Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 22, 2025

Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, MN 55349

RE: CCN: 245278
Cycle Start Date: January 9, 2025

Dear Administrator:

On January 9, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 9, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 9, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	C 01/09/2025

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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E 000	Initial Comments On 1/6/25 through 1/9/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was found to be in compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/6/25 to 1/9/25, a recertification survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). Good Samaritan Society of Howard Lake was found not to be in compliance with requirements of 42 CFR Part 483, Subpart B and requirements for Long Term Care Facilities. The following complaint, MN:00103833/H52783800C, was found to be unsubstantiated, however, with related deficiencies cited. 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	F 000		

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

Electronically Signed | 01/27/2025

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 000	Continued From page 1 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 609	Preparation and execution of this	1/31/25

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F 609	Continued From page 2 facility failed to ensure an elopement incident was reported to the State Agency (SA) not later than 24 hours for 1 of 1 residents (R32) reviewed for elopement. Findings include: R32's admission Minimum Data Set (MDS) dated 5/12/24, indicated R32 had severe cognitive impairment and required extensive assistance with cares. R32 had diagnoses which included amputated toes of left foot, peripheral vascular disease, diabetes, and muscle weakness. R32's care plan revised 6/1/24, identified R32 had potential for elopement related to elopement 5/31/24 (completed after the reported incident). R32's progress notes were reviewed and identified the following entries: - 5/31/2024, at 8:10 p.m. assisted with toileting about 7:30 p.m. refused medications and blood sugar check. When staff went to check on resident at about 8:00 p.m. room door did not open. - 5/31/2024, at 8:15 p.m. family updated was refusing medications, door to room wouldn't open and was observed from his window to be covering up with covers in bed. - 5/31/2024, at 9:00 p.m. daughter arrived, resident did not answer family through the door. It was found that the window to room was open, the screen had been cut and resident was not in the room. Family left immediately to look for him while staff called 911. While staff on the phone with 911, family returned to report resident was at	F 609	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 purpose 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. 1. R32 care plan was updated 06/01/2024 2. As a result, DNS reviewed all the past incidents to ensure that any reportable incident was reported to the State Agency (SA) timely. Also, any new incident to any resident will be reported to the State Agency (SA) timely.¿¿ 3. To ensure systemic changes are sustained, responsible staff for reporting will have training and education on 1/28/2025 and will be educated by nurse consultant or designee on the organization's policy on "Abuse and neglect" and the timeline for reporting the abuse and neglect incidents per state regulations. 4. To ensure compliance, the DNS/designee will review daily incidents	

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F 609	Continued From page 3 home with his family, that someone had given him a ride home from the bowling alley. A Facility Reported incident was submitted to the SA on 6/3/24, at 5:00 p.m. (approximately 68 hours after resident eloped out window) which identified R32 a non-elopement risk resident left the building through window in room. Locked door with cell phone cord and placed pillows in the bed to make it appear he was laying in it. Proceeded to walk to the roadway next to the building, flag down a motorist and got ride to his home. When interviewed on 1/09/25, at 3:59 p.m. director of nursing (DON) stated R32 was supposed to discharge to home the week before the incident, facility had discharge orders from the provider at that time. Family had convinced him to stay longer. R32 had gone to an appointment the morning of the incident , believed he was going to go home afterward but the family had brought him back to the facility. The nurse went to attempt medication administration again after he had initially refused, was not able to open the door to the room and R32 was not responding to the nurse so she went outside to look through the window observing R32 laying down in bed and covering up. Nurse had called the family for assistance since he was not responding to her, family arrived about 45 minutes later. R32 did not respond to the family who then went to the window discovering the window open and screen cut, resident was no longer in the room. Facility staff called 911 while the family left and located him at his residence in town. the nurse talked to the good samaritan that R32 flagged down, had not felt comfortable with driving him anywhere but someone from the bowling alley had overheard and gave R32 a ride. Was not reported at the	F 609	to determine if any meet reporting guidelines to ensure they're reported to the State Agency (SA) timely.¿ Results will be brought to QAPI for further evaluation on the need to increase, decrease or discontinue audits.	

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F 609	Continued From page 4 time of the incident as did not feel that this was an elopement, had an order the week prior to discharge, he had a destination and arrived to that destination. Family brought him back later that night. Facility policy titles Abuse and Neglect - Rehab/Skilled, Therapy and Rehab revised 7/22/24, indicated if there is an allegation that does not involve abuse and there is no serious bodily injury, then it will be reported not later than 24 hours after the allegation is made.	F 609		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence.	F 636		1/31/25

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F 636	Continued From page 5 (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to accurately complete a comprehensive Minimum Data Set (MDS)	F 636	1. R23's oral dental care assessment has been updated to reflect accurate dental status.	

