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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 4VDH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00019

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245278**

2.STATE VENDOR OR MEDICAID NO.
(L2) **608716700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - HOWARD LAKE**
(L4) **413 13TH AVENUE**
(L5) **HOWARD LAKE, MN** (L6) **55349**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/28/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor — 11/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 01/24/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 01/27/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/22/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245278
January 24, 2017

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

Dear Ms. Salonek:

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 November 11, 2016 the above facility is certified for or recommended for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 24, 2017

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

RE: Project Number S5278024

Dear Ms. Salonek:

On October 25, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 6, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 28, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 14, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 6, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 11, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 6, 2016, effective November 11, 2016 and therefore remedies outlined in our letter to you dated October 25, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245278 Y1	A. Building B. Wing Y2	11/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0312	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(a)(3)	Completed
LSC	11/11/2016	LSC	11/11/2016	LSC	11/11/2016
ID Prefix F0371	Correction	ID Prefix F0463	Correction	ID Prefix F0465	Correction
Reg. # 483.35(i)	Completed	Reg. # 483.70(f)	Completed	Reg. # 483.70(h)	Completed
LSC	11/11/2016	LSC	11/11/2016	LSC	11/11/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 01/24/2017	SIGNATURE OF SURVEYOR 10562	DATE 11/28/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/6/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245278	A. Building 01 - MAIN BUILDING 01 B. Wing	11/14/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 11/11/2016	ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 11/11/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 01/24/2017	SIGNATURE OF SURVEYOR 19521	DATE 11/14/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/5/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 4VDH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00019

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245278**

2.STATE VENDOR OR MEDICAID NO.
(L2) **608716700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - HOWARD LAKE**
(L4) **413 13TH AVENUE**
(L5) **HOWARD LAKE, MN** (L6) **55349**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/28/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor — 11/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 01/24/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 01/27/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/22/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245278
January 24, 2017

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

Dear Ms. Salonek:

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 November 11, 2016 the above facility is certified for or recommended for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 24, 2017

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

RE: Project Number S5278024

Dear Ms. Salonek:

On October 25, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 6, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 28, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 14, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 6, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 11, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 6, 2016, effective November 11, 2016 and therefore remedies outlined in our letter to you dated October 25, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245278 Y1	A. Building B. Wing Y2	11/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0312	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(a)(3)	Completed
LSC	11/11/2016	LSC	11/11/2016	LSC	11/11/2016
ID Prefix F0371	Correction	ID Prefix F0463	Correction	ID Prefix F0465	Correction
Reg. # 483.35(i)	Completed	Reg. # 483.70(f)	Completed	Reg. # 483.70(h)	Completed
LSC	11/11/2016	LSC	11/11/2016	LSC	11/11/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 01/24/2017	SIGNATURE OF SURVEYOR 10562	DATE 11/28/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/6/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245278	A. Building 01 - MAIN BUILDING 01 B. Wing	11/14/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 11/11/2016	ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 11/11/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY	REVIEWED BY	DATE	SIGNATURE OF SURVEYOR / TITLE	DATE
STATE AGENCY ☐	**(INITIALS)** TL/KJ	01/24/2017	**SIGNATURE OF SURVEYOR** 19521	11/14/2016
CMS RO ☐	**(INITIALS)**		**TITLE**	

FOLLOWUP TO SURVEY COMPLETED ON
10/5/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 4VDH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00019

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245278**

2.STATE VENDOR OR MEDICAID NO.
(L2) **608716700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - HOWARD LAKE**
(L4) **413 13TH AVENUE**
(L5) **HOWARD LAKE, MN** (L6) **55349**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/06/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Michelle Koch, HFE NE II — 11/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 11/22/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 11/22/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 25, 2016

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

RE: Project Number S5278024

Dear Ms.. Salonek:

On October 6, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the October 6, 2016 standard survey the Minnesota Department of Health completed an investigation of complaints numbered H5278006 & H5278007 that were found to be unsubstantiated.

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

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

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

Electronic Plan of Correction - when a plan of correction will be due and the information to be

contained in that document;

Remedies - 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;

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 15, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 15, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

imposition of these remedies.

