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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 2YPC
Facility ID: 00021

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245600**

2. STATE VENDOR OR MEDICAID NO.
(L2) **336240000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BLACKDUCK**
(L4) **172 SUMMIT AVENUE WEST**
(L5) **BLACKDUCK, MN** (L6) **56630**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **061/7/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **30** (L18)

13.Total Certified Beds **30** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	30			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE
Lyla Burkman, Unit Supervisor
Date : 06/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath, Enforcement Specialist
Date: 06/17/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/16/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245600

June 17, 2015

Mr. Gordon Hormann, Administrator
Good Samaritan Society - Blackduck
172 Summit Avenue West
Blackduck, Minnesota 56630

Dear Mr. Hormann:

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 June 9, 2015 the above facility is certified for:

30 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 30 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 17, 2015

Mr. Gordon Hormann, Administrator
Good Samaritan Society - Blackduck
172 Summit Avenue West
Blackduck, Minnesota 56630

RE: Project Number S5600024

Dear Mr. Hormann:

On May 13, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 1, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On June 17, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 1, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 1, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 9, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 1, 2015, effective June 9, 2015 and therefore remedies outlined in our letter to you dated May 13, 2015, will not be imposed.

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

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

Sincerely,

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

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

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245600	A. Building B. Wing	6/17/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0242 Reg. # 483.15(b) LSC	05/31/2015	ID Prefix F0250 Reg. # 483.15(g)(1) LSC	05/31/2015	ID Prefix F0329 Reg. # 483.25(l) LSC	06/09/2015
ID Prefix F0465 Reg. # 483.70(h) LSC	06/02/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	06/17/2015	28035	06/17/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/1/2015				

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245600	A. Building / B. Wing: 01 - MAIN BUILDING 01	6/1/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0017	05/13/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	06/17/2015	27200	06/01/2015
CMS RO				

Followup to Survey Completed on: 4/29/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 2YPC
Facility ID: 00021

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(L1) **245600**

2.STATE VENDOR OR MEDICAID NO.
(L2) **336240000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BLACKDUCK**
(L4) **172 SUMMIT AVENUE WEST**
(L5) **BLACKDUCK, MN** (L6) **56630**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/01/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **30** (L18)

13.Total Certified Beds **30** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	30			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE
Theresa Gullingsrud, HFE NEII
Date : 05/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
Date: 06/15/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 06/16/2015 Co.

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 13, 2015

Mr. Gordon Hormann, Administrator
Good Samaritan Society - Blackduck
172 Summit Avenue West
Blackduck, Minnesota 56630

RE: Project Number S5600024

Dear Mr. Hormann:

On May 1, 2015, 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 no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601
lyla.burkman@state.mn.us
Telephone: (218) 308-2104
Fax: (218) 308-2122

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 June 10, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 1, 2015 (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 November 1, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

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
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING ______ B. WING ______	05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLACKDUCK	**172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident bathing preferences were accommodated for 2 of 3 residents (R1, R16) reviewed for choices in daily routine. Findings include:	F 242	1) R1 and R16 were interviewed to determine bathing preferences and a 2nd bath has been added to the bath schedule according to their individual preferences. 2) All residents have been interviewed to determine their individual bathing preferences and bath schedule is being adjusted to accommodate each residents individual preferences for bathing.	5/31/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/24/2015

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

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GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

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F 242	Continued From page 1 R1 was not offered increased frequency of bathing as preferred. R1's quarterly Minimum Data Set (MDS) dated 3/19/15, indicated R1 was cognitively intact and had diagnoses that included chronic pain, macular degeneration and osteoarthrosis (a mechanical abnormality involving degradation of joints). The MDS also indicated R1 required physical help with bathing. R1's ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 6/19/14, identified staff continued to provide limited assist in all areas and it was expected R1 would continue to need staff assist to complete ADLs [activities of daily living]. R1's undated care plan identified R1 required 1 staff participation with bathing. On 4/27/2015, at 6:39 p.m. R1 stated she was not asked how many baths she would like per week. R1 stated she was told she could get one bath a week but would like to have two. On 04/30/2015, at 10:01 a.m. nursing assistant (NA)-C stated R1 preferred a bath and to her knowledge, had never requested additional baths. The bath schedule was reviewed with NA-C who confirmed R1 received one bath per week. NA-C stated the nurses set up the bath schedule. On 04/30/2015, at 10:09 a.m. registered nurse (RN)-A confirmed the bath schedule was	F 242	3) All newly admitted residents will be given choices to accommodate their individual bathing preferences. IDT will review preferences at care conferences to ensure each residents preferences have been met. 4) DNS or designee will complete monthly audits X 3 months to ensure residents preferences are honored. Audit results to QA for further recommendations.	

