Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 11, 2023

Administrator
Good Samaritan Ambassador
8100 Medicine Lake Road
New Hope, MN 55427

RE: CCN: 245149
Cycle Start Date: March 16, 2023

Dear Administrator:

On April 10 2023, we informed you that we may impose enforcement remedies.
On May 15, 2023, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On May 17, 2023, the Minnesota Department of Health, completed a revisit and on June 23, 2023 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. Based on our visit, we have determine:

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 16, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 15,2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 16,2023, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 14, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 11, 2023

Administrator
Good Samaritan Ambassador
8100 Medicine Lake Road
New Hope, MN 55427

Re: Reinspection Results
Event ID: 3HDV12

Dear Administrator:

On May 17, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 16, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 10, 2023

Administrator
Good Samaritan Ambassador
8100 Medicine Lake Road
New Hope, MN 55427

RE: CCN: 245149
Cycle Start Date: March 16, 2023

Dear Administrator:

On March 16, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 June 16, 2023 (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).

In addition, if substantial compliance with the regulations is not verified by September 16, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
E 000	Initial Comments On March 13 - 16, 2023, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		5/4/23

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

Electronically Signed | 04/20/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect their emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.3.7, 8.3.8 8.4.1, 8.4.2, 8.4.2.3, 8.4.9, 8.4.9.1, 8.4.9.2, and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could only provide documentation showing that monthly inspections of the emergency generator were completed five of the last twelve months (6/15/2022, 7/5/2022, 8/3/2022, 9/7/2022, and 10/03/2022). 2. On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that any weekly inspections of their emergency generator have been completed. 3. On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that a 36-month 4-hour test has been completed on the emergency generator within the last 36 months. 4. On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by a review of available	E 041	Maintenance staff will be educated between 4/11/23-4/27/23 on the correct emergency generator inspections and documentation needed to ensure proper function of generator. Monthly inspections of the emergency generator resumed by maintenance staff April 2023. Weekly inspections of the emergency generator resumed by maintenance staff the week of April 17th, 2023. The 36- month 4- hour test will be completed by maintenance staff and Total Energy by 5-4-23. A fuel quality test will be performed on the emergency generator by maintenance staff and Total Energy by 5-4-23. Audits of the emergency generator weekly, monthly, 36-month, and fuel quality test will be conducted by maintenance staff. Audits will begin weekly for the first month, monthly for 3 months, and quarterly thereafter as conducted by the Maintenance Supervisor. Results of the audit will be reviewed by the maintenance team for trends and patterns and implement improvement ideas. Findings will be reported to the QA committee for further evaluation and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
E 041	Continued From page 4 documentation that the facility could not provide documentation showing that a fuel quality test has been performed on the fuel for the emergency generator. An interview with the Administrator verified this deficient finding at the time of discovery.	E 041		
F 000	INITIAL COMMENTS On March 13 - 16, 2023, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H51499101C (MN00089519). H51499159C (MN00083121). H5149063C (MN00082388). H51499100C (MN00091556). The facility is enrolled in ePOC, therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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	Continued From page 5 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the ability of 2 of 2 residents (R38 and R32) to self-administer medications observed to be left at bedside, or without a nurse present during administration. Findings include: R38's quarterly Minimum Data Set (MDS) dated 12/27/22, identified R38 was cognitively intact, and able to express needs. R38 was identified as receiving limited assistance to complete activities of daily living (ADLs). R38's diagnoses included, dementia, anxiety, depression, chronic obstructive pulmonary disease (COPD) and coronary artery disease. During interview on 3/13/23, at 2:28 p.m. it was noted R38 had the following medications on her bedside stand: 1. a 30 milliliter bottle of artificial tears 2. a 180 count bottle of vitamin C Gummies - approximately 1/2 full 3. a bottle of TUMS 160 count - approximately 1/2 full	F 554	On 3-15-2023 Orders were received for R38 from MD for ok to keep Vitamin C Gummies and Calcium Carbonate (TUMS) at bedside and take per directions on bottle Self Administration of medication assessment was completed on 3-16-2023 and re-assessed on 3-28-23. R38□s Son educated that if he brings in any medications for his Mom he needs to give to nurse and the nurse will call the MD for orders. Care plan reviewed and updated Self Administration of medication assessment was completed for R32 on 3-16-2023 and pysician orders were obtained for ok to self administer nebulizer after set up. Care plan reviewed and updated Medical record reviews completed on residents who self admisnister medications and interviews with nurses conducted to determine if any residents had medications at bedside to ensure proper assessment and physician order to support self administration of medications.	