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

If substantial compliance with the regulations is not verified by January 6, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 6, 2017 (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
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,

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

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaints H5278006 and H5278007 was completed and found not to be substantiated.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with eating as identified in the care plan for 1 of 3 residents (13) who were dependent on staff for activities of daily living. Findings include: R13's quarterly Minimum Data Set (MDS), dated	F 282	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. For the	11/11/16

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

Electronically Signed | 11/03/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	10/06/2016

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F 282	Continued From page 1 8/15/16, identified R13 required extensive assistance of one with eating, but had no problems with eating, swallowing or weight loss. Review of R13's Care Area Assessment dated 2/17/16, identified R13 had poor eyesite and required set up and assistance and or supervision with eating. R13's care plan dated 8/15/16, identified R13 had a terminal prognosis of Chronic Obstruction Pulmonary disease and was on hospice. Further, the care plan identified R13 was to have all food in bowls due to poor vision, and required extensive assistance of one with eating. During interview with R13 on 10/3/16, at 5:46 p.m. R13 stated it was often, "difficult to eat" by himself as he had an arm sling and was almost completely blind in both eyes. Further, R13 stated he was thankful when his family came and assisted him to eat in the evenings. During observation on 10/03/16, at 5:46 p.m. R13 was sitting in his recliner attempting to eat the evening meal. R13's food was not in bowls as directed by the care plan. There was no staff in R13's room assisting him (R13) to eat his meal. During observation on 10/04/16, at 9:00 a.m. R13 was sitting in his room by himself eating breakfast. There was no facility staff in his room assisting him to eat breakfast. On 10/05/16, at 11:48 a.m. dietary aid (DA)-B was observed setting up R13's meal tray after the assistant director of nursing (ADON) came into R13's room and explained staff needed to be present during all meals to assist R13 with eating. After the ADON left R13's room at 11:52 a.m. the	F 282	purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. F282 R13□s care plan interventions for eating assistance was reviewed with his direct care givers on 11/4/16. R13 is receiving assistance with eating in accordance with his plan of care. All current and future residents who require assistance with eating will be provided eating assistance in accordance with their plan of care. These needs will be communicated via the care plan, Kardex and shift to shift reports. Nursing & dietary staffing will be provided with re-education, by DON or designee, by 11/11/16 regarding following care planned interventions for eating assistance and accessing communication of the care planned interventions in the Kardex. The DON or designee will conduct audits for R13 and random other residents requiring assistance to eat to ensure care planned interventions for assistance are being provided. These audits will be completed weekly x 4, monthly X 3. Audit results will be reviewed by facility QAPI committee for further recommendations. Completion date: 11/11/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 2 dietary aid (DA)-B stated she was not aware of any facility staff helping R13 to eat his meals in his bedroom. Further, DA-B stated R13 had been "barely eating anything" over the past few months. When interviewed on 10/05/16, at 12:05 p.m. registered nurse (RN)-A stated R13 needed assistance with eating and a staff member needed to be present with R13 at all times in his bedroom. RN-A stated she was unsure if facility staff were in R13's room for breakfasts. During interview on 10/05/16 at 12:06 p.m. dietary manager (DM) stated R13 had his tray set up in his room per his preference. When (R13) first came to the facility in February 2016 he was independent with eating. Over the last few months, he has required supervision and set up with all meals. When interviewed on 10/05/16, at 1:24 p.m. assistant director of nursing (ADON) stated R13 required an extensive assistance with eating and was not always being assisted with his meals. A facility Cares policy titled, "Care Plan"dated 09/14, identified "residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		11/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 3 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to complete a comprehensive wound assessment for 2 of 3 residents (R45, R13) assessed for non-pressure related skin conditions. Findings include: R45 was observed on 10/3/16 at 2:55 p.m., in their room with a dressing that encircled R45's head and secured with a large elastic dressing. R45 stated she had the dressing because of an old injury which was assessed while at the hospitalized and was on antibiotic treatments. R45's facility face sheet completed at admission on 9/28/16 identified that R45's medical diagnoses included osteomyelitis (bone infection) with underlying chronic lesions and diabetes mellitus (body unable to produce or respond to the hormone insulin). R45's hospital discharge summary, dated 9/28/16, identified (R45) had a chronic wound with inflammation on her scalp that was, "probable scalp osteomyelitis" and was admitted to the facility for continued IV (intravenous therapy-infusion of medication directly into the vein) antibiotic therapy. The hospital discharge summary history and physical, dated and	F 309	F309 R45□s wounds were assessed, measured and documented on 10/5/16. All current residents with wounds have been reviewed to ensure that all assessments, measurements and documentation have been completed per facility policy and procedure. All licensed nursing staff will be provided with re-education, by DON or designee, by 11/11/16 regarding the facility policy and procedure for skin and wound assessment, monitoring and documentation. Focus audits will be conducted for R45 and random other residents with wounds to ensure appropriate assessment, monitoring and documentation have been completed weekly X4 then monthly X 3. Audit results will be reviewed by facility QAPI committee for further recommendations. Completion date: 11/11/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	10/06/2016

