

Certified Mail # 7013 3020 0001 8869 3399

July 20, 2018

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

Subject: Good Samaritan Society - Ambassador - IDR CMS Certification Number (CCN) 245149 Project # S5149028

Dear Ms. Barta:

This is in response to your letter of April 6, 2018, in regard to your request of an independent informal dispute resolution (I IDR) for the federal deficiency at tag F576 issued pursuant to the survey event 45LK11, completed on March 15, 2018. A letter was received from your facility dated 7/17/18, requesting the IIDR be changed to an IDR after a preparatory meeting between the administrative law judge, the state agency and facility.

The information presented with your letter, the CMS 2567 dated March 15, 2018, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of Licensing and Certification staff have been carefully considered and the following determination has been made:

F576 - 42 CFR

§483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.

 $\S483.10(g)(7)$ The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to:

- (i) A telephone, including TTY and TDD services;
- (ii) The internet, to the extent available to the facility; and
- (iii) Stationery, postage, writing implements and the ability to send mail.

§483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:

- (i) Privacy of such communications consistent with this section; and
- (ii) Access to stationery, postage, and writing implements at the resident's own expense.

 $\S483.10(g)(9)$ The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.

- (i) If the access is available to the facility
- (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.
- (iii) Such use must comply with State and Federal law.

Good Samaritan Society - Ambassador July 20, 2018 Page 2

Summary of the facility's reason for IDR of this tag.

The facility did not staff the main reception desk on Saturdays until 11:00 a.m., and they did not have anyone to secure the mail once delivered. Residents had been seen going through the mail to see if they had received any. The facility felt the postal service was unable to secure the mail on Saturdays and so had worked with the postal service over 1 year ago to stop the Saturday mail deliveries. The facility believed that they met the F576 regulation, because they had stopped Saturday mail delivery to the facility.

Summary of findings:

The facility is responsible to ensure residents receive their mail promptly which would include Saturdays that are normal delivery days.

This is a valid deficiency at this tag. The scope and severity will be reduced from a D to a C level (a deficiency that has the potential for causing no more than minimal harm and has the potential to affect all residents).

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Pam Kerssen, Assistant Program Manager Licensing and Certification Program

Health Regulation Division 705 5th Street NW, Suite A Bemidji, MN 56601

Telephone: (218) 308-2129 Fax: (218) 308-2122

cc: Office of Ombudsman for Long-Term Care Licensing and Certification File

Kathleen Lucas, St. Cloud Team B Unit Supervisor

Becky Wong, Nurse Evaluator II

PRINTED: 07/20/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		E SURVEY PLETED
		245149	B. WING _		03/	15/2018
	PROVIDER OR SUPPLIER	- AMBASSADOR		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	Emergency Prepare conducted on Marc during a recertificat compliance with the Preparedness Requinitial Commentation on March 12 throustandard survey was the Minnesota Depit your facility was in requirements of 42	rgh March 15, 2018, a as completed at your facility by artment of Health to determine	F 00	00		
SS=C	allegation of complienrolled in the elective (ePOC), a signature of the first page o	ion will serve as your facility's ance. Since your facility is ance. Since your facility is aronic Plan of Correction is in the interest of the communication of communication with the en attained in accordance with a communication with the en attained in accordance with the en attained in accordance with communication with the en attained in accordance with the en attained in accordance with communication with the en attained in accordance with the use of a telephone, and a place in alls can be made without being ludes the right to retain and en at the resident's own	F 57	TITLE		4/23/18 (X6) DATE

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

(X6) DATE

Electronically Signed

04/06/2018

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245149	B. WING		03/	15/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 576	facilitate that resicindividuals and enfacility, including r (i) A telephone, inc (ii) The internet, to facility; and (iii) Stationery, posthe ability to send \$483.10(g)(8) The and receive mail, and other material resident through a service, including (i) Privacy of such with this section; a (ii) Access to stati implements at the \$483.10(g)(9) The reasonable access electronic communicat (i) If the access is (ii) At the resident expense is incurred access to the resicing Such use must law. This REQUIREMED by: Based on interviet failed to ensure mon Saturdays. This	ent's right to communicate with tities within and external to the easonable access to: cluding TTY and TDD services; the extent available to the estage, writing implements and mail. Tresident has the right to send and to receive letters, packages is delivered to the facility for the means other than a postal the right to: communications consistent and onery, postage, and writing resident's own expense. Tresident has the right to have is to and privacy in their use of nications such as email and citions and for internet research, available to the facility is expense, if any additional and by the facility to provide such	F 5	Preparation and execution response and plan of corre constitute an admission or the provider of the truth of alleged or conclusions set statement of deficiencies. Correction is prepared and/	ection does not agreement by the facts forth in the The plan of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245149	B. WING		03/15/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427	,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
F 576	residents met to dis When asked wheth mail Monday through they did not received did not know why. During an interview activity director (AD stated residents did Saturdays because facility as a "busine Saturday deliveries. When interviewed administrator stated Friday mail delivery on Saturdays." The a problem with the on the unattended and residents were mail, so arrangeme office at least a year mail, and to only deadministrator stated postman can't secuthat it's secure." The technically violating deliver on Saturday. Review of the facility dated 2/17, include privacy in oral, writt communications, in promptly receive undid not received.	a.m. a group of four scuss the resident council. er residents received their gh Saturday, residents stated their mail on Saturdays and to no 3/14/18, at 1:45 p.m. the end and the music therapist (MT) if not receive mail on the postal service treated the ss" so they did not receive to no 3/15/18, at 1:42 p.m. the dr. "We have Monday through and we do not have delivery administrator stated they had postal service leaving the mail reception desk on Saturdays going through other residents are ago to hold the Saturday eliver it during the week. The dr. "It's not secure because the are it. They can't guarantee e administrator stated, "It's not the regulation if they don't its." by's policy, Resident Mail, dr. "The resident has the right to en and electronic cluding the right to send and nopened mail and other letters, it materials delivered to the	F 576	solely because it is required by the provisions of federal and state law the purposes of any allegation that center is not in substantial complia with federal requirements of particithis response and plan of correction constitutes the center is allegation compliance in accordance with secondations of the State Operations Manual Postal office will deliver mail on Sateffective 4/14/18. Resident mail rewill be delivered. Random audits to ensure mail is reconsidered by the HIM staff for one month, monthly for 3 month quarterly thereafter. Results will be reviewed by the HIM Director with changes implemented as needed. Findings will be reported to the QA Committee for further evaluation a recommendation.	For the ince ipation, on of ction ual. Iturdays ceived dents weekly ths and e

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY IPLETED
		245149	B. WING		03/	15/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		STREET ADDRESS, CITY, STATE, 3 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 692 F 692 SS=D	Nutrition/Hydration CFR(s): 483.25(g)(s) \$483.25(g) Assiste (Includes naso-gastoth percutaneous percutaneous endocenteral fluids). Bastomprehensive assensure that a resid \$483.25(g)(1) Mair of nutritional status desirable body weighbalance, unless that preferences indicate \$483.25(g)(2) Is of maintain proper hy \$483.25(g)(3) Is of there is a nutritional provider orders at IThis REQUIREME by: Based on interview failed to implement from the registered carbohydrate diet (R35) reviewed for Findings Include: R35's admission M (MDS) included dia	Status Maintenance 1)-(3) d nutrition and hydration. stric and gastrostomy tubes, endoscopic gastrostomy and escopic jejunostomy, and sed on a resident's sessment, the facility must ent- entains acceptable parameters that is acceptable parameter	F6F6		ote nge diet to CCHO. HO diet. Care plan o reflect reviewed on diagnoses ets had appropriate	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		E SURVEY IPLETED
		245149	B. WING _		03/	15/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		STREET ADDRESS, CITY, STATE, ZIP CO 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 692	R35's admission Coindicated R35 was Lantus sliding scale (patient) admitted to for PT (physical the therapy) and ST (sp. R35's Face Sheet regular diet. The Interagency As from the hospital, of had a diagnosis of with long term currente form indicated to dietetic association Control. The Interagency Tr. hospital, dated 1/16 tolerated. R35's Food and Nuclectronically signe (RD), and dated 1/16 tolerated. R35's Food and Nuclectronically signe (RD), and dated 1/17 received a diabetic 1/19 recommend strong R35's Order Summindicated Blood gluday, Humalog Kwik units/ML (milliliter) (scale, start date of 50 MG (milligrams) DM, Toujeo Solosta units/ML (insulin glamorning for DM, starting for DM	are Area Assessment (CAA) hyperglycemic, receiving e Humalog (insulin) added. Pt o TCU (transitional care unit) erapy), OT (occupational beech therapy). indicated R35 was on a sessment and Transfer Form lated 1/16/18, indicated R35 type 2 diabetes mellitus (DM), ent use of insulin. In addition, the diet was ADA(American) Diabetic-Carb (carbohydrate) ansfer Orders, from the 6/18, indicated diet as attrition Data Collection, d by the registered dietician 19/18, indicated that R35 diet in hospital and at home. witching to CCHO diet" arry Report, dated 5/15/18, cose monitoring 4 times per spen solution pen-injector, 100 insulin lispro)-Inject per sliding 1/31/18 for DM, Januvia-tablet daily, start date of 3/6/18 for ar solution pen-injector 300 argine) inject 16 units in the	F 69	procedure and system procedures and nutrition. Random audits to ensure recand ordered diets are in placedone by the Dietician weekly monthly for 3 months and quathereafter. Results of audits reviewed by Dietitian and DN changes implemented as ne Findings will be reported to the committee for further evaluative recommendations.	ccomended ce will be for a month, earterly will be IS with eded. he QAPI	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED	
		245149	B. WING _		03.	/15/2018	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		STREET ADDRESS, CITY, STATE, ZIP COD 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 692	assistant director of process for initiatin dietician assesses recommendation at to the nurse who set to the physician to then provides this complement. Review of the Medi (MAR) for February R35's blood glucos to 297, with one read MAR for March, with indicated a diet incitexture, regular fluid During interview on provided the Tray Ckitchen staff to follo R35's Tray Card incliquids. The RD rev Collection, dated 1 made a recommen stated the main difficult and the regular diesugar free desserts. The RD stated the new resident, compand provide to the physician for a sign recommendation at their electronic record, the and was unsure which recommendation.	finursing (ADON) stated the g special diets, is that their the resident, provides dietary and gives this recommendation ends the diet recommendation sign. Once signed, the nurse order to the kitchen to cation Administration Records and March of 2018, indicated to levels ranged from low 50's ading on 2/13/18, at 478. The indicated no special diet, The indicated no special diet, The indicated no special diet, The indicated in a print date of 3/15/18, and grow of the card that is used by the dietary recommendations). Dicated diet as regular with thin riewed the Food and Data and stated she had dation for a CCHO diet and derence between a CCHO diet is that the resident is offered is if they are on a CCHO diet. Process was to assess the olete a recommendation form nurses who would send to the lature. The RD stated this and order should be stored in ord. Upon review of the ne RD was unable to locate and happened to the lature at 19/18, at 10:27 a.m.	F 69)2			

