-F stated she facility regarding R21's however, she does not recall intal appointment or being	F4	11			
	A facility policy ent Services and Asse instructed, "The ce an outside source dental services tha and principles. Re necessary, in mak	d not eat regular food until his d. d. itled Dental/ Oral Health essments dated 1/2009, enter will provide or obtain from routine and 24 hour emergency at meet professional standards esidents will be assisted, when ing routine and annual enging transportation and			•		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	(X3) DA	(X3) DATE SURVEY COMPLETED	
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F 411	denturesReferral	in case of lost or damaged will be made to appropriate needed, as well as assistance	F 4				

Printed: 11/07/2013 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A. BUILDING 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED 245278 B. WING 11/07/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **413 13TH AVENUE** GOOD SAMARITAN SOCIETY - HOWARD LAK **HOWARD LAKE, MN 55349** (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 **FIRE SAFETY** A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey. Good Samaritan Society-Howard Lake was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Good Samaritan Society-Howard Lake is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1971 and was determined to be of Type II(111) construction. In 1981, an addition was constructed to the east wing and was determined to be of Type II(111) construction. Another addition was added in 1995 to the north wing and was determined to be Type II (111). Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 38 beds and had a census of 31 at time of the survey.

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

The requirement at 42 CFR, Subpart 483.70(a) is

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.

MET.

Printed: 11/07/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	R/CLIA /IBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DA CO		(X3) DATE SURVEY COMPLETED	
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Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7791

November 20, 2013

Ms. Laura Rindfleisch, Administrator Good Samaritan Society - Howard Lake 413 13th Avenue Howard Lake, Minnesota 55349

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5278021

Dear Ms. Rindfleisch:

The above facility was surveyed on October 28, 2013 through November 1, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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 Nursing Homes.

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

Good Samaritan Society - Howard Lake November 20, 2013 Page 2 and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to:

Brenda Fischer, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320) 223-7338

Fax: (320) 223-7348

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 me.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S COMPL	
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	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	2013, surveyors of the above provider orders were issued completed, please s these orders and re	TS: 30, 31 and November 1, this Department's staff visited and the following licensing . When corrections are sign and date, make a copy of eturn the original to the nent of Health, Division of		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal stag numbers have been assigned Minnesota state statutes/rules for Homes.	software.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Minnesota Department of Health

			(X3) DATE SURVEY COMPLETED			
		00019	B. WING		11/01/2013	
	PROVIDER OR SUPPLIER	- HOWARD LAKE 413 13TH	DRESS, CITY, S I AVENUE LAKE, MN	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET	Ë
2 000	Compliance Monito Certification Progra		2 000	The assigned tag number appears far left column entitled "ID Prefix The state statute/rule number and corresponding text of the state state out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met active evidenced by." Following the survifindings are the Suggested Method Correction and the Time Period Form Correction. PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION SUBMIT A PLAN OF CORRECTION SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Tag." the tute/rule es" oly" nis which after the s reyors d of or OING OF THIS ON FOR	
2 265	A nursing home mu policies to guide sta	st develop and implement off decisions to consult	2 265			
	practitioners, and if legal representative member of a reside accident, or death.	an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious. At a minimum, the director of and the medical director or an				

Minnesota Department of Health

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00019	B. WING		11/0	1/2013
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE 413 13TH	AVENUE LAKE, MN	55340		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 265	Continued From pa	ge 2	2 265			
	attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:					
	A. an accident involving the resident which results in injury and has the potential for requiring physician intervention;					
	B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;					
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				
	D. a decision t resident from the n	o transfer or discharge the ursing home; or				
	E. expected an	d unexpected resident deaths.				
	by: Based on interview facility failed to noti resident (R21) revie	and document review, the fy the physician for 1 of 1 ewed, who had a change in developed a pressure ulcer.				
	Findings include:					
	of left femur. The a	rd identified diagnosis fracture admission Minimum Data Set 3, identified R21 had				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00019	B. WING		11/	01/2013
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- HOWARD LAKE 413 13T	DDRESS, CITY, S H AVENUE D LAKE, MN	STATE, ZIP CODE 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 265	moderate cognitive extensive assistant daily living (ADL's), developing pressure R21's Daily Skilled 10/25/13- "Noted or what appears to be placed in treatment until resolved." 10/26/13- "What apremains on right big	impairment, needed be with with most activities of and was at high risk for	2 265	DEFICIENCY		
	great toe; no chang 10/28/13- "Blood bli no change noted in 10/29/13- "Blood bli 10/30/13- Blood blis When interviewed clicensed practical n nurses are monitori	ister intact on right great toe; size." ister on right great toe intact." ster on right great toe intact." on 10/30/13, at 12:40 p.m. urse (LPN)-A stated the ng the blood blister. LPN-A				
	stated she could no medical record that notified of this area. When interviewed coccupational therapjust started wearing week and a half agreemently had a "blo had not notified the	of find any where in R21's the physician had been the physician had been on 10/30/13, at 9:30 a.m. the poist (OT)-G stated R21 had a shoes in the last week to be she was not aware R21 od blister" on his right toe, and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7.1. 20.23			
		00019	B. WING		11/0	1/2013
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- H()WARI) I AKF	I AVENUE LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 265	A stated she had be blister" on his right have not been mead be difficult to know lack of monitoring. blister on his toe canot think it was presure "Doesn't wear shoop hysician had not be discovering the bloot the physician. When interviewed director of nursing made aware of the had not had time to verified the nurses assessment to dete documenting size, physician. DON stabeen done. She all beginning to wear hof the blood blister pressure of his shoop the physician of abnormal or unsured apressure area, the state of the physician of abnormal or unsured.	een monitoring R21's "blood toe. She stated the nurses asuring it and verified it would if it was healing related to the RN-A was unsure where the ame from but stated she did ssure related because R21, es." RN-A verified the been notified and the nurse od blister should have notified on 10/31/13, at 10:35 a.m. (DON) stated she was just blood blister two days ago but blook at the area. The DON should have done an ermine the cause, should be and should have notified the ated none of the above had so verified the timing of R21 his shoes and the development was probably related to the les. In a policy entitled Skilled and Documentation dated instructed, "Nursing lelp support a skilled nursing lelp support a skilled nursing lelp support and documentation table conditions"	2 265	DELIGITION)		

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
		00019	B. WING		11/0	1/2013	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE	LAKE, MN	55349			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 265	Continued From pa	ge 5	2 265				
	defines pressure ul localized area of dis blood-filled blister d	ure Ulcer Advisory Panel cer's, "Purple or maroon scolored intact skin or lue to damage of underlying ssure and or shear," as ssue injury."					
	The Director of Nur the policies and pro of the physician. A the physician of res educated regarding	THOD FOR CORRECTION: sing could review and revise ocedures regarding notification a staff involved with notifying ident changes could be the procedure. The quality ee could randomly audit ompliance.					
	TIME PERIOD FOR days.	R CORRECTION: Thirty (30)					
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565				
		omprehensive plan of care personnel involved in the					
	by: Based on interview facility failed to ens for 3 of 4 residents	and document review the ure the care plan was followed (R19 and R36 and R2) assessed as needing					