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F 309	Continued From page 4	F 309		

scanned 9/30/16, identified under the HEENT (head, eyes, ears, nose and throat) section described the area as, "head with large wound at the vertex, mild erythema, some scabbing, none appears acute. Thin skin."

The electronic record Nursing Admit-Re-Admit Data Collection V-2 completed on 9/28/16 by licensed practical nurse (LPN)-B identified (R45) had "abnormal configuration" which was checked for the head and neck. The narrative description indicated "Due to current diagnosis, head is wrapped and we are unable to see it." Further, the Skin Integrity Section of the assessment identified (R45) had no wounds.

The Admission/Readmission note, completed on 9/28/16 at 5:52 p.m. by registered nurse (RN)-A identified R45 was admitted for IV antibiotic therapy and wound care. The resident had a diagnosis of osteomyelitis of the skull, with a dressing covering her head. There was no indication that a description, appearance, or size of the wound was identified as part of the assessment.

R45's care plan which was initiated on 9/28/16 and identified R45 had "Limited physical mobility r/t [related to] osteomyelitis e/b [evidenced by] weakness." There was no mention of the head wound, how to care for it or any existing skin problems affected by the osteomyelitis.

During interview on 10/3/16 at 7:16 p.m., the director of nursing (DON) reviewed R45's electronic medical record and stated that there were no assessments or documentation that addressed measurements or description of scalp wound. The resident came on Wednesday

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 5	F 309		

(9/28/16), and someone should have assessed and documented on the wound.

During observation on 10/5/16 at 8:47 a.m., R45 had removed the dressing.
R45's scalp was exposed with serous (yellow-clear) drainage on dressing which was removed. RN-A cleansed the area and then proceeded to obtain measurements which included measurement of inclusive areas including scabs/slough. The inclusive area on the crown of R45's head measured 12 cm (centimeters) by 12.5 cm. Within this area, there were four separate areas that were scabbed and had slough near the outer edge of the total circumference. The areas of scab and slough from the upper left measured 5.5 cm x 2 cm and the area on the rear left measured 3 cm by 3.5 cm. On the right rear area, the scab/slough measured 2 cm by 3.4 cm, with the area on the right front measuring 1.2 cm by 3 cm. In the center of the area had white colored lighter tissue in two distinct areas. The area towards the occiput measured 4.5 cm by 3 cm. The second area more faint in appearance and measured 3 cm by 3 cm. Following measurements, wound care was completed with Xeroform dressing applied, covered with mepilex (a soft absorbent dressing which does not adhere to skin) and secured with gauze wrap.

During interview on 10/6/16, at 11:40 a.m., RN-B indicated the first skin assessment should be completed on admission. A wound description, size, location and wound characteristic should be on the Nursing Admit-Re-Admit Data Collection form. RN-B stated any subsequent documentation regarding concerns related to wound or wound care would be in daily progress

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 6	F 309		

notes. RN-B stated the initial assessment would be completed on the day of admission and subsequent measurement and documentation of skin concerns would be completed on Wednesdays by the LPN/RN who was on duty, which was not completed for this resident.

R13's admission record dated 2/7/16, identified multiple diagnosis including; cellulitis, osteoarthritis, edema and blindness in both eyes.

During interview on 10/04/16 at 2:37 p.m. R13 stated there were open area on the front of his nose, and on his left side of his face near his ear which had been present for more than thirty years. He thought there were cancerous skin lesions.

R13's annual Minimum Data Set (MDS) was completed on 02/07/16. The corresponding Skin Integrity Care Area Assessments (CAA)'s identified R13 had several flat rashes on his body upon admission which included; flat rash on the right/left iliac crest (area near the hip bone) and a flat rash on both of his knees. There was no mention of the open area on his nose or any areas on the left side of R13's face near his ear.

Review of subsequent quarterly MDS's dated 5/17/16 and 8/15/16 did not identify any open areas on R13's nose and or the left side of his cheek.