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F 242	Continued From page 2	F 242		

determined by the nurses who took into consideration the residents' needs based on such things as incontinence or excessive sweating. RN-A stated residents were notified upon admission one bath per week was usually provided in addition to washing up in the morning and evening. RN-A also stated if a resident requested additional baths one would be provided however, they did not specifically identify residents' preferences regarding bathing frequency.

On 04/30/2015, at 10:47 a.m. R1 indicated she had been asked what day she would like to have her bath but the facility had not asked how often she would like a bath/shower. R1 stated she bathed more often when she was at assisted living and would have preferred to have at least 2 baths per week.

On 05/01/2015, at 9:49 a.m. the director of nursing (DON) indicated additional baths were accommodated if requested, however was unaware R1 preferred additional baths per week. The DON confirmed the facility had not determined residents' preferences for bathing frequency.

R16 was not offered the opportunity to choose her own bathing schedule.

R16's annual MDS dated 11/13/14, indicated R16 was cognitively intact, able to communicate all needs and remains independent in most activities of daily living and at risk for poor hygiene.

R16's quarterly MDS dated 2/12/15, indicated

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F 242	Continued From page 3 R16 required staff assist for bathing. R16's care plan dated 2/19/15 directed, staff to assist with bathing. On 04/29/2015, at 8:11 a.m. during interview, R16 stated she received her bath this morning. She stated she had one bath a week, but I would like to have more. R16 stated she had not asked for additional baths because staff were so busy she did not think they would have the time. R16's clinical record lacked evidence R16 was offered a choice in bathing schedule. The current facility Bath Schedule indicated R16 received a bath once a week on Wednesday. An additional note on the bath list indicated nurses only may change bath schedule with input from all shifts involved. On 04/29/2015, at 7:13 a.m. NA-A stated the bathing schedule was established by the nurse and we follow that schedule. NA-A verified she had not discussed a bathing schedule with R16. On 04/29/2015, at 11:34 a.m. the DON stated on admission the residents were assigned a bath. The DON stated the facility did not have a system to offer residents a choice regarding bathing preferences or schedules. The DON stated the facility could easily make changes and accommodate resident requests for bathing preferences. A bathing policy was requested and the booklet Resident's Bill of Rights for Skilled Nursing Facilities was provided. The booklet section titled Quality of Life, subsection Self-determination and participation, identified the resident had the right	F 242		

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F 242	Continued From page 4 to choose activities, schedules and health care consistent with his or her interests, assessments and plans of care and make choices about aspects of his or her life in the facility that were significant to the resident.	F 242		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure psychosocial needs had been comprehensively assessed and therapeutic conversation interventions had been developed and implemented for 1 of 1 (R27) resident in the sample reviewed for psychosocial needs. Findings include: R27's active diagnoses list in the electronic medical record identified the following diagnoses that included, but were not limited to: congestive heart failure, high blood pressure, insomnia, rosacea, macular degeneration, pain in soft tissues of limb, hypothyroidism (low functioning thyroid), scleroderma (a chronic hardening and contraction of the skin and connective tissue, either locally or throughout the body).	F 250	1) SS designee has met with R27 to assist with meeting residents psychosocial needs and will continue weekly. R27 cognitive status and PHQ-9 have been discussed with POA as use of antidepressants have been declined by them in the past. POA aware and agreed that resident is weepy with many complaints but does not want antidepressants at this time. Facility suggestion/concern forms had been completed and were on file indicating that many of the complaints R27 voiced had been addressed. 2) All residents have been reviewed by SS designee and DNS to ensure psychosocial needs are met. Weekly visits by SS with other residents as needed will take place to provide therapeutic conversation and address	5/31/15

