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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 6NGV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00898

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245149**

2.STATE VENDOR OR MEDICAID NO.
(L2) **564214100**

3. NAME AND ADDRESS OF FACILITY
(L3)**GOOD SAMARITAN SOCIETY - AMBASSADOR**
(L4)**8100 MEDICINE LAKE ROAD**
(L5)**NEW HOPE, MN** (L6) **55427**

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 **04/08/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **85** (L18)

13.Total Certified Beds **85** (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
	85			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Pam Kerssen, Assistant Program Manager 04/08/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 05/16/2014 (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
02/26/1968
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/26/2014
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number: 24-5149
Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective 3/14/2014, the facility is certified for 85 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245149

Electronically delivered

May 9, 2014

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 3/14/2014, the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 85 skilled nursing facility beds.

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 8, 2014

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

RE: Project Number S5149024

Dear Ms. Barta:

On February 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 6, 2014. 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 April 8, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 28, 2014 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 February 6, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 14, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 6, 2014, effective March 14, 2014 and therefore remedies outlined in our letter to you dated February 18, 2014, will not be imposed.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245149	A. Building B. Wing	4/8/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **03/14/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/14/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/14/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/14/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/14/2014**	ID Prefix **F0466** Reg. # **483.70(h)(1)** LSC	Correction Completed **03/14/2014**
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:	Date:
State Agency	BF/MM	4/8/2014	10679	4/8/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/6/2014			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245149	A. Building B. Wing **01 - MAIN BUILDING 01**	3/28/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **02/25/2014**	ID Prefix	Correction Completed **02/25/2014**	ID Prefix	Correction Completed **02/27/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0022		LSC K0054		LSC K0056	
ID Prefix	Correction Completed **02/28/2014**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0067		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	**Reviewed By** BF/MM	**Date:** 4/8/2014	**Signature of Surveyor:** 10679	**Date:** 3/28/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/5/2014

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245149	A. Building B. Wing **02 - NEW ADDITION**	3/28/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **03/10/2014**	ID Prefix	Correction Completed **02/27/2014**	ID Prefix	Correction Completed **03/14/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0029		LSC K0054		LSC K0056	
ID Prefix	Correction Completed **03/14/2014**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0067		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/MM	4/8/2014	10679	3/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
2/5/2014	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6NGV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00898

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245149**

2.STATE VENDOR OR MEDICAID NO.
(L2) **564214100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - AMBASSADOR**
(L4) **8100 MEDICINE LAKE ROAD**
(L5) **NEW HOPE, MN** (L6) **55427**

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 **02/06/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **85** (L18)

13.Total Certified Beds **85** (L17)

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(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):
See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Nicolle Marx, HFE NE II — 03/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 03/25/2014 (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
02/26/1968
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed 02/06/14, the facility was not in substantial compliance and the most serious deficiencies were found 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. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5069

February 14, 2014

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

RE: Project Number S5149024

Dear Ms. Barta:

On February 6, 2014, 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.

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

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

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

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

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

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:

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

Telephone: (320)223-7365
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 March 18, 2014, 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 March 18, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 6, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 6, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	02/06/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278		3/14/14

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

Electronically Signed | 03/05/2014

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

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F 278	Continued From page 1 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure accuracy of the Minimum Data Set (MDS) in regards to lower extremity range of motion (ROM) for 3 of 4 residents (R17, R53 & R117) who showed a decline in ROM. Findings include: R17 MDS was inaccurately coded which showed a decline in ROM. R17's Physical Therapy (PT) plan of care dated 11/22/13, identified a diagnosis of left total knee replacement. R17's admission MDS dated 11/21/13, indicated he had functional limitation in ROM on one side of his lower extremity. The 14 day MDS dated 12/2/13, indicated he had functional limitation of ROM on both sides of his lower extremity. Review of the PT Plan of Care dated 11/22/13, indicated he had active range of motion (AROM) to his left lower extremity to 85 degrees. The PT Progress and Discharge Summary dated 12/04/13, indicated R17 had AROM to his left lower extremity to 110 degrees. The discharge summary also indicated his goal was met and R17 was able to return home. Although the MDS's indicated R17 had a decline in lower extremity ROM, the therapy notes indicated he had an improvement and was able to return home.	F 278	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 provisions 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. MDS modifications to G0400 were done for R17, R53, and R117 to reflect accurate coding of functional limitation of lower extremity range of motion on 2/26/14 All current residents will have their MDS reviewed to ensure accurate coding. Modifications will be done as needed. Licenses Nurses who complete MDS□s will review section G0400: Functional Limitation in Range of Motion Section of the RAI manual by 03/07/14 to ensure	