4/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 554	Continued From page 6 R38 stated she had been arguing with a nurse who took her artificial tears from her, stating she could not keep them bedside. R38 would not state where she obtained the vitamin C and TUMS. R38's physicians orders, identified on 2/17/23, "OK to self administer eye drops every shift." There was another order, dated 3/14/23, "OK to keep at bedside and self administer eye drops every shift." R38's medical record had a Self-Administration of Medications assessment, dated 2/15/23, which found R38 was able to self administer her artificial tears, keeping them at bedside. There was no assessment for TUMS or Vitamin C. During interview on 3/15/23, 1:30 p.m. registered nurse (RN)-A verified R38 was assessed to have the capability to self administer and keep at bedside her eye drops, however she was unaware of the vitamin C and TUMS in R38's room. RN-A stated staff should report any medications noted in resident rooms, while R38 did not have orders for either of the other two medications in her room. R32's significant change MDS dated 12/20/22, identified R32 was cognitively intact, was able to express needs and required limited assistance	F 554	No other residents identified. Licensed Nurses will be educated 3/22/2023 through 4/27/2023 on GSS policy and procedures for Resident self admistration of medications and clarification that every medication at bedside requires assessment, physician orders and need for medications to be secured if kept at bedside. Audits for R32 and R38 and 3 random residents who self administer medications will be completed weekly for 1 month, monthly for 3 months and quarterly thereafter as coordinated by the Nurse Manager. Results of audits will be reviewed by the Nurse Manager team for trends and/or patterns and implement improvement plans. Findings will be reported to the QA committee for further evaluation and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 554	Continued From page 7 with activities of daily living (ADL's). The MDS identified the following diagnoses: hypertension, asthma/chronic obstructive pulmonary disease or chronic lung disease and respiratory failure. R32's orders directed staff to administer ipratropium 0.5 milligrams (mg)/3 milliliters 1 vial (medication to open airways, and treat air flow blockage) via nebulizer every 6 hours with albuterol sulfate 1.25mg/3ml 1 applicator via nebulizer every 6 hours. During observation on 3/13/23, at 7:10 p.m. RN-B placed both medications into medication chamber and placed nebulizer chamber into holder of machine, administered R32's oral medications, then left room reminding R32 to complete nebulizer treatment. On 3/16/23, at 8:48 a.m. RN-C stated an assessment to self-administer medications with education provided to resident and return demonstration was needed to self-administer in addition to an order from the provider. RN-C stated R32 was able to self-administer nebulizer medications after set up by nursing. RN-C reviewed R32's orders, stated no order was in medical record for OK to self-administer nebulizer's, R32 had a resident self-administer of medications dated 3/7/23, which indicated R32 was able to self-administer albuterol inhaler. On 3/16/23, at 9:00 a.m. RN-D stated R32 had a quarterly self-administration of medications assessment completed on 3/7/23. Prior self-administration assessment was completed on 8/30/22, which indicated R32 was able to self-administer albuterol inhaler, assessment had been completed during prior admission to facility,	F 554		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 554	Continued From page 8 R32 had discharged from facility on 11/9/22. R32 admitted back facility on 11/15/22 however no self-administration of medication was completed during admission. RN-D stated R32 was cognitively intact and was able to recall information so R32 was safe to self-administer nebulizer. R32's medical record lacked any assessment indicating she was safe to self administer nebulizer medications after nurse set up, record lacked any order from provider that indicated R32 was ok to self-administer nebulizer medications. The Resident Self-Administration of Medication policy, last reviewed 10/21/22, indicted the purpose of the policy was the following: " - To determine if the resident can safely self-administer medications - To identify which medications may be safely self-administered - To assist the resident who is self-administering medications to manage his or her prescribed medications in a safe manner - To provide residents who can do so safely with the opportunity to self-administer medications"	F 554		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This	F 676		4/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 676	Continued From page 9 includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review the facility failed to ensure 1 of 1 resident (R327) who had a significant weight loss received assistance with eating. Findings include: R327's admission Minimum Data Set (MDS) dated 2/21/23, indicated severe cognitive	F 676	R327 discharge to from facility to Assisted Living facility on 3-15-23 Through assessment and document review, residents identified as needing feeding assistance will be offered feeding assistance with all meals. Documentation and care plan will reflect resident refusals of feeding assistance. Licensed Nurses and Nursing Assistants	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 676	Continued From page 10 impairment and required extensive physical assistance of one person for eating. R327's care plan dated 2/21/23, indicated resident required supervision and eating assistance as needed. R327's Mini-Nutritional Assessment dated 2/17/23, indicated no weight loss or decrease in food intake in the prior 3 months, but scored at risk of malnutrition. R327's Food and Nutrition Data Collection dated 2/20/23, indicated R327's hospital admission weight was 180#. R327's Dietician Assessment dated 3/1/23, indicated weight was not stable, and resident had greater than 5% weight loss in 30 days. Additionally, R327 required feeding assistance, food intake varied 0-100% at meals, and was at risk of malnutrition. Interventions included weekly weights and feeding assistance. R327's occupational therapy (OT) assessment dated 3/14/23, indicated R327 required cueing to eat. R327's progress notes and weight documentation indicated the following: On 2/17/23, admitted to the facility. No weight was recorded this date. On 2/18/23, was fed at breakfast and had 25% intake, a poor appetite, and required cues with eating. 