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F 250	Continued From page 5 R27's annual Minimum Data Set (MDS), dated 1/1/15, indicated R27 had moderate cognitive impairment. The annual MDS indicated R27 had mood symptoms of feeling down, depressed or hopeless, had trouble falling or staying asleep, or sleeping too much and feeling tired or having little energy. The MDS identified R27 was independent with bed mobility, transfers, walking in room and required extensive assist of one for dressing. R27 was interviewed on 4/28/15, from 10:31 a.m. to 11:31 a.m. during which she cried throughout the whole resident interview. R27 had multiple complaints including her room being cold, the mattress to her bed not being long enough, staff coming into her room throughout the night and waking her and then not being able to get back to sleep thus becoming overly tired. R27 stated that she had been depressed her whole life and had been on and off medications for depression but was currently not taking anything for depression. R27 stated that she did not want any of her concerns reported for fear of retaliation from the direct care staff. R27 indicated that both her daughter and son come to see her weekly and assisted her with resolving her multiple concerns during each visit. R27 was asked if she would like to visit with a staff person regarding her concerns before they became extremely frustrating to her and she stated that yes she would welcome staff visits to address her concerns. Review of the integrated progress notes for R27 from 11/1/14-4/28/15, revealed the following related to R27's complaint's that had not been	F 250	resident concerns. 3) All newly admitted resident will be assessed to determine psychosocial needs. 4)DNS or designee will audit SS designee charting to ensure resident concerns and psychosocial needs have been addressed and followed up on.	

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F 250	Continued From page 6 followed up on or addressed, mood and behavior: Progress note dated 4/2/15, from the care planning conference held 4/1/15, identified R27's reluctance to join activities even the groups that have been developed just for R27's liking. Progress note dated 4/1/15, identified R27's PHQ-9 (an assessment to determine depression) was completed and identified R27 had a score of 4 which meant possible mild depression and was consistent with score from last time PHQ-9 had been completed. There was no indication the physician had been notified the PHQ-9 assessment showed R27 had mild depression. Progress notes dated 2/24/15, 3/16/15, 3/17/15, 3/18/15, 3/25/15, and 3/29/15, R27 complained of eye pain and voiced concern of loosing eye sight. Progress note dated 3/1/15 R27 complained of itching all over her body and complained that her clothing is not completely dried prior to staff putting it away in her dresser creating damp clothing and itching as a result. The progress note identified that no damp clothing was found in R27's room. Progress note dated 2/8/15, R27 reported that new dose of sleeping pill was knocking her out may be making her confused and have a hard time remembering. No follow-up regarding this complaint was documented in R27's record. Progress note dated 2/1/15, identified a nursing assistant reported R27 complained of being cold, itchy and having pain in feet. No follow-up regarding this complaint was documented in R27's record. Progress note dated 1/9/15, identified R27 "whining and c/o [complained] for about 5 minutes straight: She doesn't like what's been going on around here. Said nurse told her her toe is fine and to quit asking about it, She is afraid	F 250		

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F 250	Continued From page 7 she is going to be sent out in the snow, facility will shut down, making up stuff about people being completely rude and leaving her without helping her, staff came in and counted her pads and told her to stop using so many. Many complaints - nothing was positive" No follow-up regarding this complaint was documented in R27's record. Progress note dated 1/2/15, identified R27 complained of lack of heat in her room. No follow-up regarding this complaint was documented in R27's record. Progress note dated 12/26/14, identified R27 had complaints that dressing not changed timely at 6 pm although it was scheduled for a 7 p.m. change. When correct time was pointed out R27 went on to complain about another care she felt was not done correctly saying her bath was too short and done sloppily. No follow-up regarding this complaint was documented in R27's record. Progress note dated 12/3/14, identified R27 mood is better not making statements of wanting to die, being accusatory towards others, or voicing concerns of male caretakers. No follow-up regarding these complaints were documented in R27's record. Progress note dated 11/17/15, identified R27 complained room was too cold. No follow-up regarding this complaint was documented in R27's record. R27's undated care plan identified R27 had a mood and behavior problem related to fluctuating confusion and history of physical abuse in family as evidenced by history of statements of being fearful of a male resident and history of statements of wanting to die. History of false accusations towards staff. Tending to exaggerate events. The interventions included the following:	F 250		