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F 278	Continued From page 2 During interview on 2/6/14, at 10:12 a.m., Registered Nurse (RN)-C stated the MDS had a coding error and felt R17 always had impairments on both lower extremities due to his medical history of past bilateral hip fracture and peripheral neuropathy. RN-C stated the MDS should have been coded as functional limitation of ROM on both sides. R53's MDS was inaccurately coded which showed a decline in ROM. R53's admission MDS dated 10/9/13, indicated she had a diagnosis of cerebral vascular accident (CVA) and had a lower extremity impairment on one side. R53's 14 day MDS indicated she had an impairment on both sides. Review of the PT Plan of Care dated 10/07/13, revealed her right lower extremity dorsal flexion and hamstrings were 4/5 and right hip flexors and quad were 3/5. The left lower extremity dorsal flexion and hamstring was 4+/5 and left hip flexors and quads 4/5 ROM for both knees were slightly limited for both flexion and extension with discomfort at end ranges. The PT Discharge Summary dated 10/18/13, indicated the use of lower extremity exercises, transfer, stair, and gait training with a four wheeled walker had yielded an overall improvement in strength, activity tolerance, and balance allowing for improved level of function and reduced burden of care. The summary also indicated R53 was to discharge to home. Although R53's MDS's indicated she had a decline in lower extremity functional ROM, R53 had improved in PT and was discharged to home. R117's MDS was inaccurately coded which showed a decline in ROM.	F 278	understanding of accurate coding of section G0400 of the MDS. Random Audits of MDS coding will be done weekly for 1 month, monthly for 3 months and quarterly thereafter as coordinated by the Nurse Manager. Results of audits will be reviewed by the Nurse Manager team for trends and/or patterns and implement improvement plans. Findings will be reported to the QA committee for further evaluation and recommendations.	

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F 278	Continued From page 3 R117's PT Progress notes dated 9/17/13, indicated he had diagnosis of syncope and collapse. R117 admission MDS dated 9/11/13, indicated he had no impairment of his lower extremity ROM. R117's 14 day MDS dated 9/24/13, indicated he had functional limitation of ROM on both sides of his lower extremity. R117's PT Plan of Care dated 9/9/13, indicated he had right foot drop and right dorsal flexion of 2-/5. The PT Progress & Discharge Summary dated 9/17/13, indicated he had muscle strength of 4/5 in bilateral lower extremities and that he was able to ambulate with no cues to stand or to pick up his right foot. Although R117 MDS's indicated he had no impairment to impairments on both sides of his lower extremity ROM, PT indicated he had an improvement. During interview on 2/6/14, at 10:20 a.m., RN-C stated that she and RN-D completed the MDS's in the facility and the coding differences were do to the different interpretations they have when completing them. RN-C further stated R17, R53 and R117 did not have declines in the lower extremity ROM and the MDS's were inaccurately coded. During interview on 2/6/14, at 11:00 a.m., with the Director of Nursing (DON), who stated the MDS's were inaccurately coded and RN-C & RN-D had a plan in place to prevent this from happening. The DON further stated she had noticed the facility reports had shown a decline in there ADL's and felt the coding error was probably the reason. A facility policy was requested and the DON indicated they follow the Resident Assessment Instrument (RAI) manual.	F 278		

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F 279	Continued From page 4	F 279		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a comprehensive care plan related to antidepressant use for depression for 1 of 5 residents (R140) reviewed for unnecessary medications. Findings include: R140's Minimum Data Set (MDS) dated 11/7/13, indicated R140 was cognitively intact and had felt down or depressed. R140's physician orders dated 2/19/13, indicated R140 had fluoxetine	F 279	R140 had comprehensive plan of care reviewed and revised to address diagnosis of depression and use of antidepressents on 02/26/14. All residents who receive psychopharmacological medications will have careplan reviewed and revised as needed to reflect current diagnosis and use of psychopharmacological medications.	3/14/14