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
	00019		B. WING		11/0	1/2013	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE	AVENUE LAKE, MN	55349			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 565	Continued From pa	ge 6	2 565				
	restorative nursing	services.					
	Findings include:						
	R19 did not receive as directed by the c	e restorative nursing services care plan.					
	R19's quarterly Minimum Data Set (MDS) dated 9/12/13, included a diagnosis of schizophrenia and rheumatoid arthritis. The MDS indicated he was cognitively intact, did not reject cares, had functional limitations in range of motion of upper extremities, but did not receive a restorative nursing program.						
	restorative nursing directed staff to ass Restorator (an exeminutes, dowel exe	ted 9/18/13, included a program twice a week, and sist R19 with use of a rcise machine) for five ercises moving side to side and a forward and backwards and of ten.					
	dated 8/9/13, included developed a new refeels he can tolerate frequently which he Patient will use arm	rapy discharge summary ded, "Patient and therapist estorative program that patient e, despite having to rest says he had to do in the past. In bike for five minutes, lower or x 10 and dowel in all					
	R19's Care Plan Ap	oproaches report from 7/30/13					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00019	B. WING		11/	01/2013
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- HOWARD LAKE 413 1	T ADDRESS, CITY, S 3TH AVENUE ARD LAKE, MN	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 565	through 10/30/13, restorative nursing weeks, on 8/26/13 and include why R19 restorative program the care plan. When interviewed on ursing assistant (Not o assist residents who programs. She is of the afternoon to do assigned dining ser a full day restorative was cut back to just 2013. NA-B stated everyone with their of this, there is not a morning person," and program in the morn dining duties. NA-E to provide R19 with anyone. When interviewed of stated he always us nursing program in restorative aide. All	ge 7 evealed he had received his program only twice in these and 10/23/13. The report of the had not received the twice a week as directed by the twice and the twice nursing assistant, but this twices. The facility use to have nursing assistant, but this the treatment of the twice and will only do the restorative enough time. R19 "is a not will only do the restorative in the restorative program to the restorative program to the treatment of the twice the morning with the two the program. If they	d d d d d d d d d d d d d d d d d d d			
	would go. When interviewed cassistant director of though she is response restorative program	on 10/30/13, at 11:22 a.m. the financial financial financial for reviewing the last for each resident month. R19 was not attending as	en			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE S COMPL			E SURVEY PLETED	
00019		B. WING		11/0	01/2013	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	GOOD SAMARITAN SOCIETY - HOWARD LAKE 413 137 HOWAR			55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 8	2 565			
	directed by his care this to her.	plan. No one had reported				
	R36 did not receive program as directed	the restorative nursing d by the care plan.				
	diagnoses of diabet indicated he was co participated in a res	storative nursing program for ion (ROM) two times during				
	attend a restorative week. This would i minutes and/or up a	ted 9/4/13, indicated he was to nursing program twice a nclude, Restorator for ten and down the stairs twice, s with three pounds for 15				
	to 10/30/13, indicate program 14 times of was no documentate	oproaches report from 7/30/13 ed he received his restorative during these 13 weeks. There tion to indicated why R36 had ogram twice a week as				
	NA-B stated R36 do restorative nursing	on 10/31/13, at 10:22 a.m. bes not refuse to come to his program, but she does not assist him with it. She had anyone.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00019	B. WING		11/0	1/2013
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- HOWARD LAKE 413 13TH HOWARD	AVENUE LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	p a minimum p a		2 565			
	ADON stated she h program monthly, b being offered as dir one had reported th	the restorative nursing				
	The quarterly MDS moderate cognitive extensive assistance received a restoration	uded adult failure to thrive. dated 10/21/13, included impairment, required se with ambulation, and ve nursing program to include e in the assessment week.				
	assist with a restoral include ambulation walker to and from addition, the care puther use of the Rest standing alternate ruth upper extremit wooden box of six if exercises 20 repetiminutes and red pe	ed 11/28/12, directed staff to ative nursing program to with one assist and rolling all meals as tolerated. In lan directed staff to assist with orator as tolerated and/or marches 20 repetitions total y use on walker. Step up onto nches, and/or 3 pound seated tions bilateral. Pulleys for 5 gs and putty. This exercise cur daily seven days a week.				
	Summary dated 5/1 therapy (PT) had w 5/10/13, due to a de and out of bed. The staff to continue he "Current Level of Fr	apist Progress & Discharge 10/13, included physical orked with R2 4/15/13 through ecline in ability to transfer in e summary directed nursing r ambulation program. The unction," concluded R2 was 10 to 100 feet with a front				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00019	B. WING		11/0	1/2013
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE	I AVENUE LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	wheeled walker, wit	ge 10 th minimum assistance to hold e wheel chair behind.	2 565			
	through 10/31/13, s to ambulate to and care plan 655 times R2 only actually am 103 times. R2 had was no evidence R	broaches Report from 5/1/13 showed R2 had the opportunity from meals as directed by the s. The documentation showed abulated to and from meals refused 113 times. There 2 had been offered assistance from meals 439 times during				
	through 10/31/13 sl in the other restora Restorator, standin	proaches Report from 7/1/13 howed R2 had not participated tive nursing program with the g marches, pulleys or pegs his was should have occurred he frame.				
	stated she use to w She had to get help stated staff just sto just automatically to	on 10/31/13, at 1:31 p.m. R2 ralk to and from all the meals. of from staff to do this. R2 opped asking her to walk, and ake her in her wheel chair to ver been offered any other				
	stated she started v 2013, she had neve from meals. NA-A directed staff to ass	on 10/31/13, at 1:42 p.m. NA-A working in the facility in June er seen R2 ambulate to and was unaware R2's care plan sist her to ambulate to and was not aware of any other				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
			A. BOILDING.			
		00019	B. WING		11/0	1/2013
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE 413 13TH HOWARD	AVENUE LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 11	2 565			
	exercise program F	R2 was to participate in either.				
	ADON was unawar the restorative nurs care plan, even tho residents restorativ The ADON did state at times. No one hambulation and execompleted as direct During interview on Director of Nursing restorative aid who hired staff to compl and was not aware as ordered.	on 11/1/13, at 10:05 a.m. the e R2 was not participating with sing program as directed by the ugh she reviews each e nursing program monthly. e R2 would refuse to ambulate ad reported to her the ercise program were not being ted by the care plan. 11/1/13, at 10:33 a.m., the (DON) stated they had a quit in January 2013, they had ete the restorative programs they weren't receiving them				
	The administrator of system to educate system to ensure sidirected by the writing	THOD OF CORRECTION: or designee could develop a staff and develop a monitoring taff are providing care as ten plan of care. R CORRECTION: Twenty-one				
	(21) days.	, , , , , , , , , , , , , , , , , , ,				
2 885	MN Rule 4658.0529 Nursing Care; Prog	5 Subp. 1 Rehabilitation Iram required	2 885			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY LETED
			A. BOILDING			
		00019	B. WING		11/0	1/2013
NAME OF P	ROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY	- HOWARD LAKE	TH AVENUE D LAKE, MN	55349		
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
	must have an active nursing care directeresident to achieve practicable physical well-being according resident assessment in parts 4658.0400 efforts must be made and purposeful act. This MN Requirement by: Based on observation review, the facility favor as provided with a recommended, and ability declined for a for ambulation servatual harm for R2, avoidable decline in Findings include: R2's diagnoses include: R2's diagnoses include: R2's diagnoses included impairment, require transfers and amburestorative nursing ambulation one day. R2's care plan date assist with a restorative nursing ambulation, walker, to and from addition, the care properties are directly as a service plan date assist with a restorative nursing ambulation, walker, to and from addition, the care properties are directly as a service plan date a service plan date a service plan date a se	m required. A nursing home e program of rehabilitation ed toward assisting each and maintain the highest I, mental, and psychosocial g to the comprehensive nt and plan of care described and 4658.0405. Continuous de to encourage ambulation civities. ent is not met as evidenced ion, interview, and document ailed to ensure each resident ambulation services when d assessed when ambulation of 3 residents (R2) reviewed rices. This practice resulted in when she experienced and ability to ambulate. luded osteoarthritis. The Data Set (MDS) dated		DEI TOTENOT)		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D WING			
		00019	B. WING		11/0	1/2013
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	GOOD SAMARITAN SOCIETY - HOWARD LAKE 413 13T HOWAR			55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 885	and/or standing altered total with upper extronto wooden box or seated exercises 20 for 5 minutes and refered 5/1 therapy (PT) had we through 5/10/13, dutransfer in and out on ursing staff to compare the "Current Level was able to ambulated walker, we hold onto R2 and possible to another exercises at all. Restorator, standing exercises at all. Restorator, standing exercises at all. Restorator, There was why it was missed from 10/28/13, at 5:00	ernate marches 20 repetitions remity use on walker. Step up of six inches, and/or 3 pound 0 repetitions bilateral. Pulleys ed pegs and putty. apist Progress & Discharge 10/13, included physical rorked with R2 4/15/13 use to a decline in ability to of bed. The summary directed attinue her ambulation program. of Function," concluded R2 ate 60 to 100 feet, with a front with minimum assistance to sull the wheel chair behind. Proaches Report from May 1, ber 31, 2013, showed R2 had ambulate to and from meals as a plan 655 times. The lowed R2 only actually rom meals 103 times. R2 had There was no evidence R2 ssistance to ambulate to and er 439 times during this time no documentation to indicate abulated these 439 times. Proaches Report from July 1, ber 31, 2013 showed R2 had the exercise program with the granches, pulleys or pegs 12 should have been offered for the 123 days in this time no documentation to indicate no documentation to indicate	2 885			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00019	B. WING		11/0	1/2013
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- HOWARD LAKE 413 13TH	DRESS, CITY, S I AVENUE LAKE, MN	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 885	was propelled out of chair by an unknow R2 was observed in wheelchair watching. When interviewed on ursing assistant (N dining aide in the morestorative program the facility use to ha aide, but that had chalf a day. NA-B sto do everyone's reshe had not reportenever assisted R2 to that was care planning had not been instruited. When interviewed of stated she use to wand that she require this. R2 stated that just stopped asking automatically take in chair. R2 did not know the state of the state o	of the dining room in her wheel on staff person. At 6:50 p.m. in her room sitting in her g television. On 10/30/13, at 11:30 a.m. NA)-B stated she works as a ornings and does the is in the afternoons. NA-B said ave a full day restorative nurse hanged in April 2013, to just ated there is not enough time storative program, but verified and this to anyone. NA-B had on do her exercise programined to occur every day. She	2 885			
	wheelchair in her robed. Nursing assist medication aide (TN with two person assambulated to and from that since she had June 2013, she had and from meals. Nursing plan directed staff to	2 p.m. R2 was sitting in her from. R2 requested to lie in ant (NA)-A and trained MA)-A assisted R2 into bed, sist. NA-A stated R2 had not from lunch today. NA-A stated started working in the facility in a never seen R2 ambulate to A-A was unaware R2's care to assist her to ambulate to A-A was not aware of any other				