	DELAN OF CORRECTION IN IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245149	B. WING _		03	/15/2018	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		STREET ADDRESS, CITY, STATE, ZIP CO 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 692	registered nurse (Fresidents are listed to state that this is assistant that assis resident diet is. RN from the drawer in The diet was now lidate of 3/15/18. During interview on DON stated the proresident comes from Interagency Transfereviewed the formal listed as diet "as to state that typically with the dietician assess hours, makes a recommendation, or RD recommendation, or RD recommended DON reviewed current orders for FDON remarked that happened. In a subsequent into p.m. the DON state breakdown occurrent orders for FDON remarked that happened. In a subsequent into p.m. the DON state breakdown occurrent orders for FDON remarked that happened. The Facilities policy of the Facilities of the	in SN)-A, stated the diet for the on the tray card. She went on thow the nurse or nursing the with serving, know what the serving area, when a sted as CCHO and had a print and stated as Told p.m. the process they use when a new of the hospital is to follow the error orders form. The DON and stated R35's diet was derated." The DON went on to when a new resident comes, sees the resident within 24 commendation, this oes to nursing to give to the who comes 2-3 times per	F 69				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (X3)) DATE SURVEY COMPLETED
		245149	B. WING		03/15/2018
	ROVIDER OR SUPPLIER	- AMBASSADOR		STREET ADDRESS, CITY, STATE, ZIP CODE B100 MEDICINE LAKE ROAD NEW HOPE, MN 55427	0,10,20,10
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION E DATE
	practitioner as part or clinical condition nutritional status; to increase certain sul	ge 7 n ordered by a healthcare of the treatment for a disease manifesting an altered eliminate, decrease or ostances in the diet. Store/Prepare/Serve-Sanitary	F 692		4/23/18
SS=F	CFR(s): 483.60(i)(1) §483.60(i) Food safe The facility must - §483.60(i)(1) - Proceapproved or considerate or local authorical producer and local producer and local laws or received from using gardens, subject to safe growing and focilities from using gardens, subject to safe growing and focilities from using gardens, subject to safe growing and focilities from consuming focilities from consuming focilities food in accordance f	ety requirements. ure food from sources ered satisfactory by federal, rities. food items obtained directly s, subject to applicable State gulations. Des not prohibit or prevent produce grown in facility compliance with applicable end-handling practices. Des not preclude residents ods not procured by the facility. e, prepare, distribute and dance with professional		Plates, cups and surfaces were wash and sanitized on 3/14/18. DCA was re-educated on infection control and	
	74 out of 74 resider	his had the potential to affect ots currently residing in the distributed their food from the kitchen.		sanitation on 3/14/18. DAA was re-educated on cellphone usage and h washing on 3/14/18. Food and Nutrition staff will be re-educated on hand washing, glove u	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245149	B. WING _	····	03/	15/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		STREET ADDRESS, CITY, STATE, ZIP COD 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 812	was observed to be while coughing and DC-A's cough was continued to cough tops, ovens and for covering her mouth coughing another toughing another toughing another toughing another toughing another tough then immediately so food that was in me foil. While DC-A word was in the continued to cough right arm three time. During observation dietary aid (DA)-A wher cell phone in the washing room. (DA handed her a stack phone in her pocked hands took the plat cart and she wheel. On 3/14/18, at 11:00 Breezy Meadows keep took to clean cuputensils. DA-A pure when approximately the kitchenette flood up off the dining roon to the second sho observed to push to Crossing kitchenette clean dishes away. During interview or stated she typically	22 a.m. dietary cook (DC)-A e walking through the kitchen I not covering her cough. dry and non-productive as she three times over the counter od preparation table before with her bare right hand while ime. She then proceeded to out washing her hands. DC-A tarted to temp the noon meal etal containers covered with as temping the food she i into her antecubital area of	F8	and safe food handling by 4/13 Random audits will be comple Food and Nutrition Director da month, weekly for three month quarterly thereafter. Results to be reviewed and analyzed by Nutrition Director any changes implemented as needed. Find reported to the QAPI committee valuation and recommendation	ted by the illy for one is and if audits will Food and is will be ings will be ee for further	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245149	B. WING _		03	/15/2018
	NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - AMBASSADOR			STREET ADDRESS, CITY, STATE, ZIP C 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 812	typically washes hedishes away and start my hands". DA-A start safe food handling six months. During interview or manager (DM)-A start day/morning shift, sand meticulous. Do some reminders ardietary staff are transafe food handling six months. During interview or registered dietitian cell phones should anyone with a couguntil done coughing RD-A stated dishes and picked up by shands. Review of the staff following: DA-A received Sa and Hand Washing DC-A received trait on 8/6/17 and Hand 11/7/17. Review of the facility Hand Washing and hands after touching (face, hair, body or start on some process of the facility of the facility of the facility hands after touching (face, hair, body or start on some process of the facility	er hands before putting clean ated "darn it I forgot to wash tated the floor was just washed it wasn't completely to would have been after the pen stated she should have at 3/14/18, at 11:55 a.m. dietary atted that DA-A is new to the she is pretty good, organized M-A stated DA-A may needs and education. DM-A stated all ined on hand washing and during orientation and every at 3/15/18, at 9:00 a.m. facility (RD)-A stated she believes not be in the kitchen at all and the should leave the kitchen at all and the should leave the floor taff should always was hands. It is that have touched the floor taff should always wash their training records indicated the fee Food Handling on 1/24/18. Ining on Safe Food Handling on Washing and Hygiene on titles' 12/17, revised policy titled and Glove Use indicated washing any contaminated object clothing, garbage or dirty suphones. Jinen or money)	F 8			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		RIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245149	B. WING		03/	15/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		STREET ADDRESS, CITY, STATE, ZIP 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COME (CONTROL OF COME ACTION OF COME	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 812		coughing or blowing nose.	F 8			4/00/40
F 880 SS=D	Infection Prevention CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 8	80		4/23/18
	infection prevention designed to provide comfortable enviror	tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable				
	program. The facility must es	tablish an infection prevention (IPCP) that must include, at owing elements:				
	reporting, investigate and communicable staff, volunteers, vis providing services userrangement based	upon the facility assessment g to §483.70(e) and following				
	procedures for the put are not limited to (i) A system of surve possible communic infections before the persons in the facili (ii) When and to who communicable disereported;	eillance designed to identify able diseases or ey can spread to other				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURV	
		245149	B. WING _		03/15/20	18
	PROVIDER OR SUPPLIER	- AMBASSADOR		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE COMP	X5) PLETION PATE
F 880	to be followed to pr (iv)When and how resident; including (A) The type and di depending upon the involved, and (B) A requirement t least restrictive pos- circumstances. (v) The circumstan- must prohibit emple disease or infected contact with reside contact will transmi (vi)The hand hygiel by staff involved in §483.80(a)(4) A sys- identified under the corrective actions t §483.80(e) Linens. Personnel must ha transport linens so infection. §483.80(f) Annual I The facility will con- IPCP and update th This REQUIREMED by: Based on observa- review the facility fa properly changed g hygiene during pers infection control pra-	revent spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility by ees with a communicable skin lesions from direct into or their food, if direct it the disease; and ne procedures to be followed direct resident contact. Istem for recording incidents a facility's IPCP and the aken by the facility.	F 88	RN-B was re-educated on 3-12-1 and procedures for Hand hygiene, washing and proper glove use. No reeducated on policy and procedured Hand hygiene, Hand washing and glove use on 3-14-18. All residents in facility were review.	Hand A-A was res for proper	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		SURVEY PLETED
		245149	B. WING		03/-	15/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		STREET ADDRESS, CITY, STATE 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 880	diagnoses of deme of protein that can progressive decline history of urinary transcription of urinary dated 1/29/18, identificant change dated 1/29/18, identificant of urinary impairments assistance for all a frequently incontined. During an observation of urinary and u	ecord, dated 12/27/17, included entia with Lewy bodies (clumps form in the brain, causing in intellectual functioning), act infection, and history of acterial infection). R42's Minimum Data Set (MDS), atified R42 had severe nt, required extensive ctivities of daily living, and was ent of bowel and bladder. Sion of personal cares on m. R42's call light was on, and RN)-B entered the room. R42 to be changed. RN-B donned at a brief. RN-B unfastened the brief into the garbage, and a washcloth to clean R42's peri late's bottom with a towel and under her. Without removing RN-B pulled up R42's pajama or blankets, placed R42's call domen, and used the bed e bed. Still, without removing RN-B tied the garbage bag and throom, where she used the copen the bathroom door. Throom, RN-B removed the ned her hands, and left the garbage bag. On 3/12/18, at 6:40 p.m. RN-B lid have taken off the soiled de, after completing peri cares, R42's bed controls, call light,	F 8	facility acquired infection No facility acquired infection identified at time of revolution Nursing staff will be re-4/13/18 on Infection con Procedures for hand H washing and proper global Random Infection cont completed by nursing smonth, monthly for 3 m quarterly thereafter as Infection Preventionist Results of audits will be analyzed by Infection PDNS with changes imponeded. Infection Preventionings to the Quarther evaluation and surface in the Control of the Con	ections were iew. educated by antrol Policy and ygiene, Hand ove use. rol audits will be staff weekly for 1 anonths and coordinated by the Nurse and DNS. e reviewed and Preventionist and elemented as entionist Nurse will aAPI committee for	