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F 279	Continued From page 5 (Prozac) ordered 20 milligrams (mg) daily. The MDS also identified R140's diagnoses included depression. R140's care plan revised on 11/12/13, did not address R140's depression or the use of the antidepressant medication. An interview on 2/6/14, at 9:39 a.m., with assistant director of nursing (ADON) verified that R140's comprehensive plan of care did not address the use of fluoxetine with indications for use or individualized interventions. The facility's procedure Psychopharmacological Medication and Sedative/Hypnotics dated 9/12, indicated the medication must be represented on the care plan.	F 279	Licensed Nurses and Social workers will be inserviced 2/17-3/14 on facility policy and procedures for careplanning of psychopharmacological medications. Random audits of careplans for psychopharmacological medication use will be done weekly for 1 month, monthly for 3 months and quarterly thereafter as coordinated by the Nurse Manager. Results of audits will be reviewed by the Nurse Manager team for trends and/or patterns and implement improvement plans. Findings will be reported to the QA committee for further evaluation and recommendations.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		3/14/14

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F 329	Continued From page 6 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to attempt a gradual dose reduction (GDR) for 1 of 5 residents (R140) reviewed for unnecessary medications. Findings include: R140's Minimum Data Set (MDS) dated 11/7/13, indicated R140 was cognitively intact and had felt down or depressed. R140's physician orders dated 2/19/13, indicated R140 was ordered fluoxetine (antidepressant) 20 milligrams (mg) daily. The MDS also identified R140 had diagnoses that included depression. R140's Consultant Pharmacist's Medication Regimen Review for recommendations created between 4/1/13 and 4/10/13 and medication regimen review dated 4/9/13, indicated that R140 was on fluoxetine 20 mg daily for depression since 9/12. A Consultant Pharmacist's Medication Regimen Review Recommendation Pending a Final Response for recommendations created between 10/1/13 and 10/9/13, with the medication regimen review dated 8/23/13 also indicated the R140 was on fluoxetine 20 mg daily for depression since 9/12. The forms also instructed a gradual dose reduction (GDR) should	F 329	Careplan team met to review antidepressent medication use for R140. Gradual dose reduction and monitoring for changes in mood initiated on 02/26/14. All residents receiving antidepressents will have chart review for their current use of antidepresssent and gradual dose reductions will be initiated as indicated. Licensed Nurses will be inserviced 2/17-3/14 on facility policy and procedures for gradual dose reductions for antidepressents. Random Audits of residents receiving antidepressents will be completed to ensure gradual dose reductions are attempted during at least 2 separate quarters (with at least 1 month in between) unless clinically contraindicated with in first year of use. These audits will be done weekly for 1 month, monthly for 3 months and quarterly thereafter by the consultant pharmacist and/or Nurse Manager. Results will be reported to the QA committee for further evaluation and recommendations	

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F 329	Continued From page 7 be attempted twice in the first year, in two separate quarters, unless clinically contraindicated per Center for Medicare and Medicaid Services (CMS) guidelines. An interview on 2/6/14, at 9:39 a.m. with the assistant director of nursing (ADON) established the ADON did not review the pharmacist recommendations. An interview on 2/6/14, at 11:49 a.m. with assistant director of nursing (ADON) verified there were no GDR completed on R140's fluoxetine 20 mg daily as recommended by the consultant pharmacist. The ADON indicated that there was no documentation that it was clinically contraindicated by the physician. The facility's procedure Psychopharmacological Medication and Sedative/Hypnotics dated 9/12, indicated GDR must be done according to the federal regulations.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by:	F 428		3/14/14