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F 250	Continued From page 8 Assist R27 in developing/provide resident with a program of activities that was meaningful and of interest such as spiritual activities listening to old time music, visiting with staff, residents, visitors and table mates. Provide encouragement, assistance and support to maintain as much independence and control as possible and 1-1 visits to read the bible upon her requests. Nursing assistant (NA)-B was interviewed on 4/29/15, at 7:20 a.m. and stated that R27's personality had always been negative and R27 had multiple concerns weekly which she dwelled upon and voiced repeatedly. NA-B stated that when R27 showed signs of distress her daughter would come in and listen to R27's multiple complaints and this seemed to help R27 calm down. NA-B stated that R27 had told her that she didn't like her mattress and wanted a mattress like the one in the room across the hall, and also complained that her room was too cold. NA-B stated that she had not reported R27's complaint to the charge nurse or SSD-A. The social service designee (SSD)-A was interviewed on 4/30/15, 10:59 a.m. and stated that generally R27 voiced multiple concerns to her daughter weekly, and that R27's daughter reported unresolved concerns to SSD-A. SSD-A stated that no matter what you do for R27 it seemed that R27 could not be pleased. SSD-A confirmed she had not tried meeting with R27 on a regular basis (for example weekly or bi-weekly) to review R27's current concerns and provide therapeutic conversation and problem solving strategies to work through R27's ongoing concerns. SSD-A confirmed that R27's PHQ-9	F 250		

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F 250	Continued From page 9 (an assessment used to identify depression) identified R27 had mild depression symptom's however that had not been reported to residents physician. SSD-A confirmed that she had not adequately documented the follow-up to R27's ongoing complaints identified in R27's integrated progress notes.	F 250		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329		6/9/15

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F 329	Continued From page 10 Based on interview and document review the facility failed to ensure consultant pharmacist (CP)recommendations were acted upon for 2 of 5 residents (R26, R1) whose medication regimens were reviewed. Findings include: R26's CP recommendations were not acted upon by the facility, as required. R26's quarterly MDS dated 2/5/15, indicated R26 had severe cognitive impairment, R26's Diagnosis Report dated 5/1/15, indicated R26 had diagnosis that included generalized pain and pathologic fracture of vertebrae. R26's Order Summary Report dated 5/1/15, indicated R26 had medication orders that included diclofenac sodium gel 1% apply 1 application transdermally to the affected area three times a day related to generalized pain and Flector patch 1.3% apply 1 patch transdermally in the morning related to pathologic fracture of vertebrae The Consultant Pharmacist's Medication Review documents were reviewed from May 2014 through April 2015 and indicated the following: -On 2/20/15, the CP indicated Flector patch and diclofenac gel 1% indicated both products contained diclofenac requested an evaluation for duplicate therapy and the continued need for both	F 329	1) R26 pharmacy review has been faxed to MD to be addressed. If not addressed by MD pharmacy review will be faxed weekly to physician until next MD appt at which DNS will attend if pharmacy review has not been addressed. DNS attended MD appt with R1 to address pharmacy reviews with MD and determine MD preference for receiving pharmacy reviews. DNS had conversation with medical director re: pharmacy reviews and medical director will write letter to specific physicians as necessary. 2) pharmacy reviews for all residents will be sent by fax to be addressed by the physicians that do not come to the facility. Physicians that come to the facility have requested that pharmacy review be addressed with each individual patient as they are seen by physician. 3) Pharmacy reviews will be sent by Fax weekly until pharmacy review has been addressed. If not addressed by next MD appt DNS will contact nurse at clinic to alert that pharmacy review is with resident and will need to be addressed. 4) Pharmacy reviews will be audited by DNS or designee to ensure that they are addressed timely. Audits to take place monthly X 3 months with further recommendations by the Quality Assurance committee.	

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F 329	Continued From page 11 products. The CP identified an implementation time frame to review the recommendation with the resident's physician during his/her next visit, but no later than two months. -On 4/21/15, the CP indicated Flector patch and diclofenac gel 1% indicated both products contained diclofenac requested an evaluation for duplicate therapy and the continued need for both products. The CP also indicated the recommendation was a duplicate of an original sent 2/15. The CP identified an implementation time frame to review the recommendation with the resident's physician during his/her next visit, but no later than two months. Review of the Medication Records from 2/1/15 through 4/30/15, indicated R1 continued to receive diclofenac sodium gel 1% and Flector patch 1.3% daily from 2/22/15 through 4/30/15. On 05/01/2015, at 8:55 a.m. the director of nursing (DON) stated her process was to send the pharmacist recommendations along with the resident to their scheduled physician appointment or have them available for the physician at the time of the appointment for those residents seen by their physician at the facility. The DON stated if she had not received the information back after the appointment, she then faxed the information to the physician office. The DON further indicated she had difficulty, at times, receiving a response to the pharmacist recommendations. The DON confirmed there had been no physician response to the pharmacist's recommendations regarding R26's duplicate medications.	F 329		

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R1's CP recommendations were not acted upon by the facility, as required.