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F 636	Continued From page 6 assessment for 1 of 1 resident, (R23), who was reviewed for dental status Finding include: R23's Admission assessment Minimum Data Set (MDS), dated 8/14/24, identified R23 had significant cognitive impairment, however, was independent with eating and oral hygiene. The MDS indicated R23 required assistance with dressing, personal grooming (outside of oral hygiene), and required full assistance with mobility. R23's medical diagnoses included a joint replacement, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), multiple sclerosis (MS-a disease process which has been known to cause numbness, weakness, trouble walking, vision changes and other symptoms), anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), atrial fibrillation (an irregular and often very rapid heart rhythm), heart failure (a progressive heart disease that affects pumping action of the heart muscles, which may cause fatigue, shortness of breath.), hypertension (high blood pressure), and end stage renal (kidney) disease. The MDS indicated R23 had no concerns with broken or missing teeth, or abnormal mouth issues and indicated "None of the above were present. R23's quarterly MDS assessment of 10/30/24 lacked entry for dental status of R23. A subsequent MDS of 12/18/24 indicated there were no dental concerns identified. R23's care plan, dated 8/8/24, identified R23 experienced a self-care deficit related to hip	F 636	2. All current residents' oral dental care assessments have been reviewed to ensure accuracy. 3. Training for all licensed nurses on oral dental care assessments and the relationship between them and the comprehensive Minimum Data Set (MDS) will be completed by DNS or designee. 4. The DNS or designee will continue to audit R23's oral dental care assessments x 4 months and conduct audits of oral dental care assessments of new admissions to facility x 4 months. Results will be brought to QAPI for further evaluation on the need to increase, decrease or discontinue audits.	

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F 636	Continued From page 7 fracture. The care plan identified R23 had his own teeth, was able to brush his teeth independently once set up, and was able to eat independently. The care plan directed staff to assist in dressing, grooming, mobility, with a goal to improve current level of function. A review of the record lacked indication R23 was missing the upper portion of his teeth on both the upper and lower jaw, with only the lower portion of teeth remained present. On 1/6/25, at 12:59 p.m., R23 was observed in his room following the noon meal. On the tray, it was noted there were two slices of bread with only the outer crusts remaining, with the center absent. R23 was observed to have only partial teeth on the upper and lower jaw. The lower portion of the teeth remained, however, there were no biting surfaces in place, and appeared to be only the pulp and roots remaining. R23 stated he was aware he needed to go to the dentist, although denied pain. On 1/8/25, at 3:59 p.m., a review was completed with registered nurse (RN)-A of the dental assessments on the MDS' of 8/14/24, 10/30/24, and 12/18/24. RN-A verified the documentation reviewed indicated there were no dental concerns identified. A review of the care plan at this time also lacked any indication of dental concerns. RN-A stated this data is automatically entered from the NARA (Nursing Admit Re-Admit Data Collection) form completed form the time of admission. RN-A was requested to evaluate the R23's dental status and follow up after investigation completed. At 5:26 p.m., RN-A identified R23 was noted to have broken/missing teeth in the center of the upper and lower jaw.	F 636		

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F 636	Continued From page 8 RN-A stated dental assessments were completed initially upon admission, and quarterly thereafter, and the dental assessments should have reflected the status of the resident. RN-A stated she had conferred with the director of nursing (DON), who had attended the resident care conference on 12/12/24, at which time R23's dental status was reviewed. The notes reflected plans were made for dental status review at a follow up medical appointment on 1/7/25. Although identified at the care conference, this was not reflected in the care plan. RN-A stated with the concern identified, she would anticipate it would have been identified within the care plan. On 1/9/25, at 3:30 p.m., the DON stated it was her expectation for the MDS to accurately reflect the status of the resident. Additionally, DON stated it was her expectation the care plan be reflective of resident status, and direct staff as to resident needs for assistance and care. The facility policy, MDS 3.0 (Minimum Data Set) RAI (Resident Assessment Instrument)-Rehab/Skilled & Therapy and Rehab, last reviewed/revised 8/27/24 was reviewed. The policy identified during the observation period, each team member will review the EMR (electronic medical record) to determine if there is accurate documentation to support coding for the MDS. The policy directs that if, while reviewing the medical record, the time finds conflicting information, a clarifying note was to be written as part of a supportive documentation note. The guidelines indicated the staff were to attempt to conduct interviews with all residents. The facility policy, Denture and Oral Care, Dental	F 636		

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(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 636	Continued From page 9 Health Assessment, Dental Services, last reviewed and revised on 6/3/24, identified multiple purposes, which included to observe the oral cavity for abnormalities, provide comfort and well-being, and to maintain healthy condition of teeth and oral cavity. The policy outlines dental assessments are conducted upon admission, quarterly, and with the annual MDS, or with any other oral changes. The purpose of these assessment was identified as early identification and evaluation of any dental/oral health problems for treatment by a dentist or other health professional.	F 636		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 22, 2025

Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, MN 55349

Re: State Nursing Home Licensing Orders
Event ID: 6UK411

Dear Administrator:

The above facility was surveyed on January 6, 2025 through January 9, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00019	A. BUILDING: _____ B. WING _____	C 01/09/2025

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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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/6/25 to 1/9/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to NOT in compliance with MN State Licensure. The following complaints were reviewed during	2 000		