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F 428	Continued From page 8 Based on interview and document review the facility failed to act upon irregularities reported by the pharmacist for 1 of 5 residents (R140) reviewed for unnecessary medications. Findings include: R140's Minimum Data Set (MDS) dated 11/7/13, indicated R140 was cognitively intact and had felt down or depressed. R140's physician orders dated 2/19/13, indicated R140 was ordered fluoxetine (antidepressant) 20 milligrams (mg) daily. The MDS also identified R140 had diagnoses that included depression. R140's Consultant Pharmacist's Medication Regimen Review for recommendations created between 4/1/13 and 4/10/13, and medication regimen review dated 4/9/13, indicated that R140 was on fluoxetine 20 mg daily for depression since 9/12. A Consultant Pharmacist's Medication Regimen Review Recommendation Pending a Final Response for recommendations created between 10/1/13 and 10/9/13, with the medication regimen review dated 8/23/13, also indicated the R140 was on fluoxetine 20 mg daily for depression since 9/12. The forms also instructed a gradual dose reduction (GDR) should be attempted twice in the first year, in two separate quarters, unless clinically contraindicated per Center for Medicare and Medicaid Services (CMS) guidelines. An interview on 2/6/14, at 11:49 a.m. with assistant director of nursing (ADON) indicated there was no documentation that it was clinically contraindicated by the physician to continue with R140's fluoxetine.	F 428	Consultant Pharmacist did a chart review for R140 on 02/06/14 and made recommendation to MD/NP for reduction in antidepressent medication. MD/NP followed up on recommendation on 02/26/14. Consultant Pharmacist will review the drug regimen of each current resident at least monthly. Recommendations will be forwarded to the MD/NP. Nurse Managers will oversee that recommendations are followed up on by MD/NP. DNS met with Consultant pharmacist 2/20/14 to review policy and procedure of monthly chart reviews. Licensed Nurses will be inserviced 2/17-3/14 on facility policy and procedures for pharmcist recommendations and communication to MD. Random audits to ensure Pharmacy recommendations are followed up on will be done monthly as coordinated by the DNS. Results of audits will be reviewed and analyzed by Nurse Manager team with changes implemented as needed. Findings will be reported to the QA committee for further evaluation and recommendations	

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F 428	Continued From page 9 An interview on 2/6/14, at 1:35 p.m. with pharmacist established that there were no documented clinical contraindications from the physician for a GDR. The pharmacist established that there had been no GDR on R140's fluoxetine since it was started 9/12. The pharmacist verified it was the pharmacist's responsibility to make sure the physicians were responding to the recommendations by the pharmacist. The facility's procedure Psychopharmacological Medication and Sedative/Hypnotics dated 9/12 indicated GDR must be done according to the federal regulations. The facility's policy Pharmaceutical Services dated 9/12 established that any irregularities are reported to the attending physician or the director of nursing services and the reports must be acted upon.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		3/14/14

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F 441	Continued From page 10 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure potentially contaminated laundry was handled in a manner to prevent cross contamination. This had the potential to affect all 82 residents who reside in the facility. Findings include: During a tour of the laundry room on 2/6/14, at 9:02 a.m., housekeeping assistant (HA)-A indicated the residents' personal laundry, bed spreads and napkins were completed at the facility. Things such as blankets, towels and wash cloths were sent out to be laundered. HA-A indicated she did not wear a gown when sorting through the dirty laundry but rather just gloves and a long sleeve shirt worn under a scrub top.	F 441	Staff handling soiled linen have been educated on the use of personnal protective equipment use of gown and gloves while handling soiled linen in order to prevent the spread of infection. Random audits of personnel handling soiled linen either sorting or washing, will be done weekly for one month, monthly for three months and quarterly thereafter. Audits and their results will be coordinated, reviewed, and evaluated by the Administrator and/or Housekeeping/Laundry Supervisor. Findings will be reported to the QA committee for further evaluation a	

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F 441	Continued From page 11 HA-A further indicated she was also responsible for folding the clean laundry and would do so without changing her shirt and after sorting through the dirty laundry. During interview on 2/6/14, at 9:05 a.m., the infection control registered nurse (RN)-A, confirmed the staff should be wearing a gown when sorting through the dirty laundry to prevent potential cross contamination. Review of the laundry procedure infection control guide last reviewed on 11/06, revealed employees sorting or washing linens must wear an impervious gown, and gloves.	F 441	recommendation.	
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an appropriate emergency water plan to ensure the residents would have enough potable and non-potable water in the event of a loss of normal water supply. This had the potential to affect all 82 residents who reside in the facility Findings include: The facility's emergency water supply procedure	F 466	Emergency Water Procedure has been updated to reflect the method for distributing the water and estimating the gallons needed for residents and staff should there be a loss of water supply emergency. Staff have been updated with the changes of the Emergency Water Procedure. Emergency Water Procedure is reviewed	3/14/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	02/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 466	Continued From page 12 was reviewed. The contract did not specify a method for distributing the water or calculations for estimating the gallons of water required daily to meet the needs of the residents and staff should there be loss of the water supply in an emergency. During interview on 2/5/14, at 2:26 p.m., maintenance-A identified the facility had about 166 gallons of bottled water in the basement. Maintenance-A was not sure how that was decided to be an appropriate number to have. During interview on 2/5/14, at 2:37 p.m., the administrator identified the facility had estimated about one gallon of water per resident and staff when deciding how much bottled water to have on hand, in addition to water tanks which could be emptied for potable water. Administrator confirmed the facility's policy did not contain specifications for how any water would be distributed or calculations for how much total potable and non potable water would be needed in the event of a water emergency.	F 466	and updated in the Safety Committee at miniumum on an annual basis and more frequently if changes are required. Safety Committee Chair person is responsible to ensure emergency water procedure is reviewed and updated.	