173.1#. On 2/20/23, had a poor appetite and required moderate assistance with eating. 169.6 #. On 2/21/23, had a poor appetite and ate 25% of his meal. 167#.	F 676	will be educated 3/22/2023 through 4/27/2023 on ensuring residents who need assistance with ADLS, including feeding assistance are provided the necessary care and services to meet the residents highest level of well being. Dining Audits to ensure residents identified as needing assistance with feeding are receiving assistance and refusals are documented will be completed weekly for 1 month, monthly for 3 months and quarterly thereafter as coordinated by the Nurse Manager. Results of audits will be reviewed by the Nurse Manager team for trends and/or patterns and implement improvement plans. Findings will be reported to the QA committee for further evaluation and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 676	Continued From page 11 On 2/22/23, fed himself with cueing and some hands-on assistance. On 2/24/23, ate about 40% of meals with cues. On 2/24/23, the care conference progress note lacked information in the nutritional section of the note. On 2/25/23, had low appetite and required encouragement to eat, with a diagnosis of gastrointestinal (GI) cancer, which was not previously mentioned in progress notes, nor on the diagnosis list or nutritional assessment. On 2/27/23, lacked mention of appetite, intake, or level of assistance required for eating. 164#. On 2/28/23, required cues for eating, and had poor appetite. 163.4#. On 3/2/23, the nutritional status note indicated a significant weight loss of 6.4%/-11 pounds, " Likely due to disease progression and sub-optimal intake. " R327 required supervision and prompting to improve intake. 162#. On 3/4/23, had eaten less than 50% of meals. Level of assistance required to eat was not documented. On 3/6/23, had eaten less than 50% of meals, and had fed self after set-up. On 3/8/23, fed self and needed, "Lots of help with eating and drinking." On 3/93/23, the care conference note indicated intake greater than 50% of meals, required feeding supervision, food intake varied 0-100% at meals, weight 162# with a significant weight loss of 6.1%, and was at risk of malnutrition. On 3/9/23, the skilled care progress note indicated staff was monitoring needs related to GI cancer. 159.6#. On 3/10/23, appetite remained poor to fair. Level of assistance required to eat was not documented. Required cues for drinking fluids. On 3/11/23, appetite fair to poor. 159#.	F 676		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 676	Continued From page 12 On 3/12/23, was able to feed self after set-up, but required prompts to participate. On 3/14/23, had good appetite for breakfast, but not the rest of the days. On 3/14/23, had red flags for significant weight loss based on weight recorded 3/11/23, 159#, which was a 8/1% loss or -14 # since admission, "Likely due to progression of dementia, advanced age, and sub-optimal intake." R327 required supervision and prompting to improve intake. No additional weights were recorded prior to discharge on 3/15/23. R327's Discharge Summary dated 3/12/23, lacked mention of weight loss or level of assistance required for eating. When interviewed on 3/13/23 at 6:04 p.m., family member (FM)-C stated, "He's lost his appetite, and he eats better when we feed him. He was worse after surgery. They set him up and pretty much expect him to eat on his own. " During observation on 3/14/23 at 8:54 a.m., staff provided meal set-up, but did not provide additional physical help or cueing for the meal. R327 ate his cold cereal but mostly poked at the scrambled eggs, sliced banana, and French Toast with the fork. By the end of the meal, R327 had eaten a couple of bites of eggs and the sliced banana. Staff removed him from the dining room without encouraging or assisting the resident to eat. During observation on 3/14/23 at 1:12 p.m., staff provided meal set-up, but did not provide additional physical assistance or cueing for the meal. R327 was served beef tips, green beans, mashed potatoes, and a chocolate magic cup	F 676		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 676	Continued From page 13 (nutritional supplement for extra calories). R327 ate a few bites of his beef tips and his magic cup. Occupational therapist (OT)-D was also observing the meal. When interviewed on 3/14/23 at 1:40 p.m., OT-D stated R327 ate about 50% of the meal and the purpose of that OT observation and assessment was about the functionality of eating with the adaptive utensil, not intake. When interviewed on 3/14/23 at 1:50 p.m., the registered dietician (RD) stated it was part of R327's dementia diagnosis to push food around on the plate. Additionally, the RD stated staff should provide feeding assistance if the MDS assessment and care plan indicated feeding assistance was required and was unsure if staff was providing feeding assistance. The RD stated the medical record indicated R327 was eating greater than 50% of his meals, but the medical record progress notes lacked documentation to support R327 was eating greater than 50% of his meals. When interviewed on 3/15/23 at 7:58 a.m., speech therapist (ST)-E stated the RD the role of ST is to ensure food and liquid textures for the resident ensure low risk for aspiration, and the RD oversaw oral intake and monitoring weights. When interviewed on 3/16/23 at 9:43 a.m. the director of nursing (DON) stated if staff is offering to assist a resident to eat, but the resident refuses the assistance, the refusals should have been documented. The DON stated she did not know if staff was offering to feed R327. The Activities of Daily Living Policy Dated	F 676		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 676	Continued From page 14 11/29/22, indicated any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition.	F 676		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 10, 2023