R1's quarterly MDS dated 3/19/15, indicated R1 was cognitively intact and had diagnoses that included chronic pain, osteoarthrosis (a mechanical abnormality involving degradation of joints) and myalgia and myositis (pain and inflammation of the muscles).

R1's Order Summary Report dated 5/1/15, identified R1 had medications orders that included Aspirin 325 milligrams (mg) give one tablet by mouth twice a day related to after care for healing traumatic fracture of hip and Tylenol PM extra strength 500-25 mg (diphenhydramine-APAP) give one tablet by mouth one time a day related to myalgia and myositis.

The Consultant Pharmacist's Medication Review documents were reviewed from May 2014 through April 2015 and indicated the following:

-On 9/24/14, the CP recommended considering a reduction of aspirin to 81 mg per day. The CP also recommended evaluation of the risk and benefit for continued use of Tylenol PM daily for R1. The CP indicated Benadryl (diphenhydramine) was contraindicated in the elderly due to increased risk for cognitive decline,

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GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 13	F 329		

dizziness and falls. The CP further indicated R1 was also taking tolterodine ER 4 mg daily which could enhance central nervous system side effects. The CP identified an implementation time frame to review the recommendations with the physician during his/her next visit, but no later than two months.

-On 10/17/14, the CP recommended consideration of a reduced dose of aspirin to 81 mg per day due to bleeding risk with higher dose of aspirin. The CP also recommended evaluation of the risk benefit for continued use of Tylenol PM daily for R1. The CP indicated Benadryl (diphenhydramine) is contraindicated in the elderly due to increased risk for cognitive decline, dizziness and falls. The CP further indicated R1 was also taking tolterodine ER 4 mg daily which could enhance central nervous system side effects. The CP identified an implementation time frame to review the recommendations with the physician during his/her next visit, but no later than two months.

-On 12/19/14, the CP identified R1 had had recent falls and extended time on aspirin 325 mg daily. The CP recommended a reduction of aspirin to 81 mg daily. The CP identified an implementation time frame to review the recommendation with the resident's physician during his/her next visit, but no later than two months.

-On 4/21/15, the CP recommended consideration of a reduced dose of aspirin to 81 mg per day due to bleeding risk with higher dose of aspirin. The

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	245600	A. BUILDING ______ B. WING ______	05/01/2015

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GOOD SAMARITAN SOCIETY - BLACKDUCK	**172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630**

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F 329	Continued From page 14 CP also recommended evaluation of the risk benefit for continued use of Tylenol PM daily for R1. The CP indicated Benadryl (diphenhydramine) is contraindicated in the elderly due to increased risk for cognitive decline, dizziness and falls. The CP further indicated R1 was also taking tolterodine ER 4 mg daily which could enhance central nervous system side effects. The CP identified an implementation time frame to review the recommendations with the resident's physician during his/her next visit, but no later than two months. Review of the Medication Records from 2/1/15, through 4/30/15, indicated R1 continued to receive Aspirin 325 mg and Tylenol PM extra strength 500-25 mg (diphenhydramine-APAP) daily. On 05/01/2015, at 9:49 a.m. the DON confirmed the pharmacist had asked for a reduction in R1's aspirin dose and Tylenol PM yet, R1 continued to receive the medications. The DON stated she had not received a response from the physician and confirmed the facility should have followed up with the physician regarding the recommendation. A policy regarding follow up of consultant pharmacist recommendations was requested but none was provided.	F 329		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional,	F 465		6/2/15

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	245600	A. BUILDING ______ B. WING ______	05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLACKDUCK	**172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630**

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F 465	Continued From page 15 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the window in resident room 209 was maintained and minimized cold drafty air from entering the residents room for 1 of 1 resident (R27) who complained of a cold draft in the room. Findings include: R27 was interviewed on 4/28/15, from 10:31 a.m. to 11:31 a.m. during which she stated that she had complained on multiple occasions of her room being cold and that there was a cold draft coming into her room from the window. R27 stated that she placed blankets and towels up against the window to keep the cold air from coming through the windowsill. On 4/30/2015, at 10:29 a.m. the window in R27's room was observed and it was noted that there were blankets and towels rolled up around the frame of the window. The towels and blankets were removed from the window frame and it was noted that a cold draft was coming from the window. Review of the integrated progress notes for R27 from 11/1/14-4/28/15, revealed the following related to R27's complaint's that her room was	F 465	1) Window in R27 room has been caulked and bathroom vents were checked to ensure no drafts. R27 has been offered the room across the hall with heat registers on two walls. Resident did accept and was moved to that room. 2) All windows have been checked and caulked as needed. Bathroom vents have been checked to ensure proper working condition to prevent drafts. 3) Housekeeping will report to maintenance any drafts noted during routine cleaning. Heating system will be explained to residents at next resident council meeting. 4) Housekeeping and maintenance will be responsible to report to Quality assurance committee for further recommendations.	