CLIVILI	10 I OIT WILDIOATTL	A MEDICAID SERVICES				<u> JIVID IVO.</u>	. 0330-0331
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY IPLETED
		245149	B. WING	· <u> </u>		03/	15/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		8	TREET ADDRESS, CITY, STATE, ZIP CODE 100 MEDICINE LAKE ROAD IEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	nursing assistant (Nares for R42 with ga washcloth to was R42's torso and arribrief. NA-A used the peri area of incontina towel, and applied bottom. NA-A reme exposing another gremove the soiled gamers, putting on sit on the edge of the stand lift sling around the lift to transfer Rin the wheelchair, Nare R42, offered to assist the plastic bag continued to the bathrone remaining glove on bare hand, and a rehand, exposing and Without performing up the plastic bag wopened R42's room with her right hand. hallway, stopped at opened it, threw the and removed the glit away. NA-A came room, touching the nearby sink and wapushed R42 to a direction.	ion on 3/14/18, at 7:49 a.m. NA)-A was performing personal gloved hands. NA-A gave R42 h her face. NA-A washed npits, and unfastened her washcloth to clean R42's nent stool, dried the area with d barrier cream to R42's oved the soiled right glove, love underneath. NA-A did not glove on the left hand. NA-A R42, pulling open dresser clothing, and assisted R42 to be bed. NA-A placed the sit to be decay and proceeded to use 42 into the wheelchair. Once la-A placed a pillow behind ist with brushing her teeth, tied asining the soiled brief, and born. NA-A removed the the right hand, exposing her emoved a glove from the left other glove underneath. hand hygiene, NA-A picked with her gloved left hand, and a door leading into the hallway NA-A pushed R42 through the the soiled utility room door, a plastic bag into a large bin, ove on her left hand and threw a back out of the soiled utility door handle, and walked to a shed her hands. NA-A then	F	880			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY IPLETED
		245149	B. WING _		03/	15/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	she had been a nur and "double gloving habit." NA-A stated not okay but that's moving, then I don' out." During an interview director of nursing educated upon hire hand hygiene, and testing on handwas of personal protecti demonstration and stated staff are rem removed after peri washed before tour resident. DON state of gloves was not at the facility because the glove undernea further stated, "The change their gloves after taking gloves Review of the facility Taking Off Personal dated 2/18, directed during resident, path hands will move from (e.g., perineal area.)	so it's clean." NA-A indicated rsing assistant for 30 years g" was "maybe just a bad, "It's [double gloving] probably how I do it. It keeps me thave to stop to switch them on 3/14/18, at 12:22 p.m. the (DON) stated staff were regarding glove use and had annual competency thing and donning and doffing ve equipment, with return demonstration. DON sinded that gloves should be care, and hands should be care, and hands should be care, and hands should be care that was taught at practice that was taught at the would be clean." DON expectation is that staff would in between cares and wash	F 88			

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL		ID: 45LK
1. MEDICARE/MEDICAID PROVIDE (L1) 245149 2.STATE VENDOR OR MEDICAID NO (L2) 564214100	ER NO.	3. NAME AND AD (L3) GOOD SAM (L4) 8100 MEDIC (L5) NEW HOPE	DRESS OF FACIL ARITAN SOCI CINE LAKE RO	LITY ETY - AM	BASSADOR (L6) 55427	4. TYPE OF AC 1. Initial 3. Termination 5. Validation 7. On-Site Visit	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF O (L9) 6. DATE OF SURVEY 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 77 (L37) (L38)	08/2018 (L34) (L10) N 77 (L18) 77 (L17)	Compliance1.	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/IID 12 RHC 5:	02	8. Full Survey A FISCAL YEAR EN 12/31 he Following Requirem 6. Scope 7. Medica	After Complaint RDING DATE: (L35) ents: of Services Limit al Director Room Size
STATE SURVEY AGENCY REMA 17. SURVEYOR SIGNATURE	ARKS (IF APPLICABLI	E SHOW LTC CANCE	ELLATION DATE):	18. STATE SURVEY AGENCY	APPROVAL	Date:
Carlene Lange, HFE			05/22/2018 BY HCFA RE	(L19)	Joanne Simon, Enfo	•	ecialist 05/22/2018
DETERMINATION OF ELIGIBILE X 1. Facility is Eligible to	TTY Participate	20. COM	PLIANCE WITH GHTS ACT:		21. 1. Statement of Fina	ncial Solvency (HCFA- ol Interest Disclosure St	
22. ORIGINAL DATE OF PARTICIPATION 02/26/1968 (L24) 25. LTC EXTENSION DATE: (L27)	23. LTC AGREEM BEGINNING I (L41) 27. ALTERNATIV A. Suspension B. Rescind Suspension	PE SANCTIONS of Admissions:	4. LTC AGREEM ENDING DAT (L25) (L44) (L45)		26. TERMINATION ACTION: VOLUNTARY 01- 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fa nent 06-Fa n OTHE	ovider Status Change
28. TERMINATION DATE:	29.	INTERMEDIARY/C	CARRIER NO.		30. REMARKS		

(L31)

(L33)

DETERMINATION APPROVAL

32. DETERMINATION OF APPROVAL DATE

05/02/2018

31. RO RECEIPT OF CMS-1539

(L28)

(L32)



CMS Certification Number (CCN): 245149

May 22, 2018

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

Dear Ms. Barta:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 8, 2018 the above facility is recommended for:

Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health Licensing and Certification Program Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us



Electronically delivered May 22, 2018

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

RE: Project Number S5149028

Dear Ms. Barta:

On March 29, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 15, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 8, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 15, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 8, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 15, 2018, effective May 8, 2018 and therefore remedies outlined in our letter to you dated March 29, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us



Electronically delivered

May 22, 2018

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

Re: Reinspection Results - Project Number S5149028

Dear Ms. Barta:

On May 8, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 15, 2018, with orders received by you on March 29, 2018. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL FE SURVEY AGENCY		45LK ility ID: 00898
1. MEDICARE/MEDICAID PROVII (L1) 245149 2.STATE VENDOR OR MEDICAID (L2) 564214100	DER NO.	3. NAME AND AD (L3) GOOD SAM (L4) 8100 MEDIC (L5) NEW HOPE	DDRESS OF FAC IARITAN SOC CINE LAKE F	CILITY CIETY - AN		4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 7. OUTPOST OF SURVEY 8. ACCREDITATION STATUS: 9. Unaccredited 1. TJC 2. AOA 3. Other	15/2018 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	GORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	7. On-Site Visit 8. Full Survey After Co FISCAL YEAR ENDING 12/31	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	77 (L18) 77 (L17)	Compliance1. A X B. Not in Con	equirements e Based On:	gram	And/Or Approved Waivers Of 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural SI 5. Life Safety Code * Code: B *	7. Medical Direct	ces Limit tor
14. LTC CERTIFIED BED BREAKD 18 SNF 18/19 SNF 77 (L37) (L38)		ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REI17. SURVEYOR SIGNATURELou Anne Degagne, HFE		Date : 04/10/2		Í	18. STATE SURVEY AGENCY Amy Johnson, Enforce		Date: 04/26/2018
PA	ART II - TO BE	COMPLETED I	BY HCFA RE	(L19) EGIONAL	OFFICE OR SINGLE S	STATE AGENCY	(L20
DETERMINATION OF ELIGIB 1. Facility is Eligible to 2. Facility is not Eligible.	Participate		IPLIANCE WITH	H CIVIL		ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HC /e:	CFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 02/26/1968 (L24) 25. LTC EXTENSION DATE: (L27)	A. Suspensio		4. LTC AGREEM ENDING DAY (L25) (L44)		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	0 INVOLUNTA 05-Fail to Med sement 06-Fail to Med on OTHER	et Health/Safety et Agreement
28. TERMINATION DATE:	29). INTERMEDIARY/	(L45) CARRIER NO.		30. REMARKS		
		00140		(121)	-		
	(L28)			(L31)			

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)

31. RO RECEIPT OF CMS-1539



Electronically delivered March 29, 2018

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

RE: Project Number S5149028

Dear Ms. Barta:

On March 15, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us

Phone: (320) 223-7343 Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 24, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 24, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Good Samaritan Society - Ambassador March 29, 2018 Page 4

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 15, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the

Good Samaritan Society - Ambassador March 29, 2018 Page 5

failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 15, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 Good Samaritan Society - Ambassador March 29, 2018 Page 6

> St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist

Minnesota Department of Health

Health Regulation Division

Mostuly En

Program Assurance Unit

phone 651-201-4117 fax 651-215-9697

email: michaelyn.bruer@state.mn.us

PRINTED: 04/23/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		E SURVEY MPLETED
		245149	B. WING _		03/	/15/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	Emergency Prepar conducted on Marc during a recertificat compliance with the Preparedness Req INITIAL COMMENT On March 12 throus standard survey was the Minnesota Dep if your facility was i requirements of 42	TS ugh March 15, 2018, a as completed at your facility by artment of Health to determine	F 00	00		
	allegation of complen enrolled in the electic (ePOC), a signature of the first page	ion will serve as your facility's iance. Since your facility is tronic Plan of Correction re is not required at the bottom the CMS-2567 form. acceptable ePOC an on-site ty may be conducted to antial compliance with the en attained in accordance with Communication w/ Privacy 6)-(9) resident has the right to have to the use of a telephone, TDD services, and a place in alls can be made without being cludes the right to retain and e at the resident's own	F 57	76		4/23/18

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

(X6) DATE

Electronically Signed 04/06/2018

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.

TITLE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		245149	B. WING		03/	15/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 576	facilitate that residindividuals and enfacility, including refacility, including refacility, including refacility; and (iii) The internet, to facility; and (iii) Stationery, posthe ability to send §483.10(g)(8) The and receive mail, and other material resident through a service, including (i) Privacy of such with this section; a (ii) Access to static implements at the §483.10(g)(9) The reasonable access electronic communicat (i) If the access is (ii) At the resident' expense is incurre access to the resid (iii) Such use must law. This REQUIREMED by: Based on intervie failed to ensure mon Saturdays. This	facility must protect and ent's right to communicate with tities within and external to the easonable access to: cluding TTY and TDD services; the extent available to the stage, writing implements and mail. resident has the right to send and to receive letters, packages is delivered to the facility for the means other than a postal the right to: communications consistent and onery, postage, and writing resident's own expense. resident has the right to have is to and privacy in their use of nications such as email and ions and for internet research, available to the facility is expense, if any additional ind by the facility to provide such	F 576	Preparation and execution of this response and plan of correction of constitute an admission or agree the provider of the truth of the fact alleged or conclusions set forth in statement of deficiencies. The placorrection is prepared and/or executions.	does not ment by ts the an of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY PLETED
		245149	B. WING _		03/	15/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 576	On 3/14/18, at 10:2 residents met to dis When asked wheth mail Monday throughthey did not received did not know why. During an interview activity director (AD stated residents did Saturdays because facility as a "busine Saturday deliveries" When interviewed administrator state Friday mail delivery on Saturdays." The a problem with the on the unattended and residents were mail, so arrangement office at least a year mail, and to only deadministrator state postman can't secuthat it's secure." The technically violating deliver on Saturday. Review of the facility dated 2/17, included privacy in oral, writt communications, in promptly receive united to the same as the same	27 a.m. a group of four scuss the resident council. her residents received their gh Saturday, residents stated at their mail on Saturdays and on 3/14/18, at 1:45 p.m. the 20) and the music therapist (MT) of not receive mail on the postal service treated the ess" so they did not receive so they did not receive on 3/15/18, at 1:42 p.m. the did, "We have Monday through of and we do not have delivery administrator stated they had postal service leaving the mail reception desk on Saturdays agoing through other residents' ents were made with the post ar ago to hold the Saturday eliver it during the week. The did, "It's not secure because the ure it. They can't guarantee he administrator stated, "It's not get the regulation if they don't of the regulation if they don't of the nand electronic including the right to send and nopened mail and other letters, or materials delivered to the	F 57	solely because it is required by the provisions of federal and state lathe purposes of any allegation the center is not in substantial compwith federal requirements of parthis response and plan of correct constitutes the center! sallegatic compliance in accordance with some 7305 of the State Operations Marker Postal office will deliver mail on effective 4/14/18. Resident mail will be delivered. Random audits to ensure mail is on Saturdays and delivered to rewill be completed by the HIM states for one month, monthly for 3 maguarterly thereafter. Results will reviewed by the HIM Director with changes implemented as needed. Committee for further evaluation recommendation.	w. For at the liance icipation, tion on of ection inual. Saturdays received received sidents aff weekly onths and be h d. QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
	245149	B. WING		03/15/2018
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY -	AMBASSADOR		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427	03.10.2010
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION E DATE
(Includes naso-gastriboth percutaneous e percutaneous endosenteral fluids). Base comprehensive asseensure that a resider §483.25(g)(1) Mainta of nutritional status, sidesirable body weigh balance, unless their demonstrates that the preferences indicate §483.25(g)(2) Is offermaintain proper hydribarian proper hydribarian proper hydribarian provider orders a their This REQUIREMENthis REQUIREMENthis REQUIREMENthis registered discarbohydrate diet (Congress) reviewed for nutritional provider orders and from the registered discarbohydrate diet (Congress) reviewed for nutritional provider orders and from the registered discarbohydrate diet (Congress) reviewed for nutritional provider orders and from the registered discarbohydrate diet (Congress) reviewed for nutritional provider orders and from the registered discarbohydrate diet (Congress) reviewed for nutritional provider orders and from the registered discarbohydrate diet (Congress) reviewed for nutritional provider orders and from the registered discarbohydrate diet (Congress) reviewed for nutritional provider orders and from the registered discarbohydrate diet (Congress) reviewed for nutritional provider orders and from the registered discarbohydrate diet (Congress) reviewed for nutritional provider orders and from the registered discarbohydrate diet (Congress) reviewed for nutritional provider orders and from the registered discarbohydrate diet (Congress) reviewed for nutritional provider orders and from the registered discarbohydrate diet (Congress) reviewed for nutritional provider orders and from the registered discarbohydrate diet (Congress) reviewed for nutritional provider orders and from the registered discarbohydrate diet (Congress) reviewed for nutritional provider diet (Congress) reviewed for nutritional	nutrition and hydration. ic and gastrostomy tubes, ndoscopic gastrostomy and copic jejunostomy, and d on a resident's essment, the facility must nt- ains acceptable parameters such as usual body weight or nt range and electrolyte resident's clinical condition is is not possible or resident otherwise; red sufficient fluid intake to ration and health; red a therapeutic diet when problem and the health care	F 692 F 692		plan