Administrator
Good Samaritan Ambassador
8100 Medicine Lake Road
New Hope, MN 55427

Re: State Nursing Home Licensing Orders
Event ID: 3HDV11

Dear Administrator:

The above facility was surveyed on March 13, 2023 through March 16, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 only a suggestion 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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On On March 13 through March 16, 2023, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued: (TAG). Please indicate in your	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
2 000	Continued From page 1 electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. The following complaint(s) were reviewed during the survey, no licensing orders were issued: H51499101C (MN00089519). H51499159C (MN00083121). H5149063C (MN00082388). H51499100C (MN00091556). 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on interview, observation, and document	2 915	Corrected.	4/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
2 915	Continued From page 3 review the facility failed to ensure 1 of 1 resident (R327) who had a significant weight loss received assistance with eating. Findings include: R327's admission Minimum Data Set (MDS) dated 2/21/23, indicated severe cognitive impairment and required extensive physical assistance of one person for eating. R327's care plan dated 2/21/23, indicated resident required supervision and eating assistance as needed. R327's Mini-Nutritional Assessment dated 2/17/23, indicated no weight loss or decrease in food intake in the prior 3 months, but scored at risk of malnutrition. R327's Food and Nutrition Data Collection dated 2/20/23, indicated R327's hospital admission weight was 180#. R327's Dietician Assessment dated 3/1/23, indicated weight was not stable, and resident had greater than 5% weight loss in 30 days. Additionally, R327 required feeding assistance, food intake varied 0-100% at meals, and was at risk of malnutrition. Interventions included weekly weights and feeding assistance. R327's occupational therapy (OT) assessment dated 3/14/23, indicated R327 required cueing to eat. R327's progress notes and weight documentation indicated the following: On 2/17/23, admitted to the facility. No weight was recorded this date.	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
2 915	Continued From page 4 On 2/18/23, was fed at breakfast and had 25% intake, a poor appetite, and required cues with eating. 173.1#. On 2/20/23, had a poor appetite and required moderate assistance with eating. 169.6 #. On 2/21/23, had a poor appetite and ate 25% of his meal. 167#. On 2/22/23, fed himself with cueing and some hands-on assistance. On 2/24/23, ate about 40% of meals with cues. On 2/24/23, the care conference progress note lacked information in the nutritional section of the note. On 2/25/23, had low appetite and required encouragement to eat, with a diagnosis of gastrointestinal (GI) cancer, which was not previously mentioned in progress notes, nor on the diagnosis list or nutritional assessment. On 2/27/23, lacked mention of appetite, intake, or level of assistance required for eating. 164#. On 2/28/23, required cues for eating, and had poor appetite. 163.4#. On 3/2/23, the nutritional status note indicated a significant weight loss of 6.4%/-11 pounds, " Likely due to disease progression and sub-optimal intake. " R327 required supervision and prompting to improve intake. 162#. On 3/4/23, had eaten less than 50% of meals. Level of assistance required to eat was not documented. On 3/6/23, had eaten less than 50% of meals, and had fed self after set-up. On 3/8/23, fed self and needed, "Lots of help with eating and drinking." On 3/93/23, the care conference note indicated intake greater than 50% of meals, required feeding supervision, food intake varied 0-100% at meals, weight 162# with a significant weight loss of 6.1%, and was at risk of malnutrition. On 3/9/23, the skilled care progress note	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
2 915	Continued From page 5 indicated staff was monitoring needs related to GI cancer. 159.6#. On 3/10/23, appetite remained poor to fair. Level of assistance required to eat was not documented. Required cues for drinking fluids. On 3/11/23, appetite fair to poor. 159#. On 3/12/23, was able to feed self after set-up, but required prompts to participate. On 3/14/23, had good appetite for breakfast, but not the rest of the days. On 3/14/23, had red flags for significant weight loss based on weight recorded 3/11/23, 159#, which was a 8/1% loss or -14 # since admission, "Likely due to progression of dementia, advanced age, and sub-optimal intake." R327 required supervision and prompting to improve intake. No additional weights were recorded prior to discharge on 3/15/23. R327's Discharge Summary dated 3/12/23, lacked mention of weight loss or level of assistance required for eating. When interviewed on 3/13/23 at 6:04 p.m., family member (FM)-C stated, "He's lost his appetite, and he eats better when we feed him. He was worse after surgery. They set him up and pretty much expect him to eat on his own. " During observation on 3/14/23 at 8:54 a.m., staff provided meal set-up, but did not provide additional physical help or cueing for the meal. R327 ate his cold cereal but mostly poked at the scrambled eggs, sliced banana, and French Toast with the fork. By the end of the meal, R327 had eaten a couple of bites of eggs and the sliced banana. Staff removed him from the dining room without encouraging or assisting the resident to eat.	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