When interviewed on 10/04/16 at 10:24 p.m. the wound registered nurse (RN)-B stated R13 had a habit of picking at his face because of anxiety. Further, RN-B stated open areas should be monitored daily by facility staff and she (RN-B)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 7 was unable to find any assessment of the open areas on R13's nose and left side of face, which identified size, location, and skin characteristics. During interview on 10/05/16, at 1:24 p.m. director of nursing (DON) stated she was unaware of any skin assessments or monitoring for R13's open area on the tip of his nose and the left side of his cheek. Further, DON stated a skin assessment should have been completed upon admission and at a minimum on R13 quarterly assessments. A facility policy titled, "Skin Assessment, Pressure Ulcer and Wound documentation" dated 04/2016, identified it is the facilities responsibility to systematically assess residents in regards to skin breakdown and to quarterly assess/monitor.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide routine nail care for 1 of 3 residents (17) who were dependent on staff for nail care. Further, the facility failed to provide feeding assistance for 1 of 1 residents (R13) who needed extensive staff assistance with eating.	F 312	F312 Staff providing direct care for R13 and R17 were re-educated on providing for these care planned needs on 10/4/16 and 10/6/16 respectively. All current and future residents requiring assistance with eating or nail hygiene have been reviewed and will be provided	11/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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F 312	Continued From page 8 Findings include: R17's quarterly Minimum Data Set (MDS), dated 8/24/16, identified R17 was cognitively intact and required extensive assistance of one to complete personal hygiene cares. R17's care plan, dated 8/31/16, identified R17 had a self care deficit, and listed an intervention of, "Personal Hygiene-resident requires one staff assistance. Provide nails care after showers and on an as needed basis." During observation on 10/03/16, at 5:46 p.m. R17 was seated in a recliner chair in her room. R17 had long fingernails on both hands, with visible thick, brown debris present underneath several of the nails on her left hand. When interviewed on 10/03/16, at 5:46 p.m. R17 stated staff helped her with bathing, and she needed help to clip her fingernails. She stated her nails were dirty and she had just received her weekly bath, on Monday (10/3/16). An un-dated facility Bath List identified R17 received a weekly bath and required extensive assistance of one with personal hygiene. A subsequent observation, on 10/04/16 at 9:07 a.m. and on 10/5/16 at 10:39 a.m. R17 continued to have long fingernails with visible thick, dark debris underneath several of her fingernails on her left hand. When interviewed on 10/05/16, at 10:49 a.m. NA-B stated R17 was dependant on staff for her personal hygiene, and had just received her weekly bath on Monday (10/3/16). Further, NA-B stated R17's fingernails appeared dirty and she	F 312	assistance as specified per their care plan. Nursing staff will be provided with re-education, by the DON or designee, by 11/11/16 regarding accessing the Kardex/care plan and following the care planned interventions for residents requiring assistance with eating and nail hygiene. DON or designee will complete focus audits for R13 and R17 as well as random other residents to ensure care planned interventions are communicated and being followed per their care plan/Kardex weekly X4, then monthly X 3. Audit results will be reviewed by facility QAPI committee for further recommendations. Completion date: 11/11/2016	

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	245278	A. BUILDING _____ B. WING _____	10/06/2016

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GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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F 312	Continued From page 9	F 312		

did not believe nail care had been completed.

During interview on 10/05/16, at 12:30 a.m. director of nursing (DON) stated she was not aware of R17's nail preference, but they were to be trimmed and cleaned on scheduled bath days.

R13's quarterly Minimum Data Set (MDS), dated 8/15/16, indicated R13 required extensive assistance of one with eating. Further, the MDS indemnified R13 had no problems with eating, swallowing or any concerns with weight loss.

Review of R13's Care Area Assessment dated 2/17/16, identified R13 had poor eyesite, required set up and assistance and/or supervision with eating.

R13's care plan dated 8/15/16, identified R13 had a terminal prognosis of Chronic Obstruction Pulmonary disease and was on hospice. Further, the care plan identified R13 was to have all food in bowls due to poor vision, and required extensive assistance of one with eating.

During interview with R13 on 10/3/16, at 5:46 p.m. R13 stated it was often, "difficult to eat" by himself as he had an arm sling and was almost completely blind in both eyes. Further, R13 stated he was thankful when his family came and assisted him to eat in the evenings.