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		E SURVEY IPLETED
		245149	B. WING _		03/	15/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		STREET ADDRESS, CITY, STATE, ZIP C 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 692	indicated R35 was Lantus sliding scale (patient) admitted to for PT (physical the therapy) and ST (see R35's Face Sheet regular diet. The Interagency As from the hospital, of had a diagnosis of with long term current the form indicated dietetic association Control. The Interagency Tree hospital, dated 1/16 tolerated. R35's Food and Nuclectronically signed (RD), and dated 1/10 "received a diabetic 1/19 recommend see R35's Order Summindicated Blood gluday, Humalog Kwikunits/ML (milliliter) (scale, start date of 50 MG (milligrams) DM, Toujeo Solosta units/ML (insulin glamorning for DM, steries and see R35'ML (insulin glamorning for DM, steries and see R35'ML (insulin glamorning for DM, steries R35'ML (insulin glamorning for DM)	are Area Assessment (CAA) hyperglycemic, receiving to Humalog (insulin) added. Pto TCU (transitional care unit) to TCU (transitional peech therapy). Indicated R35 was on a sesessment and Transfer Form that the diagram and transfer Form that the diagram and transfer Form the transfer Orders, from the transfer Orders, f	F 69	procedure and system procorders and nutrition. Random audits to ensure reand ordered diets are in pladone by the Dietician weekl monthly for 3 months and quadrenater. Results of audits reviewed by Dietitian and Dichanges implemented as not recommittee for further evaluative recommendations.	eccomended ace will be y for a month, uarterly s will be NS with eeded. the QAPI	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION		E SURVEY PLETED
		245149	B. WING		 	03/	15/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		810	REET ADDRESS, CITY, STATE, ZIP CODE 10 MEDICINE LAKE ROAD W HOPE, MN 55427	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	assistant director of process for initiating dietician assesses recommendation at to the nurse who set to the physician to sthen provides this complement. Review of the Medi (MAR) for February R35's blood glucos to 297, with one read MAR for March, wit indicated a diet include texture, regular fluid During interview on provided the Tray Ckitchen staff to follor R35's Tray Card incliquids. The RD rev Collection, dated 1-made a recommenstated the main difficult and the regular diet sugar free desserts The RD stated the new resident, compand provide to the rephysician for a sign recommendation at their electronic record, the and was unsure wherecommendation.	f nursing (ADON) stated the g special diets, is that their the resident, provides dietary and gives this recommendation ends the diet recommendation sign. Once signed, the nurse order to the kitchen to cation Administration Records and March of 2018, indicated the levels ranged from low 50's ading on 2/13/18, at 478. The andicated no special diet, The haprint date of 3/15/18, uding CCHO diet regular disconsistency, for DM. 3/15/18 at 9:11 a.m., the RD card (the card that is used by a widetary recommendations). dicated diet as regular with thin itewed the Food and Data 19-18, and stated she had dation for a CCHO diet and derence between a CCHO diet is that the resident is offered as if they are on a CCHO diet. Process was to assess the olete a recommendation form nurses who would send to the ature. The RD stated this and order should be stored in ord. Upon review of the ne RD was unable to locate	F6	92			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245149	B. WING		03	/15/2018
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP C 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE
F 692	registered nurse or residents are listed to state that this is assistant that diet is. Refrom the diet was now date of 3/15/18. During interview of DON stated the president comes from the state that typically the dietician asses hours, makes a recommendation nurse practitioner week. The DON recommendation, RD recommendation, RD recommendation, RD recommended DON reviewed current orders for DON remarked the happened. In a subsequent in p.m. the DON state we know nurse practitioner to state we know nurse practitioner that the state was the state where the state we know nurse practitioner that the state was the state was the state where the state was the state	(RN)-A, stated the diet for the ed on the tray card. She went on a how the nurse or nursing ist with serving, know what the N-A pulled out the tray card in the dining room serving area. I listed as CCHO and had a print on 3/15/18, at 1:06 p.m. the rocess they use when a new om the hospital is to follow the effer Orders form. The DON in and stated R35's diet was colerated." The DON went on to when a new resident comes, sees the resident within 24 ecommendation, this goes to nursing to give to the comes 2-3 times per	F6	592		
		cy on Diet Orders, with a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED
		245149	B. WING		03/15/2018
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - AMBASSADOR				STREET ADDRESS, CITY, STATE, ZIP CODE 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427	,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 692	Continued From page 7		F 69	2	
	practitioner as part or clinical condition nutritional status; to increase certain su Food Procurement	ordered by a healthcare of the treatment for a disease manifesting an altered eliminate, decrease or bstances in the diet. Store/Prepare/Serve-Sanitary	F 81:	2	4/23/18
55=F	CFR(s): 483.60(i)(1 §483.60(i) Food sa The facility must -				
	approved or consid state or local autho (i) This may include from local producer and local laws or re (ii) This provision defacilities from using gardens, subject to safe growing and for (iii) This provision of	e food items obtained directly s, subject to applicable State			
	serve food in accor standards for food: This REQUIREMED by: Based on observative review, the facility for serving utensils we sanitary manner. To according to the serving utensils we sanitary manner. To according to the serving utensils we sanitary manner. To according to the serving utensils we sanitary manner.	e, prepare, distribute and dance with professional service safety. NT is not met as evidenced tion, interview and document ailed to ensure food and re served and handled in a this had the potential to affect at currently residing in the ditheir food from the kitchen.		Plates, cups and surfaces were wa and sanitized on 3/14/18. DCA was re-educated on infection control an sanitation on 3/14/18. DAA was re-educated on cellphone usage ar washing on 3/14/18.	s d
	Findings include:			Food and Nutrition staff will be re-educated on hand washing, glov	re use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245149	B. WING		03/1	15/2018	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		81	TREET ADDRESS, CITY, STATE, ZIP CODE 100 MEDICINE LAKE ROAD EW HOPE, MN 55427	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	was observed to be while coughing and DC-A's cough was continued to cough tops, ovens and for covering her mouth coughing another tiput on gloves withouthen immediately sifood that was in me foil. While DC-A was continued to cough right arm three time. During observation dietary aid (DA)-A wher cell phone in the washing room. (DA handed her a stack phone in her pocke hands took the plat cart and she wheeled on 3/14/18, at 11:0 Breezy Meadows k stacks of clean cuputensils. DA-A puswhen approximately the kitchenette floo up off the dining roonto the second shobserved to push the Crossing kitchenette clean dishes away to the second should be secon	2 a.m. dietary cook (DC)-A walking through the kitchen not covering her cough. dry and non-productive as she three times over the counter of preparation table before with her bare right hand while me. She then proceeded to ut washing her hands. DC-A tarted to temp the noon meal etal containers covered with as temping the food she into her antecubital area of es. on 3/14/18, at 11:40 a.m. was observed to be talking on e kitchen in front of dish.)-B walked up to DA-A and of clean plates. DA-A put her t and without washing her es and set them on a brown ed cart into the dining room. 0 a.m. DA-A was observed in itchenette with a cart that had is, tongs, and several other shed the cart out of the area of 10 clear plastic cups fell on r. DA-A then picked the cups of 10 clear plastic cups fell on r.	F8	12	and safe food handling by 4/13/18. Random audits will be completed be Food and Nutrition Director daily for month, weekly for three months and quarterly thereafter. Results of audie be reviewed and analyzed by Food Nutrition Director any changes will limplemented as needed. Findings were ported to the QAPI committee for evaluation and recommendation	r one d lits will and be will be	
	stated she typically	3/14/18, at 11:05 a.m. DA-A puts dirty dishes on the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245149	B. WING _		03	/15/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 812	dishes away and s my hands". DA-A s 15 minutes ago so contaminated like in ight shift. DA-A th washed her hands During interview or manager (DM)-A s day/morning shift, and meticulous. D some reminders and ietary staff are trasafe food handling six months. During interview or registered dietitian cell phones should anyone with a couguntil done coughing RD-A stated dishes and picked up by shands. Review of the staff following: DA-A received Sa and Hand Washing DC-A received tra on 8/6/17 and Han 11/7/17. Review of the facili Hand Washing and hands after touchir (face, hair, body or	er hands before putting clean tated "darn it I forgot to wash stated the floor was just washed it wasn't completely t would have been after the nen stated she should have	F 81.	2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245149	B. WING _		03/1	5/2018	
	PROVIDER OR SUPPLIER	- AMBASSADOR		STREET ADDRESS, CITY, STATE, ZIP COE 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 812 F 880 SS=D	Infection Preventio	, coughing or blowing nose. n & Control	F 81			4/23/18	
	infection prevention designed to provide comfortable environdevelopment and to diseases and infection program.	stablish and maintain an n and control program e a safe, sanitary and nment and to help prevent the ransmission of communicable					
	a minimum, the foll §483.80(a)(1) A system reporting, investigated and communicable staff, volunteers, viproviding services arrangement based	stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual dupon the facility assessmenting to §483.70(e) and following					
	procedures for the but are not limited (i) A system of surv possible communic infections before th persons in the facil (ii) When and to wh communicable dise reported;	reillance designed to identify cable diseases or ley can spread to other					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245149	B. WING		03/	03/15/2018	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		STREET ADDRESS, CITY, STATE, ZIP COE 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	to be followed to pr (iv)When and how resident; including (A) The type and d depending upon the involved, and (B) A requirement t least restrictive pos- circumstances. (v) The circumstan- must prohibit emploisease or infected contact with reside contact will transm (vi)The hand hygie by staff involved in §483.80(a)(4) A sys- identified under the corrective actions t §483.80(e) Linens. Personnel must ha transport linens so infection. §483.80(f) Annual The facility will con IPCP and update tl This REQUIREME by: Based on observa- review the facility fa properly changed of hygiene during per- infection control pra-	revent spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the ssible for the resident under the ces under which the facility oyees with a communicable I skin lesions from direct ints or their food, if direct int the disease; and ne procedures to be followed direct resident contact. Stem for recording incidents a facility's IPCP and the aken by the facility.	F 880	RN-B was re-educated on 3- and procedures for Hand hygi washing and proper glove use reeducated on policy and proc Hand hygiene, Hand washing glove use on 3-14-18. All residents in facility were re	ene, Hand e. NA-A was cedures for and proper		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245149	B. WING		03/15/2018		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		10/2010	
GOOD S	AMARITAN SOCIET	/-AMBASSADOR		8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES :Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	R42's admission rediagnoses of demonstrates of protein that can progressive decline history of urinary to Escherichia coli (beginificant change dated 1/29/18, idecognitive impairment assistance for all a frequently incontine. During an observation observation of the control of the collection of the	ecord, dated 12/27/17, included entia with Lewy bodies (clumps form in the brain, causing e in intellectual functioning), ract infection, and history of acterial infection). R42's Minimum Data Set (MDS), ntified R42 had severe ent, required extensive activities of daily living, and was ent of bowel and bladder. Ition of personal cares on m. R42's call light was on, and RN)-B entered the room. R42 to be changed. RN-B donned ed a brief. RN-B unfastened the brief into the garbage, and a washcloth to clean R42's peri R42's bottom with a towel and funder her. Without removing RN-B pulled up R42's pajama er blankets, placed R42's call domen, and used the bed he bed. Still, without removing RN-B tied the garbage bag and throom, where she used the to open the bathroom door. athroom, RN-B removed the hed her hands, and left the garbage bag. on 3/12/18, at 6:40 p.m. RN-B alld have taken off the soiled ide, after completing peri cares, g R42's bed controls, call light,	F8	facility acquired infections of the No facility acquired infection identified at time of review. Nursing staff will be re-eduted 4/13/18 on Infection control Procedures for hand Hygiet washing and proper glove. Random Infection control accompleted by nursing staff month, monthly for 3 month quarterly thereafter as cool Infection Preventionist Nurnesults of audits will be reanalyzed by Infection Prevention Prevent	cated by I Policy and Ine, Hand Use. Audits will be Weekly for 1 hs and rdinated by the se and DNS. Viewed and entionist and ented as onist Nurse will committee for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245149	B. WING	B. WING		03/15/2018	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		81	TREET ADDRESS, CITY, STATE, ZIP CODE 100 MEDICINE LAKE ROAD EW HOPE, MN 55427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	During an observat nursing assistant (N cares for R42 with a washcloth to was R42's torso and arr brief. NA-A used th peri area of incontina towel, and applied bottom. NA-A reme exposing another gremove the soiled gremove the lift to transfer R in the wheelchair, NR42, offered to assist the plastic bag continued to the bathrone maining glove on bare hand, and a rehand, exposing and Without performing up the plastic bag wopened R42's room with her right hand. hallway, stopped at opened it, threw the and removed the git away. NA-A came room, touching the nearby sink and wapushed R42 to a di	ion on 3/14/18, at 7:49 a.m. NA)-A was performing personal gloved hands. NA-A gave R42 h her face. NA-A washed mpits, and unfastened her e washcloth to clean R42's nent stool, dried the area with d barrier cream to R42's oved the soiled right glove, love underneath. NA-A did not glove on the left hand. NA-A R42, pulling open dresser clothing, and assisted R42 to be bed. NA-A placed the sit to had R42 and proceeded to use 42 into the wheelchair. Once NA-A placed a pillow behind ist with brushing her teeth, tied taining the soiled brief, and born. NA-A removed the the right hand, exposing her emoved a glove from the left other glove underneath. I hand hygiene, NA-A picked with her gloved left hand, and in door leading into the hallway NA-A pushed R42 through the sthe soiled utility room door, a plastic bag into a large bin, love on her left hand and threw the back out of the soiled utility door handle, and walked to a ushed her hands. NA-A then	F	380			
	[gloves] on each hakeeps it moving." N	NA-A stated, "I usually put two and so when I put cream on, it IA-A verified R42 had a bowel ted, "I removed the dirty one					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245149	B. WING _		03/15/2018	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- AMBASSADOR		STREET ADDRESS, CITY, STATE, ZIP COD 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	after I cleaned her, she had been a nur and "double gloving habit." NA-A stated not okay but that's I moving, then I don't out." During an interview director of nursing (educated upon hire hand hygiene, and testing on handwas of personal protecti demonstration and stated staff are rem removed after peri washed before tour resident. DON state of gloves was not a the facility because the glove undernea further stated, "The change their gloves after taking gloves of the facility Taking Off Personal dated 2/18, directed during resident, path hands will move fro (e.g., perineal area)	so it's clean." NA-A indicated rising assistant for 30 years g" was "maybe just a bad, "It's [double gloving] probably now I do it. It keeps me thave to stop to switch them on 3/14/18, at 12:22 p.m. the (DON) stated staff were, regarding glove use and had annual competency thing and donning and doffing we equipment, with return demonstration. DON sinded that gloves should be care, and hands should be care, and hands should be ching other belongings of the ed wearing more than one pair practice that was taught at the would be clean." DON expectation is that staff would in between cares and wash	F 88	30		