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00019	B. WING		11/01/2013	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE	AVENUE LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 885	next to the dining rousing the hallway gethe hall. R2 was as (PT)-A if she could can't walk anymore ambulate. NA-A arwith a transfer belt was able to ambulate assistance of two nalso pulling the whostated in May 2013 to 100 feet with only PT-A stated R2 hastambulate. PT-A stated R2 hastambulate. PT-A stated R2 use to aranymore, "it is too had to have a stated this changes at the stated the nursing a restorative program that duty to work or happens when staff "just short."	a.m. R2 was in the hallway from sitting in her wheelchair, rab bars to pull herself down ked by the physical therapist watch her walk. R2 replied, "I was agreed to attempt to ad NA-D assisted R2 to stand and front wheeled walker. R2 ate 20 feet with weight bearing assistants who were beel chair behind her. PT-A, R2 was able to ambulate 60 yone assist, for balance. d declined in her ability to ated staff needed to	2 885	DEFICIENCY)		
	Summary Quarterly "Resident has goals [ambulation] and O and physical therap AMB [ambulate] [w then [one] assist to	review dated 8/7/13, included s of participation in AMB T/PT [occupational therapy by]Resident continues to ith] assist of [two] to get up AMB [ambulate]. Often er reason than "I'm 101 years				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00019		B. WING		11/0	1/2013
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- HOWARD I AKE	13 13TH	DRESS, CITY, S AVENUE LAKE, MN	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIOI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 885	Continued From pa	ge 16		2 885			
	" Goal of ambulat [related to] refusals hundred, I shouldn't When interviewed of assistant director of does the reviews or nursing program ev R2 had not been particularly nursing programs in ambulation as direct ADON said if R2 was documented and restated she should restate she should restated she should restate she should r	ew dated 10/21/13, incluing to all meals not met. Simply states, "I'm at have to" on 11/1/13, at 10:05 a.m f nursing (ADON) stated neach resident's restoratery month, but was unatticipating with the restorational meaning exercise and sted by the care plan. The as refusing, it should be prorted to her. The ADO eview the Care Plan as and speak with nursing e reviews the restorative not. The ADON did not inary Assessment and did not address the exercise care planned to do.	the she ative aware prative he				
	included R2 had a	en Form dated 11/1/13, change in condition and odification of the function am.					
	Director of Nursing restorative aid who had hired staff to coprograms, but was not being implement refused to ambulate it wasn't being offer not know R2 had no	on 11/1/13, at 10:33 a.m (DON) stated they had a quit in January 2013, ar omplete the restorative not aware the programs nted. The DON stated Fie at times, she was not a ed. The DON stated shever received the exercised have helped with R2's ance.	a and they were as ware aware le did se				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00019	B. WING		11/0	1/2013
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD I AKE	H AVENUE D LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 885	Continued From pa	ge 17	2 885			
	Restorative Nursing revised 1/2013, indidocument restoration for re-screens, document occurred; upon do follow-up and management.	rative Nursing Program/ g Documentation policy, last icated the purpose is to ve nursing appropriately. " ument if a functional change comparison with last screen, ake referral to therapists as progress and reason as well ecrease in goals."				
	SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the policy and procedures related to continued resident assessment for range of motion programs and ambulation needs and the prevention of contractures. Administer or designee could provide ongoing education to all staff to ensure residents do not experience a loss in range of motion or ambulation.		6			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-on-	Э			
2 895	MN Rule 4658.0528 Motion	5 Subp. 2.B Rehab - Range o	2 895			
	that is directed towa through positioning implemented and m comprehensive resi of nursing services	motion. A supportive prograr ard prevention of deformities and range of motion must be naintained. Based on the ident assessment, the directo must coordinate the ursing care plan which				
		h a limited range of motion e treatment and services to				