2 915	Continued From page 6 During observation on 3/14/23 at 1:12 p.m., staff provided meal set-up, but did not provide additional physical assistance or cueing for the meal. R327 was served beef tips, green beans, mashed potatoes, and a chocolate magic cup (nutritional supplement for extra calories). R327 ate a few bites of his beef tips and his magic cup. Occupational therapist (OT)-D was also observing the meal. When interviewed on 3/14/23 at 1:40 p.m., OT-D stated R327 ate about 50% of the meal and the purpose of that OT observation and assessment was about the functionality of eating with the adaptive utensil, not intake. When interviewed on 3/14/23 at 1:50 p.m., the registered dietician (RD) stated it was part of R327's dementia diagnosis to push food around on the plate. Additionally, the RD stated staff should provide feeding assistance if the MDS assessment and care plan indicated feeding assistance was required and was unsure if staff was providing feeding assistance. The RD stated the medical record indicated R327 was eating greater than 50% of his meals, but the medical record progress notes lacked documentation to support R327 was eating greater than 50% of his meals. When interviewed on 3/15/23 at 7:58 a.m., speech therapist (ST)-E stated the RD the role of ST is to ensure food and liquid textures for the resident ensure low risk for aspiration, and the RD oversaw oral intake and monitoring weights. When interviewed on 3/16/23 at 9:43 a.m. the director of nursing (DON) stated if staff is offering to assist a resident to eat, but the resident refuses the assistance, the refusals should have	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
2 915	Continued From page 7 been documented. The DON stated she did not know if staff was offering to feed R327. The Activities of Daily Living Policy Dated 11/29/22, indicated any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the ability of 2 of 2 residents (R38 and R32) to self-administer medications observed to be left at bedside, or without a nurse present during administration. Findings include:	21565	Corrected.	4/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
21565	Continued From page 8 R38's quarterly Minimum Data Set (MDS) dated 12/27/22, identified R38 was cognitively intact, and able to express needs. R38 was identified as receiving limited assistance to complete activities of daily living (ADLs). R38's diagnoses included, dementia, anxiety, depression, chronic obstructive pulmonary disease (COPD) and coronary artery disease. During interview on 3/13/23, at 2:28 p.m. it was noted R38 had the following medications on her bedside stand: 1. a 30 milliliter bottle of artificial tears 2. a 180 count bottle of vitamin C Gummies - approximately 1/2 full 3. a bottle of TUMS 160 count - approximately 1/2 full R38 stated she had been arguing with a nurse who took her artificial tears from her, stating she could not keep them bedside. R38 would not state where she obtained the vitamin C and TUMS. R38's physicians orders, identified on 2/17/23, "OK to self administer eye drops every shift." There was another order, dated 3/14/23, "OK to keep at bedside and self administer eye drops every shift." R38's medical record had a Self-Administration of Medications assessment, dated 2/15/23, which found R38 was able to self administer her artificial tears, keeping them at bedside. There was no assessment for TUMS or Vitamin C. During interview on 3/15/23, 1:30 p.m. registered nurse (RN)-A verified R38 was assessed to have the capability to self administer and keep at	21565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
21565	Continued From page 9 bedside her eye drops, however she was unaware of the vitamin C and TUMS in R38's room. RN-A stated staff should report any medications noted in resident rooms, while R38 did not have orders for either of the other two medications in her room. R32's significant change MDS dated 12/20/22, identified R32 was cognitively intact, was able to express needs and required limited assistance with activities of daily living (ADL's). The MDS identified the following diagnoses: hypertension, asthma/chronic obstructive pulmonary disease or chronic lung disease and respiratory failure. R32's orders directed staff to administer ipratropium 0.5 milligrams (mg)/3 milliliters 1 vial (medication to open airways, and treat air flow blockage) via nebulizer every 6 hours with albuterol sulfate 1.25mg/3ml 1 applicator via nebulizer every 6 hours. During observation on 3/13/23, at 7:10 p.m. RN-B placed both medications into medication chamber and placed nebulizer chamber into holder of machine, administered R32's oral medications, then left room reminding R32 to complete nebulizer treatment. On 3/16/23, at 8:48 a.m. RN-C stated an assessment to self-administer medications with education provided to resident and return demonstration was needed to self-administer in addition to an order from the provider. RN-C stated R32 was able to self-administer nebulizer medications after set up by nursing. RN-C reviewed R32's orders, stated no order was in medical record for OK to self-administer nebulizer's, R32 had a resident self-administer of medications dated 3/7/23, which indicated R32	21565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