F5149027

Printed: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245149

B. WING

03/14/2018

NAME OF PROVIDER OR SUPPLIER

GOOD SAMARITAN SOCIETY - AMBASSADOR

STREET ADDRESS, CITY, STATE, ZIP CODE

8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

	NEW H	OPE, 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	K 000		
	FIRE SAFETY		5 °	
	An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 14, 2018. At the time of this survey, Good Samaritan Society Ambassador was found 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code.			
	Good Samaritan Society Ambassador Building 1 is a 1-story building with a partial basement. The building was constructed at 2 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. There is a 2-hour fire wall between the 2010 addition and the rest of the building. Therefore, the facility is surveyed as two buildings with two CMS-2786R forms used. The facility is protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors			
	that is monitored for automatic fire department notification. The facility has a capacity of 77 beds and had a census of 73 at time of the survey.	er Haj		3
	The requirement at 42 CFR, Subpart 483.70(a) is MET.			
LABORATO	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	SNATURE	TITLE	(X6) DATE

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

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

Printed: 03/20/2018

	PEPARTMENT OF HEALTH AND HUMAN SERVICES SENTERS FOR MEDICARE & MEDICAID SERVICES							
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM				(X3) DATE SURVEY COMPLETED		
		245149		B. WING		03/1	4/2018	
	PROVIDER OR SUPPLIER SAMARITAN SOCIE	TY - AMBASSADOR	8100 M		TATE, ZIP CODE AKE ROAD 55427	·		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCI (EACH DEFICIENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)		REGULATORY PREFIX (EACH COR		(EACH CORRECTIVE ACTION S	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)		
					±			

F5149027

Printed: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - NEW ADDITION

(X3) DATE SURVEY COMPLETED

245149

B. WING

03/14/2018

NAME OF PROVIDER OR SUPPLIER

GOOD SAMARITAN SOCIETY - AMBASSADOR

STREET ADDRESS, CITY, STATE, ZIP CODE

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)	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	K 000			
	FIRE SAFETY				
	An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 14, 2018. At the time of this survey, Good Samaritan Society Ambassador was found 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code.		# # # # # # # # # # # # # # # # # # #		
	Good Samaritan Society Ambassador Building 2 is a 1-story building without a basement. The building was built in 2010 and was determined to be of Type V (111) construction. There is a 2-hour fire wall between the 2010 addition and the rest of the building. Therefore, the facility is surveyed as two buildings with two CMS-2786R forms used. The facility is protected throughout by an automatic fire sprinkler system and 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.				
9	The facility has a capacity of 77 beds and had a census of 73 at time of the survey.		* * * * * * * * * * * * * * * * * * * *		
	The requirement at 42 CFR, Subpart 483.70(a) is MET.				
	4 2				

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

TITLE

(X6) DATE

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 29, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5149028

Dear Ms. Barta:

The above facility was surveyed on March 12, 2018 through March 15, 2018 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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

Good Samaritan Society - Ambassador March 29, 2018 Page 2

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 Kathleen Lucas, Unit Supervisor, at (320) 223-7343 or kathleen.lucas@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist

Minnesota Department of Health

Health Regulation Division

Mostaly En

Program Assurance Unit

phone 651-201-4117 fax 651-215-9697

email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED		
		00898	B. WING	B. WING		
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, S			
GOOD S	AMARITAN SOCIETY	- AMRASSADOR	OPE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEN	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a survey found that the deficit herein are not corrected shall I with a schedule of fithe Minnesota Department of the Minnesota Department of the Minnesota Department of the number and MN Ru When a rule contain comply with any of the lack of compliance. re-inspection with a result in the assess that was violated ducorrected.	nether a violation has been compliance with all rule provided at the tagule number indicated below. In several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the iteruring the initial inspection was	m s			
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
innesota D	receipt of State licer the Minnesota Depa Informational Bulleti http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/in e licensing orders are				