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00019	B. WING		11/01/2013	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE	LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 18	2 895			
	increase range of n decrease in range of	notion and to prevent further of motion.				
	by: Based on observative review, the facility for recommended rest prevent a decline in	orative nursing services, to range of motion, for 2 of 3 36) reviewed who had				
	Findings include:					
	R19 did not receive as directed.	restorative nursing services				
	9/12/13, included a and rheumatoid art was cognitively inta functional limitation	imum Data Set (MDS) dated diagnoses of schizophrenia hritis. The MDS indicated he act, did not reject cares, had s in range of motion of upper not receive a restorative				
	restorative nursing directed staff to ass Restorator (an exer minutes, dowel exe	ted 9/18/13, included a program twice a week, and sist R19 with use of a rcise machine) for five ercises moving side to side and forward and backwards and of ten.				
	B19's Physical The	rapy discharge summary				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED		
		00019		B. WING		11/	01/2013
	PROVIDER OR SUPPLIER	- HOWARD LAKE	413 13TH	DRESS, CITY, S I AVENUE LAKE, MN	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 895	dated 8/9/13, included developed a new refeels he can tolerate frequently which he Patient will use arm extremity Restorate planes." R19's Care Plan Apthrough 10/30/13, restorative nursing	led, "Patient and the estorative program the estorative program the estorative program the says he had to do in bike for five minutes or x 10 and dowel in a expression and the program only twice in the extension of the extensio	at patient rest in the past. is, lower all in 7/30/13 ived his in these 13	2 895			
	weeks, on 8/26/13 and 10/23/13. The report did not include why R19 had not received the restorative program twice a week as directed by the care plan. When interviewed on 10/30/13, at 11:30 a.m. nursing assistant (NA)-B stated she works as a dining aide in the mornings, and does the restorative programs in the afternoons. NA-B stated she had not been able to offer R19 his restorative program since she does not have time, and also stated R19 is a morning person and she is unable to offer the restorative nursing						
	it in the afternoon. facility used to have all day but that was When interviewed of stated he used to a program in the more rehab aide had retitle staff no longer a exercise program.	orning. R19 does not NA-B further stated restorative aide that stopped in January on 10/30/13, at 1:03 laways go to his restoration with the rehab a red about six months asked him to go to the R20 also stated if the gram to him in the months.	I the t worked 2013. o.m. R19 rative aide. The s ago, and e e staff				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00019	B. WING		11/0	11/01/2013	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE	LAKE, MN	55349			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
2 895	Continued From pa	ge 20	2 895				
	would attend.						
	assistant director o reviews the restora she was not aware program. She state attending and shou the staff should inf there program. During observation was observed to be completing his rest with no difficulties. During interview on	on 10/30/13, at 11:22 a.m. the f nursing (ADON) stated she tive programs monthly, but R19 was not attending his ed she just assumed he was ldn't have. The ADON stated orm her if someone is refusing 10/31/13, at 1:03 p.m. R19 in the therapy room orative program with NA-B 10/31/13 at 1:10 p.m., NA-B eed to complete his program					
	R36 did not receive program as ordered	his restorative nursing d.					
	diagnoses of diabe indicated he was co extensive assistand participated in a res	S dated 9/4/13, included tes and depression. The MDS ognitively intact, required the with dressing, and storative nursing program for the during the assessment					
		ted 9/4/13, included a					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00019	B. WING		11/0	01/2013
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- HOWARD LAKE 413 13T	DDRESS, CITY, S H AVENUE D LAKE, MN	STATE, ZIP CODE 55349		
(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)	ULD BE	(X5) COMPLETE DATE
2 895	directed staff to ass ten minutes, and/or and/or leg exercises 15 repetitions. R36's Care Plan Ap to 10/30/13, indicate restorative program	sist R36 with the Restorator for up and down the stairs twice is with three pound weights for opproaches report from 7/30/13 ed R36 had only received his a 14 times out of 24	,			
	indicate why R36 had times as directed by When interviewed of NA-B stated R36 diameters in program, but the state of the s	on 10/31/13, at 10:22 a.m. loes not refuse his restorative ut she doesn't always have ist him with it. She had not				
	ADON stated R36 of restorative program attending the program also stated the staff	on 10/31/13, at 12:30 p.m. the doesn't not refuse his i, she had thought he was am as ordered. The ADON f had not informed her he restorative nursing.				
	was observed in the restorative program When interviewed on NA-B stated R19 &	on 10/31/13, at 1:30 p.m. R36 had not declined in their				
	functional range of When interviewed of	motion (ROM). on 11/1/13. at 9:43 a.m. NA-C				

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STATEMENT OF DEFICIENCIES (X1)

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00019	B. WING		11/0	1/2013
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE 413 13TH HOWARD	AVENUE LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 22	2 895			
	there ROM. NA-C have a restorative a the restorative prog but there is just not	nad not had any declines in also stated the facility used to aide who worked all day and grams were completed then, enough time to complete are only allowed half a day. ed this to anyone.				
	director of nursing (restorative aid who hired staff to compl	on 11/1/13, at 10:33 a.m. the (DON) stated they had a quit in January 2013, they had ete the restorative programs of formed they were not being red.				
	A policy was request facility.	sted, but not provided by the				
	SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise the policies and procedures for the range of motion programs, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance.					
	TIME PERIOD FOR days.	R CORRECTION: Thirty (30)				
2 900	MN Rule 4658.0529 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				

