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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6URX

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 **2/25/2015** (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):

17. SURVEYOR SIGNATURE Date :
Jessica Sellner, Unit Supervisor 02/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist / 02/26/2015 (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: **00** (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 03/16/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/19/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245149
February 26, 2015

Ms. Marie Barta, Administrator
Good Samaritan Society - Ambassador
8100 Medicine Lake Road
New Hope, Minnesota 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 February 9, 2015 the above facility is certified for or recommended 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.

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
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 26, 2015

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

RE: Project Number S5149025

Dear Ms. Barta:

On January 23, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 8, 2015. 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 February 25, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 12, 2015 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 January 8, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 9, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 8, 2015, effective February 9, 2015 and therefore remedies outlined in our letter to you dated January 23, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245149	A. Building B. Wing	2/25/2015

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **02/09/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **02/09/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **02/09/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **02/09/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **02/09/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **02/09/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **02/09/2015**	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	JS/KJ	2/26/2015	29249	2/25/2015
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
1/8/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245149	01 - MAIN BUILDING 01	2/12/2015

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 Reg. # NFPA 101 LSC K0029	Correction Completed 02/09/2015	ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 02/09/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** JS/KJ	**Date:** 2/26/2015	**Signature of Surveyor:** 28120	**Date:** 2/12/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 1/12/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6URX

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 **01/08/2015** (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
X 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):

17. SURVEYOR SIGNATURE Date :
LoAnne DeGagne, HFE NE II 02/05/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 02/12/2015 (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
Posted 02/19/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 23, 2015

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

RE: Project Number S5149025

Dear Ms. Barta:

On January 8, 2015, 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7365

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 February 17, 2015, 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 February 17, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 8, 2015 (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 July 8, 2015 (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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
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 _____	01/08/2015

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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		2/9/15

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

Electronically Signed | 02/02/2015

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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	245149	A. BUILDING _____ B. WING _____	01/08/2015

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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F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide appropriate Medicare liability notices when skilled services ended for 2 of 3 residents (R155, R58) reviewed for liability notices. Findings include: R155 was admitted to the facility for a skilled stay on 11/7/14, for short term rehabilitation following a hospital stay. A 14 day Minimum Data Set (MDS) dated 12/1/14, identified R155 was cognitively intact. A Notice of Medicare Non-Coverage dated 11/28/14, identified skilled service coverage would end on 12/2/14. On the signature line of the	F 156	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. Copy of the Notice of Medicare	

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F 156	Continued From page 3 Medicare Non-Coverage form, a facility employee hand wrote the resident and daughter were notified verbally of the coverage ending. There was no signature from either the resident or daughter indicating they had received the written notice. R155 discharged from the facility on 12/3/14. R58 was admitted to the facility for a skilled stay on 9/29/14, for short term rehabilitation following a hospital stay. The admission MDS dated 10/6/14, identified R58 had moderate cognitive impairment. A Notice of Medicare Non-Coverage dated 11/18/14, identified skilled service coverage would end on 11/24/14. On the signature line of the form, a facility employee hand wrote R58's son was called on the phone and notified of the end of covered services. There was no signature from either the resident or the son indicating they had received the written notice. R58 discharged from the facility on 11/25/14. During interview on 1/8/14, at 11:03 a.m. the assistant director of nursing (ADON) stated she was in charge of overseeing the Medicare part of a resident's stay. The ADON stated the social workers would generate the forms after rounds and then she would log them in the medical record. The ADON confirmed R58's and R155's forms had not been signed by either the resident or a responsible party. Upon review of the medical records, the ADON confirmed R155's signature should have been sought out and potentially R58's although she was uncertain if R58 could have signed the form or not. Additionally, the ADON stated the facility never	F 156	Non-Coverage was mailed (certified) to R155 and family representatives for R58 on 1-29-15. All Notice of Medicare Non-Coverages that have been issued in the last 30 days will be reviewed to ensure facility policy and procedure were followed for appropriate notification when skilled services were ending. Nurse Managers and Social Workers who issue notifications of Medicare Non coverage Notices were educated on policy and procderues for Non-Coverage Notifications on 1-28-15. Random Audits of Notice of Medicare Non-coverage forms will be done weekly for 1 month, monthly for 3 months and quarterly thereafter as coordinated by the Medicare Nurse. Results of audits will be reviewed by the Medicare team for trends and/or patterns and implement improvement plans. Findings will be reported to the QAPI committee for further evaluation and recommendations	