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

Electronically Signed 04/06/18

TITLE

STATE FORM 6899 If continuation sheet 1 of 15 45LK11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00898		B. WING		03/	15/2018
NAME OF PROVIDER	OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD SAMARITA	N SOCIETY	- AMBASSADOR		DICINE LAKE PE, MN 5542			
	CH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	ES Y FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Departityou ele is nece enter the text. You state lie comple corrected Minness on 3/12 Departit the follow Please correction and ide Minness the State federal assigned Nursing The Nursing Nursi	ctronically. ssary for State word "coru must then censure prootion date, the ded prior to e total Department's staff owing correction dicate in you not that you not that you not the Licensing software. To de to Minnes of Homes. Isigned tag mentitled "ID rule out of cary Statement or ary Statement or statement or suggested eriod for Column IDER'S PLA	alth orders being sub Although no plan of ate Statutes/Rules, prected" in the box as indicate in the electronically submitted the date your orders when the feet of Health. 13/15/18, surveyors visited the above protion orders are issuryour electronic plan or have reviewed these when they will be a ment of Health is doon to be a considered to the electronic plan or have reviewed these are when they will be a ment of Health is doon to be a considered to the electronic plan or have be so a state statutes/rule and the electronic plan or his column also including the surveyors of the state of Deficiencies. This Rule is not make the surveyors of the state of the surveyors of the surveyors of the surveyors of the state of the surveyors of the su	correction blease vailable for tronic ding vill be ing to the of this ovider and ed. of e orders, completed. cumenting using een ules for the tate in the column of the udes the ate statute ate as findings on and of THE on." THIS	2 000			

6899

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATI			SURVEY LETED
		00898	B. WING		03/1	5/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR	ICINE LAKE			
(X4) ID		TEMENT OF DEFICIENCIES	PE, MN 5542	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETE DATE
2 000	Continued From page 2		2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 965	5 MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status		2 965			4/23/18
	Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served.					
	by: Based on interview failed to implement from the registered carbohydrate diet ((R35) reviewed for	and record review, the facility dietary recommendations dietician of a consistent CCHO) for 1 of 4 residents nutrition and dietary status.		corrected		
	Findings Include:					
	(MDS) included dia	inimum Data Set Assessment gnoses of diabetes mellitus, ease and peripheral vascular				
	indicated R35 was Lantus sliding scale (patient) admitted to	are Area Assessment (CAA) hyperglycemic, receiving Humalog (insulin) added. Pt TCU (transitional care unit) rapy), OT (occupational				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00898	B. WING		03/	15/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR	DICINE LAKE OPE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 965	regular diet. The Interagency As from the hospital, do had a diagnosis of twith long term curred the form indicated the dietetic association. Control. The Interagency Transportation of the interagency Transportal, dated 1/16 tolerated. R35's Food and Nutle electronically signed (RD), and dated 1/10 "received a diabetic 1/19 recommend switch of the indicated Blood glued day, Humalog Kwik units/ML (milliliter) (is scale, start date of 50 MG (milligrams) DM, Toujeo Solosta units/ML (insulin glamorning for DM, start director of process for initiating dietician assesses to the interagency in the i	peech therapy). Indicated R35 was on a sessment and Transfer Form ated 1/16/18, indicated R35 type 2 diabetes mellitus (DM), ent use of insulin. In addition, he diet was ADA(American) Diabetic-Carb (carbohydrate ansfer Orders, from the 6/18, indicated diet as trition Data Collection, do by the registered dietician 19/18, indicated that R35 addet in hospital and at home. Witching to CCHO diet ary Report, dated 5/15/18, cose monitoring 4 times per pen solution pen-injector, 100 nsulin lispro)-Inject per sliding 1/31/18 for DM, Januvia-table daily, start date of 3/6/18 for ar solution pen-injector 300 argine) inject 16 units in the		DEFICIENCY		

Minnesota Department of Health

STATE FORM 6899 45LK11 If continuation sheet 4 of 15

PRINTED: 04/23/2018 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '			E SURVEY PLETED	
		00898	B. WING		03/	15/2018
NAME OF I	PROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR	MEDICINE LAK			
		NEV	V HOPE, MN 554			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 4	2 965			
	then provides this o implement.	rder to the kitchen to				
	(MAR) for February R35's blood glucose to 297, with one real MAR for February in MAR for March, with indicated a diet include texture, regular fluid During interview on provided the Tray Ckitchen staff to follo R35's Tray Card incliquids. The RD revice Collection, dated 1-made a recommend stated the main different and the regular diet sugar free desserts. The RD stated the promote to the resident, compand provide to the rephysician for a significant recommendation are their electronic record, the recommendation. During interview on registered nurse (R residents are listed to state that this is hassistant that assist resident diet is. RN-	3/15/18, at 10:27 a.m. N)-A, stated the diet for the on the tray card. She were now the nurse or nursing twith serving, know what -A pulled out the tray card	ated 50's The			
		the dining room serving ar sted as CCHO and had a				

Minnesota Department of Health

STATE FORM 6899 45LK11 If continuation sheet 5 of 15

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00898	B. WING		03/1	5/2018
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE	•	
GOODS	AMARITAN SOCIETY	- AMBASSADOR	EDICINE LAKE OPE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 965	date of 3/15/18. During interview or DON stated the proresident comes frou Interagency Transforeviewed the formalisted as diet "as to state that typically the dietician assess hours, makes a recrecommendation gonerse practitioner, week The DON recommended DON reviewed currecommended DON reviewed currecurrent orders for FOON remarked that happened. In a subsequent into p.m. the DON state breakdown occurrent orders for FOON remarked that happened. In a subsequent into p.m. the DON state breakdown occurrent orders for FOON remarked that happened. The Facilities policity is a diet intervention practitioner as part or clinical condition nutritional status; to	n 3/15/18, at 1:06 p.m. the ocess they use when a new m the hospital is to follow the er Orders form. The DON and stated R35's diet was lerated." The DON went on to when a new resident comes, sees the resident within 24 commendation, this oes to nursing to give to the who comes 2-3 times per	e			

6899

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP			SURVEY LETED
		00898	B. WING		03/1	5/2018
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR	DICINE LAKE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	Continued From pa	ige 6	2 965			
	The director of nurs policies and proced receiving the recom	THOD OF CORRECTION: sing could review and revise dures to ensure residents are nmended diet. Director of ate staff and monitor				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21000	MN Rule 4658.0610 Requirements-Hygi	0 Subp. 4 Dietary Staff iene.	21000			4/23/18
	wash their hands a their arms with soa washing facility bef as often as is nece after smoking, eatin handling soiled equ	Dietary staff must thoroughly nd the exposed portions of p and warm water in a hand ore starting work, during work ssary to keep them clean, and ng, drinking, using the toilet, or iipment or utensils. Dietary iir fingernails clean and				
	by: Based on observative review, the facility for serving utensils we sanitary manner. To a out of 74 residents.	ent is not met as evidenced ion, interview and document ailed to ensure food and re served and handled in a This had the potential to affect ints currently residing in the d their food from the kitchen.		corrected		
	Findings include:					
	was observed to be while coughing and	2 a.m. dietary cook (DC)-A walking through the kitchen not covering her cough. dry and non-productive as she				

Minnesota Department of Health

STATE FORM 6899 45LK11 If continuation sheet 7 of 15

PRINTED: 04/23/2018 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00898	B. WING		03/	15/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR	EDICINE LAKE			
(VA) ID	SHIMMADV STA	TEMENT OF DEFICIENCIES	OPE, MN 5542	PROVIDER'S PLAN OF (CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	tops, ovens and foc covering her mouth coughing another tiput on gloves witho then immediately st food that was in me foil. While DC-A was continued to cough right arm three time During observation dietary aid (DA)-A wher cell phone in the washing room. (DA handed her a stack phone in her pocke hands took the plate	three times over the counter of preparation table before with her bare right hand while me. She then proceeded to ut washing her hands. DC-A carted to temp the noon meal stal containers covered with as temping the food she into her antecubital area of es. on 3/14/18, at 11:40 a.m. was observed to be talking on e kitchen in front of dish)-B walked up to DA-A and of clean plates. DA-A put he t and without washing her es and set them on a browned cart into the dining room.				
	Breezy Meadows ki stacks of clean cup utensils. DA-A pus when approximately the kitchenette floor up off the dining ro onto the second sho observed to push the Crossing kitchenette clean dishes away with the condition of the typically washes he dishes away and stand hands. DA-A stand the condition of the typically washes he dishes away and stand hands. DA-A stand the condition of the typically washes he dishes away and stand hands. DA-A stand hands.	0 a.m. DA-A was observed in tchenette with a cart that had s, tongs, and several other shed the cart out of the area y 10 clear plastic cups fell on r. DA-A then picked the cups om floor and placed them elf of the cart. DA-A the was ne cart to the Fire Side e and proceeded to put the with out washing her hands. 3/14/18, at 11:05 a.m. DA-A puts dirty dishes on the cart. DA-A stated she r hands before putting clean ated "darn it I forgot to wash sated the floor was just washed twould have been after the				