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PRINTED: 11/19/2013 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00019 11/01/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **413 13TH AVENUE GOOD SAMARITAN SOCIETY - HOWARD LAKE HOWARD LAKE, MN 55349** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 900 Continued From page 23 2 900 A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based observation, interview, and record review, the facility failed to ensure 1 of 3 residents (R21) reviewed for pressure ulcers, had the pressure area assessed, monitored, and had interventions in place to promote healing. Findings include: R21 diagnosis included a fracture of the left femur. The admission Minimum Data Set (MDS)

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pressure ulcers.

until resolved."

dated 9/24/13, identified R21 had moderate cognitive impairment, needed extensive

assistance with with most activities of daily living (ADL's), and was at high risk for developing

R21's Daily Skilled Notes included the following:

10/25/13- "Noted on right big toe on right foot what appears to be a blood blister; nickel size... placed in treatment book to monitor every shift

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00019	B. WING		11/01/2013	
NAME OF I	PROVIDER OR SUPPLIER		DDECC CITY O	STATE, ZIP CODE	11/0	1/2013
		413 13TH	I AVENUE	STATE, ZIF GODE		
GOODS	AMARITAN SOCIETY	- HOWARD LAKE	LAKE, MN	55349		
(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 APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 900	Continued From pa	age 24	2 900			
2 900	10/26/13- "What apremains on right big size." 10/27/13- "Blood bl great toe; no change 10/28/13- "Blood bl no change noted in 10/29/13- "Blood bli 10/30/13- Blood bli 10/30/13- Blood blis R21 was observed a wheelchair prope towards his room fi wearing black sock On 10/30/13, at 12: nurse (LPN)-A obsetoe. LPN-A stated area, but not meas it. LPN-A verified the regarding the cause measurements to be to the physician to being done to ensure the physician to be being done to ensure the physician of the physician of the physician to be independent of the physician to be independent of the physician to be independent of the physician of the physician of the physician. During interview on occupational therapy	opears to be a blood blister g toe, noted no change in lister remains intact on right ge in size." lister intact on right great toe; a size." lister on right great toe intact." ster on right great toe intact." on 10/30/13, at 12:30 a.m. in alling himself with his feet back from the dining room. R21 was as and black slip on shoes. 140 p.m. licensed practical erved R21's blister on his right the nurses are monitoring the uring or doing any treatment to here was no assessment e of the pressure ulcer, ensure healing, or notification ensure adequate treatment is are healing. LPN-A stated the discovers the pressure area is suring the assessment and oppropriate, and notify's the	2 900			
	week and a half. So	g shoes in the last week to she was not aware R21 nod blister" on his right toe. The have been caused by the				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00019		B. WING		11/	01/2013
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- HOWARD LAKE	413 13TH	DRESS, CITY, S I AVENUE LAKE, MN	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 900	During interview on stated she had bee blister" on his right have not been mea be difficult to know lack of monitoring. blister on his toe ca not think it was pres "doesn't wear shoe assessment, interve physician and state area should have d	ge 25 10/31/13, at 9:45 a.r n "monitoring" R21's toe. She stated the r suring it and verified if it was healing relate RN-A was unsure wl me from but stated s ssure related becaus s." RN-A verified the entions, or notification d the nurse discoverione the assessment nine what caused the	"blood nurses it would ed to the nere the she did e R21 re was no n to the ing the	2 900			
	director of nursing (made aware of the had not had time to verified the nurses assessment to dete documenting size, a physician. DON stabeen done. She also beginning to wear hof the blood blister pressure of his sho aware if any staff hafit properly to ensur on his right toe. Although R21 had of a pressure area, the assessment was considered.	10/31/13, at 10:35 at DON) stated she was blood blister 2 days at look at the area. Do should have done and ermine the cause, should have noticated none of the above so verified the timing his shoes and the devices. DON stated she ad determined if R21 e healing of the present developed a "blood be facility failed to ensure more report into place to	s just ago but DN ould be fied the ve had of R21 velopment to the was not 's shoes sure ulcer lister" on ure an nonitoring				
	Nursing Coverage	d a policy entitled Ski and Documentation, "Nursing documenta	dated				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00019	B. WING		11/0	1/2013
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD I AKE	I AVENUE LAKE, MN	55349		
(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
2 900	help support a skille include assessmen physician contacts a abnormal or unstab The National Press defines pressure ule or maroon localized or blood-filled bliste	ed nursing service should ts, nursing concerns, and documentation of ale conditions" ure Ulcer Advisory Panel cer's which appear as, "Purple I area of discolored intact skin r due to damage of underlying ssure and or shear," as	2 900			
	The Director of Nur policies and proced residents at risk for educate staff on pre develop a monitorin compliance.	HOD OF CORRECTION: sing or designee could review ures regarding care for or with pressure ulcers, essure ulcers protocols and ng system to ensure R CORRECTION: Twenty one				
2 910	Incontinence Subp. 5. Incontiner have a continuous properties a continuous properties and a comprehensive results and a resident without an indwellinunless the resident that catheterization	of Subp. 5 A.B Rehab - ance. A nursing home must brogram of bowel and bladder luce incontinence and the freatheters. Based on the ident assessment, a nursing that: the enters a nursing home greatheter is not catheterized solinical condition indicates was necessary; and no is incontinent of bladder	2 910			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00019	B. WING		11/0	1/2013
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- HOWARD LAKE	AVENUE LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROIDEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 910	receives appropriat	ge 27 e treatment and services to t infections and to restore as er function as possible.	2 910			
	by: Based on observati review, the facility f assess the continue indwelling urinary c	ent is not met as evidenced on, interview, and document ailed to comprehensively ed need for the use of an atheter for 1 of 2 residents o had an indwelling urinary				
	Findings include:					
	and cerebrovascula admission Minimum 09/26/13, indicated and needed extens The MDS also indic catheter. R20's Un Indwelling Catheter dated 09/27/13, inc [name brand of catheter hospitalization and for ease in voiding.	cluded multiple sclerosis (MS) ar accident (CVA). The n Data Set (MDS) dated R20 was cognitively intact ive assistance with toileting. Cated she had an indwelling inary Incontinence and Care Area Assessment (CAA) luded, "Resident had Foley heter] placed during prefers to keep in at this point Is aware of infection risks. Eath [catheter] management				
	inability to toilet self Will have no urinary	ted 09/18/12, included, " f and indwelling Foley cath. y tract infections. Will progress ation of catheter. Cath cares Q				

PRINTED: 11/19/2013 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ B. WING 00019 11/01/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **413 13TH AVENUE GOOD SAMARITAN SOCIETY - HOWARD LAKE HOWARD LAKE, MN 55349** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 9 1 0 Continued From page 28 2 9 1 0 [every] shift. No leg bag in use when in bed." R20's physician orders dated 09/18/13, included, "Urinary drain: you have a urinary drain the reason for the drain is inability to get to the toilet...Urinary drain voiding trial: Pt [patient] has declined Foley removal. Prefers to keep in for ease, understands infection risk. Please keep addressing with her when she would agree to Foley removal." During observation on 10/28/13, at 6:15 p.m., R20 was observed to be sitting in her Broda [name brand] chair eating her supper meal in her room with her catheter bag attached to her chair on the right side. When interviewed on 10/29/13, at 1:00 p.m. R20 stated she has MS and has not been able to walk for the last 10 years while living at home. R20 also stated she would like to get back her bladder control, as she did prior to her CVA. R20 verified that since admission to the facility on 09/18/13, staff or her physician have not mentioned to her

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any attempts to remove her urinary catheter.