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	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/05/2014**

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GOOD SAMARITAN SOCIETY - AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

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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-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Good Samaritan Society Ambassador was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/28/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/05/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@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 Ambassador is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1996, an addition was constructed and was determined to be of Type II(000) construction. In 2010, an addition was constructed and was determined to be of Type V (111) construction. There is a 2-hour 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 building is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility	K 000		

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K 000	Continued From page 2 has a capacity of 85 beds and had a census of 80 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation, the facility has failed to provide 2 of several operational exit signs that marks the means of egress path in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.1.7 and 7.10.8.1 These deficient practices could negatively affect all residents, staff and visitors, by causing confusion in locating an exit from the building to the public way in the event of an emergency. Findings include: On facility tour between 10:30 AM to 1:30 PM on 02/05/2014, observations revealed that the patio doors located in the Garden dining room and the	K 022	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 provisions 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	2/25/14

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K 022	Continued From page 3 Sunny Ridge dining room that lead to an enclosed courtyard that does not connect to the public way are not marked as "NO EXIT". These doors are not part of a required exits and need to display a signs that read as follows: NO EXIT. The word "NO" shall be in letters 2 inches in height and with a stroke width of 3/8 inch, and the word "EXIT" in letters 1 inch in height located directly below the word "NO". This deficient condition was confirmed by the Maintenance Supervisor (DM).	K 022	7305 of the State Operations Manual. Center placed 2 appropriately sized "NO EXIT" signs on the doors leading to Waterfall Gardens and Sunny Ridge patios on 2/25/2014. The Maintenance Supervisor is responsible to make any corrections and monitor to prevent a reoccurance of the deficiency.	
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 with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview and review of available documentation, the facility has not been conducting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff. Findings include: On facility tour between 10:30 AM to 1:30 PM on 02/05/2014, a review of the facility's available fire alarm maintenance and testing documentation revealed that at the time of the inspection the	K 054	Sensitivity testing was completed for center on 2/12/14.Center has documentation verifying completion of the required sensitivity testing of each smoke detector located throughout the center. The Maintenance Supervisor is responsible to ensure regular testing is completed, documented and monitored to prevent a reoccurence of the deficiency.	2/25/14

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K 054	Continued From page 4 facility could not provide any documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient condition was confirmed by the Maintenance Supervisor (DM).	K 054		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect all residents, visitors and staff of the facility.	K 056	Spare sprinkler head box will be equipped with at least 2 of every type and style of sprinkler heads that are being used in the center. The sprinker gauges located on the main fire sprinkler riser have been replaced on 2/20/2014. The Maintenance Supervisor is	2/27/14

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K 056	Continued From page 5 Findings include: On facility tour between 10:30 AM to 1:30 PM on 02/05/2014, observations reveled the following deficient conditions were found affecting the facility's fire sprinkler system: 1. the spare sprinkler head box was not equipped with at least 2 of every type and style of sprinkler heads that are being used in the facility. The observed missing spare sprinkler heads were the elevated temperature (green bulb) type of sprinkler head. 2. It could not be verified when the sprinkler gauges located on the main fire sprinkler riser have were last tested or recalibrating. This deficient condition was confirmed by the Maintenance Supervisor (DM).	K 056	responsible for correcting and monitoring to prevent reoccurrence of the deficiency.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does	K 067	Fire and smoke dampers have been tested in building two on 2/21/14. The Center does not have smoke dampers in building one. The maintenance Supervisor	2/28/14

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K 067	Continued From page 6 not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect all residents, staff and visitors in the event of a fire. Findings include: On facility tour between 10:30 AM to 1:30 PM on 02/05/2014, it was revealed during the review of facility fire and smoke damper test and inspection documentation and confirmed by interview with the Maintenance Supervisor (DM), that the facility failed to provide documentation that the fire and smoke dampers had been tested/inspected within the last 4 years in accordance with NFPA 90(99) section 3-4.7. This deficient condition was confirmed by the Maintenance Supervisor (DM).	K 067	is responsible for correcting and monitoring to prevent a reoccurrence of the deficiency.	