During observation on 10/03/16, at 5:46 p.m. R13 was sitting in his recliner attempting to eat the evening meal. R13's food was not in bowls as directed by the care plan. There was no staff in R13's room assisting him (R13) to eat his meal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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F 312	Continued From page 10	F 312		

During observation on 10/04/16, at 9:00 a.m. R13 was sitting in his room by himself eating breakfast. There was no facility staff in his room assisting him to eat breakfast.

On 10/05/16, at 11:48 a.m. dietary aid (DA)-B was observed setting up R13's meal tray after the assistant director of nursing (ADON) came into R13's room and explained staff needed to be present during all meals to assist R13 with eating. After the ADON left R13's room at 11:52 a.m. the dietary aid (DA)-B stated she was not aware of any facility staff helping R13 to eat his meals in his bedroom. Further, DA-B stated R13 had been "barely eating anything" over the past few months.

When interviewed on 10/05/16, at 12:05 p.m. registered nurse (RN)-A stated R13 needed assistance with eating and a staff member needed to be present with R13 at all times in his bedroom. RN-A stated she was unsure if facility staff were in R13's room for breakfasts.

During interview on 10/05/16 at 12:06 p.m. dietary manager (DM) stated R13 had his tray set up in his room per his preference. When (R13) first came to the facility in February 2016 he was independent with eating. Over the last few months, he has required supervision and set up with all meals.

When interviewed on 10/05/16, at 1:24 p.m. assistant director of nursing (ADON) stated R13 required an extensive assistance with eating and was not always being assisted with his meals.

A facility Cares policy titled, "Activities of Daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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F 312	Continued From page 11 Living"dated 06/14, identified that any resident who is unable to carry out ADL's will receive the necessary services to maintain good nutrition, grooming and personal hygiene.	F 312		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to serve hamburger patties in a sanitary manner to prevent food borne illness, this had the potential to affect 14 of 23 residents who were served hamburger patties from the kitchen. Findings include: During observation on 10/4/16, at 9:28 a.m. dietary aid (DA)-A placed on a clean gloves and started food preparation for the noon meal. With her clean gloved hands, DA-A placed frozen hamburger patties in a plastic lined metal pan and poured gravy over the hamburger patties and repeated the process. She then DA-A touched the lid of the garbage can and placed waste into the garbage. With her soiled gloves, she placed one	F 371	F371 None of the residents were affected. All residents in facility were reviewed for signs and symptoms of food-borne illnesses on 10/04/16. None were noted. Dietary staff will be provided with re-education by the Director of Dietary Services by 11/11/16 regarding the facility policy and procedure for serving and preparing food under sanitary conditions. Random audits will be completed by the Director of Dietary Services for ensuring sanitary practices are being followed weekly X 4 then monthly X 3. Results of audits will be reviewed at the QAPI committee for further evaluations or recommendations.	11/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 12 metal pan with the frozen hamburger patties and gravy into the refrigerator and the second metal pan with frozen hamburger patties into the oven, without first removing her soiled gloves. DA-A continued with her soiled gloves to tie the frozen hamburger patty bag closed and placed it in the freezer. She proceeded to grab clean metal containers with her soiled gloves and placed them on the kitchen counter. DA-A then took off her soiled gloves, did not wash her hands and then washed the kitchen counter. She then opened two cans of carrots and poured the excess liquid into the sink. With her soiled hands, DA-A placed a plastic liner into both metal containers and poured the carrots into each of the metal containers. She then labeled the carrots and placed them into the refrigerator and proceeded to wash her hands. During an interview on 10/4/16 at 9:50 a.m., DA-A stated any time she touched a dirty surface such as a garbage can, she should wash her hands. Further, DA-A stated, she made a mistake after touching the dirty garbage can with her gloved hands. When interviewed on 10/4/16 at 3:02 p.m. dietary manager (DM) stated DA's are expected to wash their hands any time they come into contact with dirty surfaces such as garbage cans. The facility policy titled, "Hand Hygiene and Handwashing" dated 03/2016, the policy identifies employees were expected to wash hands if hands were visibly soiled, and anytime after removing gloves.	F 371		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463		11/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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F 463	Continued From page 13 The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights for 1 of 21 residents (R36) reviewed in the sample were functional and working properly. Findings include: R36's diagnoses, as identified on the Minimum Data Set (MDS) dated 7/5/16 included cerebral vascular accident (stroke). The MDS did not indicate a cognitive level. During observation on 10/3/16 at 2:45 p.m., R36 was seated in her wheel chair, in the day room and listening as current events were read from the newspaper. Activity department staff poured coffee and passed out snacks, and asked R36 if she wanted a cookie. R36 indicated wanting a cookie and coffee, and was observed eating the snack independently. During observation on 10/3/16 at 2:56 p.m., the resident bed-side call light was tested to activate the call light. After numerous attempts of pressing on the switch, which was attached to a cord and connected to the wall, the call light remained inactivated. Nursing assistant (NA)-A entered the room, and in presence of surveyor, also attempted, without success, to activate R36's call light. NA-A then exited the room, and	F 463	F463 R36 call light was repaired immediately on 10/03/16. All resident□s call lights in the center were checked to ensure they are working properly. This was completed by 10/6/16. Nursing will be provided with education regarding proper call light functioning.Housekeeping staff will be provided with education regarding conducting quarterly audits to ensure call lights are functioning properly by 11/11/16. Audits of call lights will be done for R36 and Random other residents by the Director of Environmental Services to ensure call lights are functioning properly daily X 7 days, then weekly X 4 then quarterly thereafter. Audit results will be reviewed by QAPI committee for further recommendations.	