21565	Continued From page 10 was able to self-administer albuterol inhaler. On 3/16/23, at 9:00 a.m. RN-D stated R32 had a quarterly self-administration of medications assessment completed on 3/7/23. Prior self-administration assessment was completed on 8/30/22, which indicated R32 was able to self-administer albuterol inhaler, assessment had been completed during prior admission to facility, R32 had discharged from facility on 11/9/22. R32 admitted back facility on 11/15/22 however no self-administration of medication was completed during admission. RN-D stated R32 was cognitively intact and was able to recall information so R32 was safe to self-administer nebulizer. R32's medical record lacked any assessment indicating she was safe to self administer nebulizer medications after nurse set up, record lacked any order from provider that indicated R32 was ok to self-administer nebulizer medications. The Resident Self-Administration of Medication policy, last reviewed 10/21/22, indicted the purpose of the policy was the following: " - To determine if the resident can safely self-administer medications - To identify which medications may be safely self-administered - To assist the resident who is self-administering medications to manage his or her prescribed medications in a safe manner - To provide residents who can do so safely with the opportunity to self-administer medications" SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self	21565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
21565	Continued From page 11 administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	21565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/14/2023. At the time of this survey, Good Samaritan Ambassador was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 04/20/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Good Samaritan Society Ambassador Building 01 is a 1-story building with a partial basement. The building was constructed at three different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1996, an addition was constructed and was determined to be of Type II(000) construction. In 2010, an addition was constructed and was determined to be of Type V (111) construction. There is a 2-hour firewall between the 2010 addition and the rest of the	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 building. The building is automatic fire sprinkler protected throughout. 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. Since Type V(111) construction is allowed for a 1-story building, the entire building will be surveyed as Type V(111). The facility has a capacity of 77 beds and had a census of 77 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clear egress path per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1 and 7.1.10.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by observation that the marked	K 211	On 3-14-23 food carts were moved to allow a clear egress path to the exit door in the kitchen Kitchen staff will be educated 4/12/23-4/27/23 on keeping a clear egress path to the exit door by not placing food carts in fornt of doors. Sign was placed on door stating Do not block Audits of kitchen exit doors, to ensure	4/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 3 exit door in the kitchen was blocked by food carts. An interview with the Administrator verified this deficient finding at the time of discovery.	K 211	clear egress path will be completed Maintenance weekly for the first month, monthly for 3 months, and quarterly therafter as coordinated by the Maintenance Director. Results of the audit will be reviewed by the maintenance team for trends and patterns and implement improvement ideas. Findings will be reported to the QA committee for further evaluation and recommendation	