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2 000	Continued From page 1 the survey with no licensing orders issued. MN:00103833/H52783800C Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements;	2 540		1/31/25

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2 540	Continued From page 2 F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to accurately complete a comprehensive Minimum Data Set (MDS) assessment for 1 of 1 resident, (R23), who was reviewed for dental status Finding include: R23's Admission assessment Minimum Data Set (MDS), dated 8/14/24, identified R23 had significant cognitive impairment, however, was independent with eating and oral hygiene. The MDS indicated R23 required assistance with dressing, personal grooming (outside of oral hygiene), and required full assistance with mobility. R23's medical diagnoses included a joint replacement, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), multiple sclerosis (MS-a disease process which has been known to cause numbness, weakness, trouble walking, vision changes and other symptoms), anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), atrial fibrillation (an irregular and often very rapid heart rhythm), heart failure (a progressive heart disease that affects pumping action of the heart muscles, which may cause	2 540	Corrected	

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2 540	Continued From page 3 fatigue, shortness of breath.), hypertension (high blood pressure), and end stage renal (kidney) disease. The MDS indicated R23 had no concerns with broken or missing teeth, or abnormal mouth issues and indicated "None of the above were present. R23's quarterly MDS assessment of 10/30/24 lacked entry for dental status of R23. A subsequent MDS of 12/18/24 indicated there were no dental concerns identified. R23's care plan, dated 8/8/24, identified R23 experienced a self-care deficit related to hip fracture. The care plan identified R23 had his own teeth, was able to brush his teeth independently once set up, and was able to eat independently. The care plan directed staff to assist in dressing, grooming, mobility, with a goal to improve current level of function. A review of the record lacked indication R23 was missing the upper portion of his teeth on both the upper and lower jaw, with only the lower portion of teeth remained present. On 1/6/25, at 12:59 p.m., R23 was observed in his room following the noon meal. On the tray, it was noted there were two slices of bread with only the outer crusts remaining, with the center absent. R23 was observed to have only partial teeth on the upper and lower jaw. The lower portion of the teeth remained, however, there were no biting surfaces in place, and appeared to be only the pulp and roots remaining. R23 stated he was aware he needed to go to the dentist, although denied pain. On 1/8/25, at 3:59 p.m., a review was completed with registered nurse (RN)-A of the dental	2 540		

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2 540	Continued From page 4 assessments on the MDS' of 8/14/24, 10/30/24, and 12/18/24. RN-A verified the documentation reviewed indicated there were no dental concerns identified. A review of the care plan at this time also lacked any indication of dental concerns. RN-A stated this data is automatically entered from the NARA (Nursing Admit Re-Admit Data Collection) form completed form the time of admission. RN-A was requested to evaluate the R23's dental status and follow up after investigation completed. At 5:26 p.m., RN-A identified R23 was noted to have broken/missing teeth in the center of the upper and lower jaw. RN-A stated dental assessments were completed initially upon admission, and quarterly thereafter, and the dental assessments should have reflected the status of the resident. RN-A stated she had conferred with the director of nursing (DON), who had attended the resident care conference on 12/12/24, at which time R23's dental status was reviewed. The notes reflected plans were made for dental status review at a follow up medical appointment on 1/7/25. Although identified at the care conference, this was not reflected in the care plan. RN-A stated with the concern identified, she would anticipate it would have been identified within the care plan. On 1/9/25, at 3:30 p.m., the DON stated it was her expectation for the MDS to accurately reflect the status of the resident. Additionally, DON stated it was her expectation the care plan be reflective of resident status, and direct staff as to resident needs for assistance and care. The facility policy, MDS 3.0 (Minimum Data Set) RAI (Resident Assessment Instrument)-Rehab/Skilled & Therapy and Rehab, last reviewed/revised 8/27/24 was reviewed. The	2 540		

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2 540	Continued From page 5 policy identified during the observation period, each team member will review the EMR (electronic medical record) to determine if there is accurate documentation to support coding for the MDS. The policy directs that if, while reviewing the medical record, the time finds conflicting information, a clarifying note was to be written as part of a supportive documentation note. The guidelines indicated the staff were to attempt to conduct interviews with all residents. The facility policy, Denture and Oral Care, Dental Health Assessment, Dental Services, last reviewed and revised on 6/3/24, identified multiple purposes, which included to observe the oral cavity for abnormalities, provide comfort and well-being, and to maintain healthy condition of teeth and oral cavity. The policy outlines dental assessments are conducted upon admission, quarterly, and with the annual MDS, or with any other oral changes. The purpose of these assessment was identified as early identification and evaluation of any dental/oral health problems for treatment by a dentist or other health professional. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review policy and provide education for staff regarding completion of an individualized comprehensive resident assessment including care area assessments for admission, annual and significant changes. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		

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	245278	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/07/2025**

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

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K 000	INITIAL COMMENTS An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/07/2025. At the time of this survey, Good Samaritan Society-Howard Lake was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. The facility is 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 32 beds and had a census of 30 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

Electronically Signed | 01/23/2025

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.