When interviewed on 10/29/13, at 2:11 p.m., nursing assistant (NA)-C stated R20 has a catheter because she has difficulty with mobility

due to her recent stroke.

During observation on 10/29/13 at 2:01 p.m., R20 was observed to be lying watching TV with her catheter bag hanging on the right side of the bed.

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00019	B. WING		11/0	1/2013
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE 413 13TH	AVENUE LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	Continued From page 29		2 910			
	director of nursing (admitted to the faci catheter, and she the "to discharge cathe	on 10/30/13, at 11:05 a.m., the (DON) stated R20 was lity with the indwelling ninks the doctor orders read ter when patient wants it N had not addressed removal R20.				
	included, "she [R20 catheter in place ar	ogress note, dated 10/24/13, of continues to have Foley and has not had any issues cipate we will discontinue it her home."				
	R20's Nursing Progress notes dated 09/18/13 through 10/28/13, only indicated R20 has a Foley catheter and a description of the fluid observed in the catheter bag. The notes did not include any discussion with R20 regarding the removal of the indwelling catheter.					
	revised 11/09, inclumay require cathete bladder distention of to a tumor or enlarge Multiple Sclerosis have documentation indwelling catheters attempts It is reconstituted at least to	cled Catheterization on) Insertion and Removal, ded "clinical conditions that erization include: relieve due to: urinary obstruction due ged prostate, urine retention, The medical record must n of attempts to remove and the results of these ommended that removal be wo or three times during it can be determined that it is				
	Although R20 had t	he indwelling catheter placed				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

O0019

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

(X4) PROVIDER/SUPPLIER/CLIA A. BUILDING: (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

c c c	Continued From page 30 prior to admission due to a recent CVA, R20 wanted to regain bladder control, and the physician ordered to attempt removal, the facility did not make any attempt to discontinue the catheter during her stay at the facility.	2 910	
jı c	SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents are comprehensively assessed for urinary catheter justification. The director of nursing or designee could educate all appropriate staff members and develop monitoring systems to ensure ongoing compliance.		
Т	TIME PERIOD FOR CORRECTION: Twenty-one (21) Days		

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Minnesota Department of Health

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 501251110.			
		00019	B. WING		11/0	1/2013
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE 413 13TH HOWARD	LAKE, MN	55349		
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 31	2 965			
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status		2 965			
	must ensure that a which supplies the determined by the cassessment. Subs	onal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food				
	by: Based on observative review, the facility for (R21) reviewed who was comprehensive	ent is not met as evidenced ion, interview, and document ailed to ensure 1 of 1 resident to had a significant weight loss, by assessed to determine plement a nutritional program reight loss.				
	Findings include:					
	speaking). The add (MDS) dated 9/24/1 cognitive impairment assistance with with (ADL's), and had no	cluded dysphasia (difficulty mission Minimum Data Set 13, identified moderate nt, needed extensive n most activities of daily living o natural teeth. The MDS did 1 had any broken or loose				
	Review of R21's we follows:	eights were documented as				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00019	B. WING		11/0	1/2013
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- HOWARD I AKE	H AVENUE D LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 965	9/17/13 (admission) 9/24/13- 122 lbs. 10/1/13- 119 lbs. 10/9/13- 115.5 lbs. 10/23/13- 117 lbs. 10/26/13- 114.5 lbs 10/30/13- 118 lbs. R21 was weighed a weight of 115 lbs. N stated R21 has bee since admission. T in the 43 days since percent weight loss When interviewed a stated his dentures to wear them any m while." R21 stated eat "mashed" (pure dentures not fitting go to the dentist to regular food. R21 s ground up food bed stated he was losing. The Physical Nursir indicated R21 had m (swelling), weight w and lower dentures him?"	gain on 10/31/13, with a Nursing assistant (NA)-A en weighed on this same sale his was a 12.5 lbs weight loss a admission, almost a 10				
		notes included the following:				

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:

(X3) DATE SURVEY COMPLETED

B. WING ___

00019

11/01/2013

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

413 13TH AVENUE

GOOD S	GOOD SAMARITAN SOCIETY - HOWARD LAKE HOWARD LAKE, MN 55349									
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE						
2 965	Continued From page 33	2 965								
	10/7/13- "Patient has dentures but states he doesn't wear them complains of not liking ground up food. Education on why need to wear dentures to participate in trails of upgrade food." 10/10/13- Speech therapy trialed R21's dentures with Fixodent. "Bottom denture came loose but top dentures stayed fixed. Patient feels it is easier to chew without his dentures inpatient unwilling/unable to keep dentures in due to discomfort"									
	On 10/10/13 Speech therapy wrote an Interdisciplinary Rehab Round note indicating, "[R21] needs to be seen by the dentist to have his dentures refit. Even with Fixodent [a denture adherant paste] his dentures do not adhere to his gums and without dentures there is no possibility of progressing him to a regular diet." This was signed and reviewed by registered nurse (RN)-B.									
	A Physician Note dated 10/10/13, included, "Appetite is made a little bit difficult by difficulty with his dentures fitting at this time."									
	R21's Nutrition Data completed on 9/18/13, indicated, "No dentures worn; does not wear." Also indicated R21 was a "meat man" and preferred to "nibble all day." This assessment was completed by the director of dietary services and R21's family member.									
	The Consultant Dietician Note written on 10/16/13, included, "[R21] discussed with nutritional risk team meeting secondary to weight loss and decreased appetite. He receives a level									