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F 156	Continued From page 4 sent out the notices to responsible parties when the resident was unable to sign for signature. During interview on 1/8/14, at 1:33 p.m. the director of nursing (DON) stated the facility should be getting a signature on the Medicare notices and placing those in the medical record to verify the notice had been provided. The facility policy entitled Non-Coverage Notifications last revised 2/14, was reviewed. The policy indicated the notices must be validly delivered which means that the beneficiary/enrollee must be able to understand the purpose and contents of the notice in order to sign receipt for it. If the beneficiary/enrollee is not able to comprehend the contents of the notice, it must be delivered and signed by an authorized representative.	F 156		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225		2/9/15

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F 225	Continued From page 5 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 facility failed to immediately report allegations of abuse/mistreatment to the state agency (SA) and facility administrator, and failed to conduct thorough investigations for 2 of 4 residents (R46, R101) reviewed for incidents of alleged mistreatment. Findings include: R46's quarterly Minimum Data Set (MDS) dated 10/9/14, indicated R46 was cognitively intact, had no signs or symptoms of delirium or behavioral symptoms, and needed extensive assistance of one facility staff for personal hygiene, toilet use, dressing, and required two staff to assist with	F 225	R46 and R101 incidents were reported to the state agency and thorough investigations were conducted. Both residents were interviewed on 1/28/15 and endorse feeling safe in their environment. Concern forms since 1/5/15 have been reviewed for other potential residents affected and reported and investigated as appropriate. Staff were educated on facility vulnerable adult policy and procedures that include abuse definitions and reporting responsibilities by 2/9/15. Audits of concern forms will be completed for identifying and reporting of potential abuse neglect or maltreatment by the	

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F 225	Continued From page 6 transferring. A facility Concern Form dated 8/15/14, indicated licensed practical nurse (LPN)-A entered R46's room and found the resident in tears. R46 had requested a certain nursing assistant (NA) to not provide cares to her anymore. R46 reported to LPN-A the NA had made a "snappy remark" to her, had not assisted her with the transfer onto the toilet, and R46 stood up and fell back into her chair (wheelchair). R46 stated upon transfer off the toilet, she requested to be assisted into her recliner, however, R46 stated the NA left the room without assisting the resident into the recliner. R46 also informed LPN-A she was very worried about "repercussions," from the named NA. The Concern Form indicated LPN-A talked to the NA and discussed the need for her to help the resident, and asked the NA to stay away from R46 for the remainder of the day. During interview on 1/08/15, at 8:53 a.m. LPN-A stated she had completed the Concern Form and thought she had given the form to either the director of nursing (DON) or the nurse manager. LPN-A stated she thought someone met with the employee, however, she had never heard any more about the incident. LPN-A stated the NA had been emotionally abusive to R46, and the NA had a history of being "nasty" to residents. LPN-A stated she had other residents complain to her of how the NA treated them during cares. During interview on 1/8/15, at 9:33 a.m. DON stated the state agency had not been informed of the allegation on 8/15/14, and also had no evidence of the administrator being notified until 9/2/14, when the administrator signed the Concern Form. The DON stated she did not feel	F 225	director of social services weekly for one month, monthly for 3 months and quarterly thereafter. Findings will be reported to the QAPI committee for further follow-up.	