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	245278	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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F 463	Continued From page 14	F 463		

returned a couple minutes later with a new call light cord. NA-A swapped the cords, then demonstrated the new switch was working properly to activate the call light.

In an interview on 10/3/16 at 3:06 p.m., NA-A said she hadn't noticed the call light not to be working in that room, and it was "the first time" she had seen that one failed to work. NA-A said she was not sure if the call lights were routinely checked, but said if they not working, nursing could swap out the cords. NA-A also said R36 did not consistently use the call light, but that all residents, "including [R36]" needed to have one available.

During an interview on 10/5/16 at 2:07 p.m., the director of environmental services (DES) stated that when call lights are noted to be non-functioning, they were "fixed immediately." The DES said however, the facility did not a process in place to routinely check on the functioning of call lights. The DES said "I cannot say" we have a process to check them on a regular basis.

In a subsequent interview on 10/6/16 at 2:12 p.m., the DES shared a facility checklist used by housekeeping and maintenance, which included direction to check the call light and cord, after a resident vacates a room. The DES said once the room was prepared for a new admission, she the form was thrown out. The DES said there was no record of this inspection for room 105. The DES said resident call lights "need to be working" and was a part of resident safety. In regard to a call-light check, the DES said she knew "exactly where to add it."

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	245278	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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F 463	Continued From page 15 A facility policy regarding resident call lights was requested, but none was available.	F 463		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain sanitary and clean conditions for 4 of 23 resident rooms and bathrooms (Rooms #115, 111, 109 and 118) which affected 4 residents who used utilized these rooms. Findings include: During an environmental tour on 10/6/16 at 1:36 p.m., with the director of environmental services (DES) and in presence of the surveyor, resident rooms and bathrooms were reviewed. Parked in bathroom in room #115 was a large, portable commode-like chair, which had been pushed into the room. On the wall opposite the door, five feet from the floor, the wall was scuffed: There were two distinct areas, each 5" (inches) in length, with scraped and missing paint, as well as dime-sized indentations into the wall. When the DES pulled the chair out of the bathroom, turned it around and pushed it back in, the scuff marks and scrapings were consistent with the height and protruding features of the chair frame. The	F 465	F465 The scuffs on the bathroom wall in room 115 were repaired. The scrape marks and missing paint on the wall in room 115 were repaired and repainted. The bathroom wall in room 118 was repaired and repainted. Completion date: 11/08/2016. The bathroom fan vents in rooms 115, 111, 109 were cleaned on 10/07/16. All resident bathrooms and rooms were inspected to access for wall damage, missing paint, and unclean fan vents, etc to ensure sanitary and clean conditions. Completion date: 11/11/2016. The facility “Daily Cleaning”, “Weekly Deep Cleaning” and “Maintenance Discharge” checklists were reviewed and revised as necessary to ensure inspection of resident rooms and bathrooms, and follow-up steps to report any issues found, in order to maintain sanitary and clean conditions. Education regarding these	11/11/16