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00019	B. WING		11/0	1/2013
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE 413 13TH	AVENUE LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	two [pureed] diet; p calorie nutritional st times a day] for wei speech to evaluate 2 diet may be impactonsuming less the weight 10/15/13 116 122. Weight loss re hospital stay Will monitoring with monito	lanned extras of NDS [a high upplement] 6 oz TID [three ight maintenance. He sees for proper diet texture. (Level cting intakes). He is in 25-75% of meals; current 6, admit weight (9/26/13) was elated to fluid losses from also add to nutritional risk nthly review" 10/31/13, at 8:50 a.m. RN-A aware R21 needed to be seen A stated usually when the facility for short term, the is not do dental appointments." 10/31/13, at 10:35 a.m. (DON) stated the medical dishe called R21's family but they did not want a dental at The DON stated she had dentures during the initial and R21's wife stated the anything without dentures and them. However, there was no arding any conversation with arding being offered a dental need to have dentures fit in ed to a regular diet per speech	2 965			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00019	B. WING		11/	01/2013
	PROVIDER OR SUPPLIER	- HOWARD LAKE 413 13	ADDRESS, CITY, S TH AVENUE RD LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
2 965	dentures, and she of needed to be fixed him to eat "regular" her he didn't like the taste and he does of FM-F stated she has regarding R21's dedoes not recall bein appointment or bein regular food until him. During interview on dietary manager (Dietary manager	did not realize his dentures in order for the facility to allow food. FM-F stated R21 told a ground up food and it had not want to eat it anymore. It is spoken to the facility intures not fitting, however, sharp offered a dental and informed R21 could not eas dentures were fixed. 10/31/13, at 12:20 p.m. M) stated she had completed assessment on R21 and was da poor appetite. DM stated R21 was not eating because ound food. DM was unaware so or not but she had been told want to go to the dentist and orgade to regular food without g dentures. R21 was not abled her he did not want to go to the dentist and a point of the dentist and organize to regular food without g dentures. R21 was not abled her he did not want to go to the dentist and a point of the dentity o	ee et t			
	registered dietician spoken to R21 and	11/1/13, at 11:15 a.m. (RD)-A stated she had not had only spoken to the facilit meeting regarding the	у			

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Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING ____ 00019

STREET ADDRESS, CITY, STATE, ZIP CODE 413 13TH AVENUE HOWARD LAKE, MN 55349							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
2 965	residents weight loss. She stated the resident was on nutritional supplements and was seeing speech, but she was not aware of the recommendations regarding the resident needing to see the dentist. RD-A stated if R21 is losing weight related to not liking the pureed food, the facility should be working with the family regarding upgrading the diet to ensure the resident receives the adequate nutrition. The facility policy entitled Dental/ Oral Health Services and Assessments dated 1/2009 instructed, "The center will provide or obtain from an outside source routine and 24 hour emergency dental services that meet professional standards and principles. Residents will be assisted, when necessary, in making routine and annual appointments, arranging transportation and referral to a dentist in case of lost or damaged denturesReferral will be made to appropriate specialized care as needed, as well as assistance given in obtaining appropriately fitting appliances."	2 965					
	SUGGESTED METHOD FOR CORRECTION: The Director of Nursing (DON) or designee could develop and implement policies and procedures to ensure residents at nutritional risk received appropriate interventions to maintain nutrition as determined necessary by their individualized assessment to ensure healing. The DON or her designee could educate all appropriate staff on the policies and procedures. The DON could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one						

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Minnesota Department of Health

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00019	B. WING		11/0	1/2013
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE 413 13TH HOWARD	AVENUE LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21325	Subpart 1. Routing home must provide resource, routine do needs of each residinclude dental exantillings and crowns, oral surgery, bridge orthodontic proceduthat are provided for community at large reimbursement politic This MN Requirement by: Based on observation reviewed regarding Findings include: R21's medical record dysphasia (difficulty Minimum Data Set R21 had moderate extensive assistant daily living (ADL's), MDS did not identificate loose fitting dentured by was a set of dentured to the subpart of t	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, s and removable dentures, ares, and adjunctive services or similar dental patients in the as limited by third party cies. The is not met as evidenced on, interview, and document alled to provide necessary of 1 resident (R21) who was dentures which did not fit. The identified diagnosis of a speaking). The admission (MDS) dated 9/2/13, identified cognitive impairment, needed the with with most activities of and had no natural teeth. The y that R21 had any broken or	21325			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00019		B. WING		11/	01/2013
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- HOWARD LAKE	113 13TH	ORESS, CITY, S AVENUE LAKE, MN	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21325	at 9:05 a.m. in the country with milk. The reside bottom dentures. During interview on stated his dentures to wear them anym	dining room eating cheed dent was not wearing to 10/28/13, at 6:30 p.m. do not fit him and he is ore. He stated they ha	R21 unable d not fit	21325			
	to eat "mashed" (pudentures not fitting go to the dentist to able to recall the laddentist and he had facility offering to as appointment. R21	stated the facility require ureed) food related to he properly, and he would get them fixed. R21 was time he had been to not recalled anyone at easist him in obtaining a stated he would probable discharged from the face	is like to as not the dental bly have				
	dated 9/17/13, indi	ciplinary Data Collectic cated R21 had no natu nd lower dentures and him?"					
	R21, "Had no dentu The information on	form dated 9/20/13, ind ires worn, does not wea this form was obtained the resident was docum	ar." from				
		ated 10/10/13, included little bit difficult by diffic ting at this time."					
		luated by speech thera et and for a diagnoses					

Minnesota Department of Health

STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00019	B. WING		11/0	1/2013
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE 413 13TH HOWARD	AVENUE LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21325	dysphasia. On 10/a Interdisciplinary F "[R21] needs to be dentures refit. Eve adherent paste] his gums and without of progressing him signed off by Regis During interview on stated she was not by the dentist. RN-residents come in tracility usually, "Dog appointments." During interview on director of nursing (records person said but the family told happointment made also brought up the care conference and resident could eat a didn't need to wear documentation regal R21 or his wife regal appointment or the fit to be upgraded to the therapy recomment. During interview on family member (FN had been getting restarting last week.	10/13, Speech therapy wrote Rehab Round note indicating, seen by the dentist to have his n with Fixodent [a denture dentures do not adhere to his lentures there is no possibility to a regular diet." This was tered nurse (RN)-B. 10/31/13 at 8:50 a.m. RN-A aware R21 needed to be seen A stated usually when the facility for short term the est not do dental 10/31/13, at 10:35 a.m. the EDON) stated the medical deshe had called R21's family ter they did not want a dental The DON stated she had dentures during the initial destant R21's wife stated the anything without dentures and them. However, there was no arding any conversation with arding being offered a dental need to have dentures which to a regular diet per speech	21325			

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Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING: _____