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	245600	A. BUILDING ______ B. WING ______	05/01/2015

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F 465	Continued From page 16 cold however, the complaint had not been followed up on or addressed: Progress note dated 2/1/15, identified a nursing assistant reported R27 complained of being cold, itchy and having pain in feet. No follow-up regarding this complaint was documented in R27's record. Progress note dated 1/2/15, identified R27 complained of lack of heat in her room. No follow-up regarding this complaint was documented in R27's record. Progress note dated 11/17/15, identified R 27 complained room was too cold. No follow-up regarding this complaint was documented in R27's record. On 4/30/2015, at 10:02 a.m. the Maintenance Director was interviewed during which he stated that he had been notified that R27 had complained of having a cold room. The maintenance director stated that he had put an external temperature gauge in R27's room this winter and found the temperature of the room to be consistently 75 degree's. The maintenance director further stated that the facilities windows were old and have metal frames and do seem cold. The maintenance director stated that the windows should be replaced and 2 years ago the facility had gotten a bid to replace all of the windows but it did not happen because the money for the project had never materialized. The maintenance director stated that the room across the hallway was the warmest room in the nursing home due to the way the heating system was vented. The maintenance director confirmed that R27 had never been offered to switch room's to be warmer and confirmed the room was currently	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING ______ B. WING ______	05/01/2015

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GOOD SAMARITAN SOCIETY - BLACKDUCK	**172 SUMMIT AVENUE WEST** **BLACKDUCK, MN 56630**

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F 465	Continued From page 17 not occupied by another resident.	F 465		

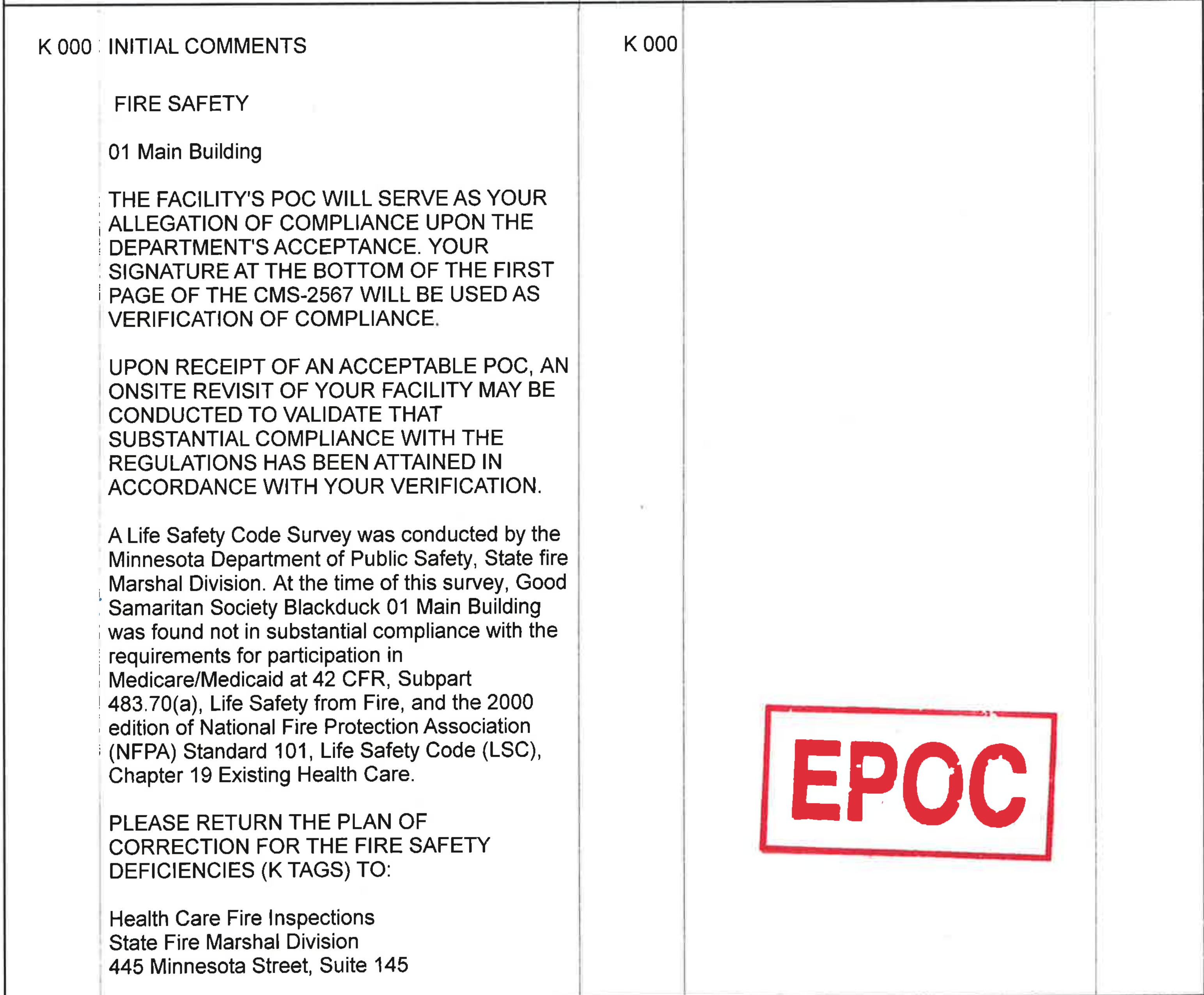
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5600024