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwells per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, 7.2.2.5.1.1, 7.1.3.2.1, 7.2.2.5.3, and 7.2.2.5.3.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by observation that the mechanical room/ roof access stairwell had bags of salt and light bulbs stored in it at the bottom near the door.	K 225	Items located in the stairwell of the mechanical room/roof access were moved The latch on the door to the stairwell was repaired to ensure it latched Maintenance staff will be educated between 4/11/23 and 4/27/23 on the keeping stairwells free of items and ensuring doors latch Audits of stairwells and stairwell door latches will be completed by Maintenance weekly for the first month, monthly for 3 months, and quarterly thereafter as	4/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 225	Continued From page 4 2. On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by observation that the door to the stairwell that leads to the front entrance did not latch. An interview with the Administrator verified these deficient findings at the time of discovery.	K 225	coordinated by the Maintenance Director. Results of the audit will be reviewed by the maintenance team for trends and patterns and implement improvement ideas. Findings will be reported to the QA committee for further evaluation and recommendation	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet)	K 321		5/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 5 g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazard rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by observation that the boiler room door was propped open with two buckets and the handle was not operational causing the door to not latch. An interview with the Administrator verified this deficient finding at the time of discovery.	K 321	The handle on the boiler room door was replaced to ensure it latches. Facility audit will be completed by 5-4-23 to ensure proper functioning of all smoke doors. Maintenance staff will be educated between 4/11/23 and 4/27/23 on ensuring doors latch appropriately. Random Audits of door latches will be completed by Maintenance weekly for the first month, monthly for 3 months, and quarterly thereafter as coordinated by the Maintenance Director. Results of the audit will be reviewed by the maintenance team for trends and patterns and implement improvement ideas. Findings will be reported to the QA committee for further evaluation and recommendation	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke	K 324		5/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 6 compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect their kitchen hood suppression system per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.1 and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility provided the surveyor with a kitchen hood inspection report dated 07/14/2022, but was not able to provide an inspection report showing that an inspection had been completed six months after that date.	K 324	Kitchen hoods are scheduled to be inspected on 5-3-23 by Summit. Dietary Manager will be educated on ensuring kitchen hoods are inspected every 6 months and inspection report obtained and filed for reference by 5-3-23. Kitchen hoods will be audited to ensure cleaning and inspections occur every 6 months and more frequently as needed monthly for 3 months, and quarterly thereafter as coordinated by the Maintenance Director. Results of the audit will be reviewed by the maintenance team for trends and patterns and implement improvement ideas. Findings will be reported to the QA committee for further evaluation and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 7 An interview with the Administrator verified this deficient finding at the time of discovery.	K 324		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.5.2 (3), 4.1.6.1, 5.2.1.1.1, and 5.2.1.1.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include:	K 353	On 4-17-23, glass bulb if sprinkler in the walk in cooler was cleaned. Maintenance team replaced the missing and broken ceiling tiles in the basement, ensuring sprinklers were not blocked. An audit will be conducted by 4-27-23 of the entire building to ensure that all ceiling tiles were in place and all sprinkler bulbs were cleaned. Maintenance staff will be educated	4/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 8 1. On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by observation that the sprinkler in the walk-in cooler had a large amount of dust on the glass bulb. 2. On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by observation that there were ceiling tiles in the basement that were missing, broken, and blocking sprinklers. An interview with the Administrator verified this deficient finding at the time of discovery.	K 353	between 4/11/23 and 4/27/23 on the process of replacing missing ceiling tiles when they are taken down or when they are damaged. Visual inspection of ceilings will be completed Maintenance weekly for the first month, monthly for 3 months, and quarterly therafter as coordinated by the Maintenance Director. Results of the audit will be reviewed by the maintenance team for trends and patterns and implement improvement ideas. Findings will be reported to the QA committee for further evaluation and recommendation.	