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	245278	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 16 DES said the markings were likely caused by the chair when it's moved in and out of the bathroom. In addition in room #115, there were scrape marks and missing paint on the wall to the left of main door. Bathrooms in rooms #115, 111 and 109 were reviewed. In each of these rooms, fan vents were found unclean, and in need of vacuuming or dusting, and were acknowledged by the DES. In an interview during the tour at 1:43 p.m., the DES stated resident rooms were cleaned daily, and there were also cleaning tasks that were done on a weekly basis. The DES also said the bathroom in room #115 did not get used as often as a normal bathroom, and the cleaning of the vent "likely got missed." The DES said the wall surfaces in room #115 were "uncleanable," and needed to be fixed. The DES said the bathroom vents in rooms #111 and 109 also needed to be cleaned. The bathroom in room #118 was also inspected, and upon opening the door, on the lower wall opposite the stool were two distinct areas with black scuff marks and chipped and scuffed paint. One area was approximately 2' (feet) in length, and the other 3', both acknowledged by the DES. During a subsequent interview on 10/6/16 at 1:59 p.m., the DES said the wall areas in room #118 in the bathroom, caused by use of the wheeled walker, also were "uncleanable because of the scraped paint." The DES said nearly daily there was new evidence of chipped paint and marks, and was familiar in the bathroom of room 118. The facility's "Daily Cleaning" and "Weekly Deep	F 465	changes and expectations communicated to all environmental services staff. Completion date: 11/11/2016. Completed “Daily Cleaning”, “Weekly Deep Cleaning” and “Maintenance Discharge” checklists are routed to Director of Environmental Services for review to ensure compliance. Director of Environmental Services or designee will conduct random audits of resident bathrooms and resident rooms to monitor performance, and to ensure the facility maintains sanitary and clean conditions. Audits will be done weekly x 4 weeks, then monthly x 2 months. Results of the audits will be brought to facility QAPI committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 17 Cleaning Schedule" form, undated, was reviewed. The form listed cleaning tasks to be done both on daily and weekly schedules. #2 on the deep cleaning schedule directed to "dust air vents."	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/05/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	**413 13TH AVENUE** **HOWARD LAKE, MN 55349**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS FORM-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 05, 2016. At the time of this survey, Good Samaritan Society Howard Lake was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/03/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/05/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	**413 13TH AVENUE** **HOWARD LAKE, MN 55349**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Good Samaritan Society Howard Lake is a one-story building with no basement. The original building was constructed in 1971, with building additions constructed in 1983 and 1994. All buildings are fully fire sprinkler protected and were determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 35 beds and had a census of 28 at time of the survey.	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and	K 025		11/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/05/2016**

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GOOD SAMARITAN SOCIETY - HOWARD LAKE	**413 13TH AVENUE HOWARD LAKE, MN 55349**

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K 025	Continued From page 2 constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to maintain 2 out of 2 smoke barrier walls in accordance with LSC 19.3.7.5. This deficient practice could affect 28 residents. Findings include: On a facility tour between the hours of 08:00 AM and 11:00 AM on 10/05/2016, observation revealed that the facility's 2 smoke barrier walls had a residential grade fire rated foam used to seal around penetrations and not a institutional commercial grade fire rated material. This deficient practice was verified by the Environmental Service Director at the time of the inspection.	K 025	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. K25 The residential grade fire rated foam around the penetrations in the smoke barriers will be removed and replaced with an institutional commercial grade fire rated material by 11/11/16. The Director of Environmental Services is responsible for this correction and monitoring to prevent a recurrence of this deficiency. Completion date: 11/11/16	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance	K 054		11/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/05/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	**413 13TH AVENUE** **HOWARD LAKE, MN 55349**

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K 054	Continued From page 3 with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on review of available documentation and staff interview, the facility had not conducted sensitivity testing of the smoke detectors 1 year after installation in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all 28 residents. Findings include: On facility tour between 8:00 AM and 11:00 AM on 10/05/2016, a review of the facility's available fire alarm test documentation revealed that the facility changed out 24 smoke detectors on 4/07/2015 and failed to conducted the required sensitivity test of each smoke detector 1 year after installation. This deficient practice was verified by the Environmental Service Director at the time of the inspection.	K 054	K54 The smoke detector sensitivity testing has been completed. Proper documentation has been acquired and will be maintained as required per the Life Safety Code Sensitivity testing on all smoke detectors was completed 10/19/16 The Director of Environmental Services is responsible for this correction and monitoring to prevent a recurrence of this deficiency. Completion date: 11/11/16	