PRINTED: 05/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**04/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLACKDUCK	**172 SUMMIT AVENUE WEST** **BLACKDUCK, MN 56630**



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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/23/2015

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**04/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLACKDUCK	**172 SUMMIT AVENUE WEST** **BLACKDUCK, MN 56630**

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K 000	Continued From page 1 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Good Samaritan Society Blackduck is a 1-story building built at three different times. The first and major portion of the building was built in 1970, is 1-story with a basement and was determined to be Type I(332) construction. In 1996 a dining room/ PT addition was constructed to the north of the original building. This addition is 1-story, with a basement and was determined to be type II (111) construction. In 2009 a connecting link and activities addition was constructed to the north of the dining room. It is separated with a 2-hour fire barrier, 1-story, no basement , Type V(111) construction facility is divided into 3 smoke zones with 30-minute fire barriers. The facility has a complete automatic fire sprinkler system with quick response heads,	K 000		

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	245600	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**04/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 2 installed in accordance with NFPA 13 The Standard for Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system which includes smoke detection throughout the corridor system and in all common areas, which is installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have single station battery operated smoke detectors and hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 32 beds had a census of 29 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017		5/13/15

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	245600	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

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K 017	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility had penetrations located in the ceiling tile located in the facility that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for 6 of 52 residents, staff and visitors. Findings include: On facility tour between 9:30 AM to 12:30 PM on 04/08/2015, observations revealed, that there was a hole found in the ceiling tile that is located by resident room 217. This deficient condition was verified by the Maintenance Supervisor.	K 017	1) Affected Ceiling tile was replaced on 5-13-15. 2) A walk through was conducted to assure that no additional holes were present in the ceiling tiles. 3) Maintenance director will continue to assure that ceiling tiles remain whole. 4) Report to QA committee monthly X 4 and for additional recommendations.	