K 363 SS=B	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open	K 363		4/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	**8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 9 devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3.5 and 19.3.6.3.10. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by observation that the door to the environmental services office was held open with a wooden wedge. An interview with the Administrator verified this deficient finding at the time of discovery.	K 363	Door to maintenance office was closed and wooden wedge removed Maintenance staff will be educated between 4/11/23 and 4/27/23 on ensuring that maintenance door remains closed and is not propped open Audits of maitenance door to ensure it is closed will be completed Maintenance weekly for the first month, monthly for 3 months, and quarterly therafter as coordinated by the Maintenance Director. Results of the audit will be reviewed by the maintenance team for trends and patterns and implement improvement ideas. Findings will be reported to the QA committee for further evaluation and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.2 and 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that a fire drill was conducted during first shift during the first quarter of 2022. 2. On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that a fire drill was conducted during first and third shifts during the second quarter of 2022.	K 712	Fire Drills were completed on 3-30-23 at 6am and 4-12-23 at 10pm. Maintenance staff will be educated between 4-11-23 and 4-27-23 on policy and procedure of conducting quarterly fire drills on each shift at different times. Audits of the quarterly fire drills will be conducted to ensure completion by maintenance supervisor or designee. Audits will be be completed weekly for the first month, monthly for the following three months and quarterly thereafter. Results of the audit will be reviewed by the maintenance team for trends and patterns and implement improvement ideas. Findings will be reported to the QA committee for further evaluation and recommendation	4/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	**8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 11 3. On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that a fire drill was conducted during second and third shifts during the third quarter of 2022. 4. On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that a fire drill was conducted during the fourth quarter of 2022. An interview with the Administrator verified this deficient finding at the time of discovery.	K 712		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility.	K 901	NFPA 99 risk assessment was completed on 4-20-23. Audits of the NFPA 99 Risk Assessments to ensure completion and accuracy will be conducted by Maintenance personnel monthly for the first quarter, quarterly for	4/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 901	Continued From page 12 Findings include: On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide a NFPA 99 risk assessment. An interview with the Administrator verified this deficient finding at the time of discovery.	K 901	the next three quarters and annually thereafter as coordinated by the Maintenance Supervisor. Results of the audit will be reviewed by the maintenance team for trends and patterns and implement improvement ideas. Findings will be reported to the QA committee for further evaluation and recommendation.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	K 918		5/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 13 readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect their emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.3.7, 8.3.8 8.4.1, 8.4.2, 8.4.2.3, 8.4.9, 8.4.9.1, 8.4.9.2, and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could only provide documentation showing that monthly inspections of the emergency generator were completed five of the last twelve months (6/15/2022, 7/5/2022, 8/3/2022, 9/7/2022, and 10/03/2022). 2. On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that any weekly inspections of their emergency generator have been completed. 3. On 03/14/2023 between 09:15 AM and 12:30	K 918	Maintenance staff will be educated between 4/11/23-4/27/23 on the correct emergency generator inspections and documentation needed to ensure proper function of generator. Monthly inspections of the emergency generator resumed by maintenance staff April 2023. Weekly inspections of the emergency generator resumed by maintenance staff the week of April 17th, 2023. The 36- month 4- hour test will be completed by maintenance staff and Total Energy by 5-4-23. A fuel quality test will be performed on the emergency generator by maintenance staff and Total Energy by 5-4-23. Audits of the emergency generator weekly, monthly, 36-month, and fuel quality test will be conducted by maintenance staff. Audits will begin weekly for the first month, monthly for 3 months, and quarterly thereafter as conducted by the Maintenance Supervisor. Results of the audit will be reviewed by the maintenance team for trends and patterns and implement improvement ideas. Findings will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 14 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that a 36-month 4-hour test has been completed on the emergency generator within the last 36 months. 4. On 03/14/2023 between 09:15 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that a fuel quality test has been performed on the fuel for the emergency generator. An interview with the Administrator verified this deficient finding at the time of discovery.	K 918	reported to the QA committee for further evaluation and recommendation.	