00019

B. WING _

Description Summary Statement of Descicion Cies Providers Pack Not Confection Commercial Co	STREET ADDRESS, CITY, STATE, ZIP CODE 413 13TH AVENUE HOWARD LAKE HOWARD LAKE, MN 55349							
fixed in order for the facility to allow him to eat "regular" food. FM-F stated R21 told her he didn't like the ground up food and it had no taste and he does not want to eat it anymore. FM-F stated she had spoken to the facility regarding R21's dentures not fitting, however, she does not recall being offered a dental appointment or being informed R21 could not eat regular food until his dentures were fixed. A facility policy entitled Dental/ Oral Health Services and Assessments dated 1/2009, instructed. "The center will provide or obtain from an outside source routine and 24 hour emergency dental services that meet professional standards and principles. Residents will be assisted, when necessary, in making routine and annual appointments, arranging transportation and referral to a dentist in case of lost or damaged denturesReferral will be made to appropriate specialized care as needed, as well as assistance given in obtaining appropriately fitting appliances." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review and revise the policies and procedures for the dental assessments and providing routine dental services, educate the appropriate personnel, and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30)	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETI			
		Continued From page 40 fixed in order for the facility to allow him to eat "regular" food. FM-F stated R21 told her he didn't like the ground up food and it had no taste and he does not want to eat it anymore. FM-F stated she had spoken to the facility regarding R21's dentures not fitting, however, she does not recall being offered a dental appointment or being informed R21 could not eat regular food until his dentures were fixed. A facility policy entitled Dental/ Oral Health Services and Assessments dated 1/2009, instructed, "The center will provide or obtain from an outside source routine and 24 hour emergency dental services that meet professional standards and principles. Residents will be assisted, when necessary, in making routine and annual appointments, arranging transportation and referral to a dentist in case of lost or damaged denturesReferral will be made to appropriate specialized care as needed, as well as assistance given in obtaining appropriately fitting appliances." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review and revise the policies and procedures for the dental assessments and providing routine dental services, educate the appropriate personnel, and appoint a designee to monitor the procedures to	21325					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00019	B. WING		11/0	1/2013
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- H()WARI) I AKF	LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21475	Continued From pa	ge 41	21475			
21475	MN Rule 4658.1009 General Requirement	5 Subp. 1 Social Services: ents	21475			
	home must have and department or progrelated social service nursing home must collaborate with out who is in need of acceptance.	I requirements. A nursing norganized social services ram to provide medically ces to each resident. A make referrals to or iside resources for a resident additional mental health, or financial services.				
	by: Based on observative review, the social secondinate dischargagency for 1 of 1 residues.	ent is not met as evidenced ion, interview, and document ervice department failed to ge services with an outside esidents (R3) reviewed who e to the community.				
	Findings include:					
	quadriplegia (paraly loss of upper and lo of pressure ulcers of Minimum Data Set identified R3 was context extensive assistant living (ADL's) except and had an active return to the comm 10/16/12, included, the community whe and "social worker/"	d indicated a diagnoses of ysis resulting in partial or total ower limb use) and had history for 10 years. The annual (MDS) dated 9/25/13, ognitively intact, needed be with all activities of daily ot eating, had pressure ulcers, discharge plan in place to unity. R3's care plan dated "Will consider placement in en open areas have healed," interdisciplinary team to assist a discharge planning."				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED			
		00019	B. WING		11/0	1/2013		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE	I AVENUE LAKE, MN	55349				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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)	LD BE	(X5) COMPLETE DATE		
21475	However, added to Currently long term needs in ADL's." During interview on stated he had been over a year. He ha about 10 years, but closer to family. Roat the facility as he common with the "cunable to find anoth family. He stated la county social worke months ago and the	this was, "Discharge plan: care related to level of care 10/28/13, at 3:40 p.m. R3 Iliving in the facility for a little d lived at a group home for moved to the facility to be stated he does not do much does not have much in older people," but he was her place to live close to his ast he had spoke with the er about discharge was several ecounty case worker was appropriate placement for him	21475					
	was in his room ear 12:25 p.m. R3 was room. On 10/29/13 observed in his elect of the facility and grand smoking a cigar interacting with other R3's progress note: 4/17/13- "Care tear Social service repowill be meeting with She will be present options." No further found in R3's medical service repowing the meeting with the service repowill be meeting with the service repowill be meeting with the service repowill be meeting with the service repowing the service repowing the service repower.	s revealed the following: n met with resident present. rts resident is stable resident n his social worker in May. ing [R3] with a list of housing er social work notes were						

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00019	B. WING		11/0	1/2013
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE 413 13TH	AVENUE LAKE, MN	55349		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21475	treatment orderR care conference an	unds are maintained by esident declined attendance at and has no concerns except lacement. Has been working	21475			
	county social works meeting she had w approximately 5-6 r wanted to find more others, "closer to hi the area so he coul CSW-J stated she living facility's in Mathem or they had a CSW-J was unable regarding what faci which facilities R3 r verified R3 had no was the resident plaalso stated she had the facility regarding does not give the facility's R3 had befurther went on to s "heard" R3 was not his wounds heal.	on 10/30/13, at 11:14 a.m. er (CSW)-J stated the last ith R3 was in May 2013, months ago. CSW-J stated R3 e appropriate placement with its age," but wanted to stay in it doe close to his family. had looked at several different ay for R3 but either R3 rejected "long waiting list." However, to provide information lities were considered and rejected going to. CSW-J active plans for discharge, nor acced on any waiting lists. She is not spoken with anyone from g R3 discharging and she acility information regarding the en spoken to about. CSW-J say that she thought she is going to be discharged until She was not aware the wounds or 10 years prior to his acility.				
	director of nursing of worker had retired so DON stated there were stated to the state of the st	on 10/30/13, at 12:33 p.m. The (DON) stated the facility social several months ago. The vas no further information arging and stated. "I never				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00019		B. WING		11/01/2013	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE 413 13TH HOWARD	AVENUE LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21475	county social worker Furthermore, she h social worker to ver in place. DON verif regarding R3 discher facility had not coor county social worker	ge 44 ge" with R3 as she thought the er was working on discharge. ad not spoken to the county rify if any discharge plan was fied there was no plan arging from the facility, and the dinated with the resident er to ensure R3 was appropriate placement.	21475			
	Suggested Method administrator or dethe policy and proceplanning. The facilistaff on policy and proceplance a monitoring compliance.	of Correction: The signee could review and revise edures as related to discharge ity could educate appropriate procedures. The facility could ag system to ensure :: Fourteen (14) days.				
21942	Resident and Famil Resident advisory of boarding care home advisory council an fewer than three per participating. If one function, the nursing home shall docume council or councils year. This subdivisi	A.10 Subd. 8b Establish by Councils council. Each nursing home or e shall establish a resident d a family council, unless ersons express an interest in or both councils do not g home or boarding care ent its attempts to establish the at least once each calendar on does not alter the rights of ites provided by section	21942			

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PRINTED: 11/19/2013

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING __ 00019 11/01/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **413 13TH AVENUE GOOD SAMARITAN SOCIETY - HOWARD LAKE HOWARD LAKE, MN 55349**

	I IOWAND	LAKE, WIN	33343	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21942	Continued From page 45	21942		
	144.651, subdivision 27.			
	This MN Requirement is not met as evidenced			
	by:			
	Based on interview and document review, the facility failed to ensure a family council group was			
	attempted at least yearly. This had the potential			
	to effect all 32 residents families who currently resided in the facility.			
	Findings include:			
	During interview on 10/31/13 at 8:55 a.m. administrator stated she was unable to locate a date of when the last family council meeting was held or attempted to hold a meeting. She stated the social worker (who had retired several months ago) had a family council meeting "years ago"			
	and she thought maybe it was in 2011. The administrator stated she was not aware the facility needed to attempt to have a family council meeting yearly.			
	The facility was not able to provide a policy regarding family council meetings.			
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