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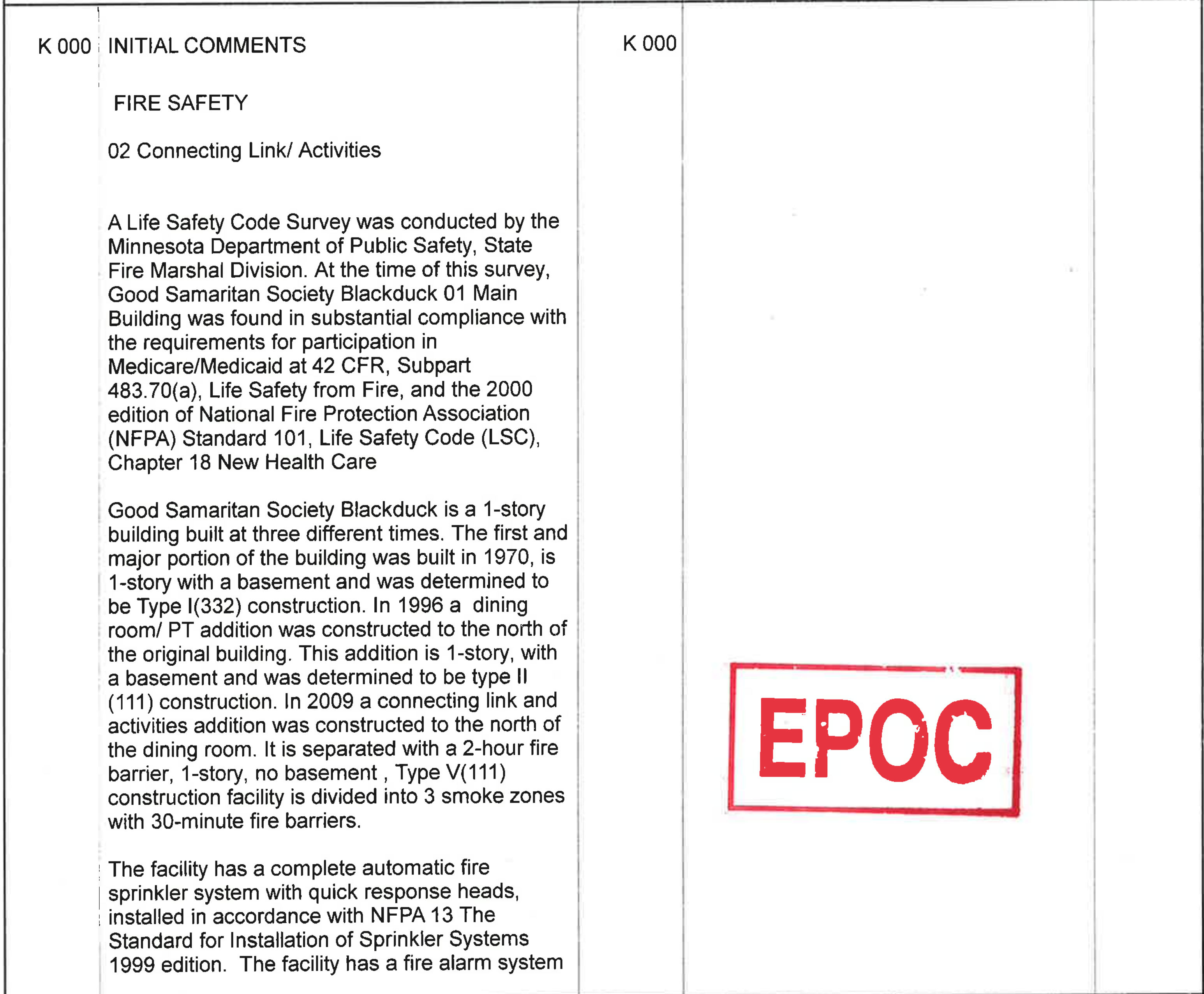
	245600	A. BUILDING **02 - ACTIVITIES ADDITION** B. WING ______	**04/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLACKDUCK	**172 SUMMIT AVENUE WEST** **BLACKDUCK, MN 56630**



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K 000	INITIAL COMMENTS	K 000	EPOC	

FIRE SAFETY

02 Connecting Link/ Activities

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society Blackduck 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care

Good Samaritan Society Blackduck is a 1-story building built at three different times. The first and major portion of the building was built in 1970, is 1-story with a basement and was determined to be Type I(332) construction. In 1996 a dining room/ PT addition was constructed to the north of the original building. This addition is 1-story, with a basement and was determined to be type II (111) construction. In 2009 a connecting link and activities addition was constructed to the north of the dining room. It is separated with a 2-hour fire barrier, 1-story, no basement , Type V(111) construction facility is divided into 3 smoke zones with 30-minute fire barriers.

The facility has a complete automatic fire sprinkler system with quick response heads, installed in accordance with NFPA 13 The Standard for Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/23/2015

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

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	245600	A. BUILDING **02 - ACTIVITIES ADDITION** B. WING ______	**04/29/2015**

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K 000	Continued From page 1 which includes smoke detection throughout the corridor system and in all common areas, which is installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have single station battery operated smoke detectors and hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 32 beds had a census of 29 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		