Minnesota Department of Health

STATE FORM 6899 45LK11 If continuation sheet 8 of 15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COME	SURVEY PLETED		
		00898		B. WING		03/	15/2018
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21000	night shift. DA-A the washed her hands. During interview on manager (DM)-A step day/morning shift, so and meticulous. Do some reminders are dietary staff are training six months. During interview on registered dietitian cell phones should anyone with a couguntil done coughing RD-A stated dishess and picked up by schands. Review of the staff following: DA-A received Sa and Hand Washing DC-A received train on 8/6/17 and Hand 11/7/17. Review of the facility Hand Washing and hands after touching (face, hair, body or utensils, dirty dishes	en stated she should	m. dietary w to the ganized y needs stated all g and id every n. facility elieves at all and itchen ands. he floor each their cated the 11/29/17 4/18. landling ene on olicy titled d washing object dirty noney)	21000			
	SUGGESTED MET	THOD OF CORREC	TION:				

6899

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '			SURVEY LETED
			A. BUILDING:			
		00898	B. WING		03/1	5/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	' - AMRASSADOR	DICINE LAKE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21000	Continued From pa	age 9	21000			
	could develop, revieducation for staff in appropriate food privitchen. The Quali (QAA) committee consure compliance					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375			4/23/18
	Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.					
	by: Based on observat review the facility fa properly changed g hygiene during pers infection control pra	tion, interview, and document ailed to ensure that staff gloves and performed hand sonal cares to maintain good actices for 1 of 4 residents ring personal cares.		corrected		
	Findings include:					
	diagnoses of deme of protein that can progressive decline history of urinary tra Escherichia coli (ba	ecord, dated 12/27/17, included entia with Lewy bodies (clumps form in the brain, causing e in intellectual functioning), act infection, and history of acterial infection). R42's Minimum Data Set (MDS),				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00898	B. WING		03/	15/2018
NAME OF	PROVIDER OR SUPPLIER	STREE	ADDRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR	MEDICINE LAKE HOPE, MN 5542	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21375	dated 1/29/18, identicognitive impairmer assistance for all ad frequently incontine. During an observation 3/12/18, at 6:34 p.m. registered nurse (R stated she needed gloves and retrieved R42's brief, tossed proceeded to use a area. RN-B dried Replaced a new brief of the soiled gloves, R pants, pulled up her light across her abord controls to lower the soiled gloves, R carried it to the batt gloved right hand to Once inside the batt soiled gloves, wash room carrying the grown carrying the grown carrying the grown carrying the grown carrying and the bathroom do During an observation of the soiled gloves at the bedsic instead of touching and the bathroom do During an observation of the soiled gloves at the bedsic instead of touching and the bathroom do During an observation of the soiled gloves at the bedsic instead of touching and the bathroom do During an observation of the soiled gloves at the bedsic instead of touching and the bathroom do During an observation of the soiled gloves. The soiled gloves at the bedsic instead of touching and the bathroom do During an observation of the soiled gloves. The soiled gloves at the bedsic instead of touching and the bathroom do During an observation of the soiled gloves. The soiled gloves at the bedsic instead of touching and the bathroom do During an observation of the soiled gloves.	tified R42 had severe nt, required extensive ctivities of daily living, and went of bowel and bladder. Son of personal cares on n. R42's call light was on, ar N)-B entered the room. R42 to be changed. RN-B donned a brief. RN-B unfastened the brief into the garbage, a washcloth to clean R42's pulled up R42's pajamar blankets, placed R42's call domen, and used the bed to bed. Still, without removing the bed her hands, and left the arbage bag. On 3/12/18, at 6:40 p.m. RN-d have taken off the soiled de, after completing peri car R42's bed controls, call ligh	d d d d d d d d d d d d d d d d d d d	DEFICIENC		
		d barrier cream to R42's oved the soiled right glove,				

Minnesota Department of Health

STATE FORM 6899 45LK11 If continuation sheet 11 of 15

PRINTED: 04/23/2018 FORM APPROVED

Wilnnesc	<u>ita Department of He</u>	ealth					
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLI	ER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION N	JMBER:	A. BUILDING:		COMP	LETED
				B. WING			
		00898		B. WING		03/1	5/2018
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS. CITY. S	STATE, ZIP CODE		
				ICINE LAKE			
GOOD S	AMARITAN SOCIETY	- AMBASSADOR		PE, MN 5542			
				E, WIN 5542			
(X4) ID		TEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD		(X5)
PREFIX TAG		/ MUST BE PRECEDED B' SC IDENTIFYING INFORM		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
IAO			,	140	DEFICIENCY)		
21375	Continued From pa	ge 11		21375			
	ovnocina another a	love underneath. N	\ \ \ did not				
		glove on the left han					
		R42, pulling open di					
		clothing, and assist					
		ne bed. NA-A placed					
		nd R42 and proceed					
	the lift to transfer R		_				
	in the wheelchair, NA-A placed a pillow behind						
	R42, offered to assist with brushing her teeth, tied						
	the plastic bag containing the soiled brief, and						
		oom. NA-A removed					
		the right hand, expo					
		emoved a glove fron					
		other glove underne					
		hand hygiene, NA-					
		vith her gloved left h					
		n door leading into th					
	with her right hand.	NA-A pushed R42 t	through the				
	hallway, stopped at	the soiled utility roo	m door,				
	opened it, threw the	e plastic bag into a la	arge bin,				
	and removed the gl	love on her left hand	l and threw				
	it away. NA-A came	e back out of the soi	led utility				
		door handle, and wa					
		ished her hands. NA					
	pushed R42 to a di	ning room table.					
	•	· ·					
	When interviewed,	NA-A stated, "I usua	ally put two				
	[gloves] on each ha						
		IA-A verified R42 ha					
	movement, and sta						
		so it's clean." NA-A					
		sing assistant for 30					
		g" was "maybe just a					
	habit." NA-A stated						
	not okay but that's l						
		t have to stop to swi					
	out."	t have to stop to swi	CH THEIH				
	out.						
	During an interview	on 3/14/18, at 12:2	2 nm the				
	unector of nursing ((DON) stated staff w	rere				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 12 of 15 45LK11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00898	B. WING		03/1	5/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AMBASSADOR	ICINE LAKE E, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21375	educated upon hire hand hygiene, and testing on handwas of personal protecti demonstration and stated staff are removed after periowashed before touc resident. DON state of gloves was not at the facility because the glove undernea further stated, "The change their gloves after taking gloves after taking off Personal dated 2/18, directed during resident, path hands will move from (e.g., perineal area) face). Always wash SUGGESTED MET administrator or designed and procedures to control techniques a could be reeducated developed to ensure	e, regarding glove use and had annual competency shing and donning and doffing we equipment, with return demonstration. DON hinded that gloves should be care, and hands should be ching other belongings of the ed wearing more than one pair a practice that was taught at , "You can't be 100% sure that th would be clean." DON expectation is that staff would in between cares and wash off." by's policy, Putting On and Il Protective Equipment (PPE), distaff to, "Change gloves clean and child care if the om a contaminated body site (e.g., hands between gloving." THOD OF CORRECTION: The signee could review policies ensure proper infection are followed. Facility staff did and an auditing system	21375			
21885	. , .	.651 Subd. 21 Patients & ac.Bill of Rights	21885			4/23/18

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8100 MFDICINE LAKE ROAD	
8100 MEDICINE LAKE ROAD	3/15/2018
GOOD SAMARITAN SOCIETY - AMBASSADOR NEW HOPE, MN 55427	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	(X5) COMPLETE DATE
Subd. 21. Communication privacy. Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. (Only portions indicated of this subdivision are subject to assessment.) This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure mail was delivered to residents on Saturdays. This had the potential to affect 16 of 74 residents who received personal mail at the facility Findings include: On 3/14/18, at 10:27 a.m. a group of four residents met to discuss the resident council. When asked whether residents received their mail Monday through Saturday, residents stated they did not receive their mail on Saturdays and did not know why. During an interview on 3/14/18, at 1:45 p.m. the activity director (AD) and the music therapist (MT) stated residents did not receive mail on Saturdays because the postal service treated the facility as a "business" so they did not receive Saturday deliveries. When interviewed on 3/15/18, at 1:42 p.m. the	

Minnesota Department of Health

STATE FORM 6899 45LK11 If continuation sheet 14 of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	
	00898	B. WING		03/1	5/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
GOOD SAMARITAN SOCIETY - AMBASSADOR 8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427					
PREFIX (EACH DEFICIENCY MU	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		21885			

6899