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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-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Good Samaritan Society Ambassador Bldg 2 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 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION	K 000	POC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/28/2014

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

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K 000	Continued From page 1 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@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 Ambassador is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1996, an addition was constructed and was determined to be of Type II(000) construction. In 2010, an addition was constructed and was determined to be of Type V (111) construction. There is a 2-hour 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 building is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for	K 000		

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K 000	Continued From page 2 automatic fire department notification. The facility has a capacity of 85 beds and had a census of 80 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observations, the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 18.3.2.1. The following deficient practice could negatively affect the residents, staff, and visitors as smoke and fire in this rooms could enter the corridor making it untenable. Findings include: On facility tour between 10:30 AM to 1:30 PM on 02/05/2014, observation revealed, that there were several penetration in the wall separating the fire sprinkler / mechanical storage room from the corridor that were sealed with a foam filler and not an approved intumescent fire calking. At the time of the inspection the facility could not verify	K 029	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 provisions 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. Foam will be removed and replaced with appropriate fire rated sealer in the	3/10/14

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K 029	Continued From page 3 the type foam used or the fire rating of the foam sealer that was used to seal the penetrations. This deficient condition was confirmed by the Maintenance Supervisor (DM).	K 029	sprinkler room. The Maintenance Superviser is responsible to correct, and monitor to prevent a reoccurrence of the deficiency.	
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 with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview and review of available documentation, the facility has not been conducting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff. Findings include: On facility tour between 10:30 AM to 1:30 PM on 02/05/2014, a review of the facility's available fire alarm maintenance and testing documentation revealed that at the time of the inspection the facility could not provide any documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient condition was confirmed by the Maintenance Supervisor (DM).	K 054	Sensitivity testing was completed for center on 2/12/14.Center has documentation verifying completion of the required sensitivity testing of each smoke detector located throughout the center. The Maintenance Supervisor is responsible to ensure regular testing is completed, documented and monitored to prevent a reoccurrence of the deficiency.	2/27/14

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect all residents, visitors and staff of the facility. Findings include: On facility tour between 10:30 AM to 1:30 PM on 02/05/2014, observations reveled the following deficient conditions were found affecting the facility's fire sprinkler system: 1. the spare sprinkler head box was not	K 056	Spare sprinkler head box will be equipped with at least 2 of every type and style of sprinkler heads that are being used in the center. The sprinker gauges located on the main fire sprinkler riser is scheduled to be replaced. The Maintenance Supervisor is responsible for correction and monitoring to prevent reoccurrence of the deficiency	3/14/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **02 - NEW ADDITION** B. WING _____	**02/05/2014**

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

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K 056	Continued From page 5 equipped with at least 2 of every type and style of sprinkler heads that are being used in the facility. The observed missing spare sprinkler heads were the elevated temperature (green bulb) type of sprinkler head. 2. It could not be verified when the sprinkler gauges located on the main fire sprinkler riser have were last tested or recalibrating. This deficient condition was confirmed by the Maintenance Supervisor (DM).	K 056		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by: Based on documentation review, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect all residents, staff and visitors in the event of a fire. Findings include: On facility tour between 10:30 AM to 1:30 PM on 02/05/2014, it was revealed during the review of	K 067	Fire and smoke dampers have been tested on 2/21/14. Center will receive documentation that verify smoke dampers have been tested from the vendor. The maintenance Supervisor is responsible for correcting and monitoring to prevent a reoccurrence of the deficiency.	3/14/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **02 - NEW ADDITION** B. WING _____	**02/05/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 6 facility fire and smoke damper test and inspection documentation and confirmed by interview with the Maintenance Supervisor (DM), that the facility failed to provide documentation that the fire and smoke dampers had been tested/inspected within the last 4 years in accordance with NFPA 90(99) section 3-4.7. This deficient condition was confirmed by the Maintenance Supervisor (DM).	K 067		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5069

February 14, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5149024

Dear Ms. Barta:

The above facility was surveyed on February 3, 2014 through February 6, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 W Division #212, St. Cloud, MN 56301. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File