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F 225	Continued From page 7	F 225		

the incident rose to the level of mistreatment which needed to be reported to the state agency, and felt it was a communication issue between the NA and R46. DON stated she met with R46 and the NA on the day of the incident, and felt the problem had been addressed. DON stated the NA accused of the rough treatment is no longer employed by the facility. No further investigation was conducted.

During interview on 1/8/15, at 10:15 a.m. R46 stated on 8/5/14, the NA who assisted her was, "rough" and was, "grouchy a lot of the time." R46 stated the NA would not listen to her and would leave the room without completing her requests. R46 stated she had heard other residents complain about the same issues with the NA. R46 stated she did not want to complain too much about the NA because she was afraid staff would get back at her.

During interview on 1/8/15, at 10:17 a.m. R46's family member (FM)-A stated R46 frequently complained about the NA, and often family would visit R46 and would find her in tears. FM-A stated R46 would blame herself for the way the NA was treating her and would say, "I made [NA] mad." FM-A reported R46 would tell her family the NA was "rough," with her and spoke to her in a rough tone. FM-A stated staff were aware of their concerns regarding the rough treatment as she had complained to the staff at least three times about the NA's rough treatment of R46. FM-A stated she was hesitant to report the rough treatment too often and was also fearful of staff retaliation.

R101's quarterly MDS dated 10/16/14, identified R101 had severe cognitive impairment, had no

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episodes of delirium or psychosis, and required extensive physical assistance from staff for transferring, toileting, and personal hygiene.
A Concern Form dated 10/17/14, which was completed by the administrator, described R101 had reported to her the employee who had gotten her up that morning was rough. R101 didn't recall the name of the employee, but was able to give a partial physical description of the employee and details about how many children the employee had. The Concern Form indicated R101 stated if staff didn't like their job, they should get another job. A note on the front of the Concern Form indicated it was forwarded to the social worker for interview.

Review of R101's medical record was completed and lacked any documentation of the incident on 10/17/14.

During interview on 1/8/14, at 5:20 p.m. social worker (SW)-A stated she recalled the incident and stated she had received the Concern Form report from the administrator in which R101 had complained of rough treatment. SW-A stated she went to interview R101 to get more details about the incident in order to determine if it was abuse or not prior to reporting the allegation. SW-A stated R101 had identified an employee had grabbed her by the arm while providing cares that morning, however, R101 was not able to identify the employee, and there was no investigation completed to determine who the employee was. SW-A stated she did not feel the incident was abuse because R101 stated she felt safe at the facility and did not have any bruising, therefore, the incident was not reported to the SA. The DON was also a part of the interview at this time and stated there was no further investigation of

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F 225	Continued From page 9 R101's allegation of rough treatment, and the facility did not determine who had assisted R101 in cares earlier that morning. DON stated all staff were given a verbal reminder to slow down and be more careful when assisting residents. The facility policy titled Abuse and Neglect dated 9/13, indicated alleged or suspected violations involving any mistreatment, neglect, or abuse would be reported immediately to officials in accordance with state law.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure alleged violations related to abuse/mistreatment were thoroughly investigated or reported to the administrator and state agency (SA) immediately per the facility policy for 2 of 4 resident (R46, R101) incidents reviewed. Findings include: R46's quarterly Minimum Data Set (MDS) dated 10/9/14, indicated R46 was cognitively intact, had no signs or symptoms of delirium or behavioral symptoms, and needed extensive assistance of one facility staff for personal hygiene, toilet use,	F 226	R46 and R101 incidents were reported to the state agency and thorough investigations were conducted. Both residents were interviewed on 1/28/15 and endorse feeling safe in their environment. Concern forms since 1/5/15 have been reviewed for other potential residents affected and reported and investigated as appropriate. Staff were educated on facility vulnerable adult policy and procedures that include abuse definitions and reporting responsibilities by 2/9/15. Audits of concern forms will be completed for identifying and reporting of potential	2/9/15

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F 226	Continued From page 10 dressing, and required two staff to assist with transferring. A facility Concern Form dated 8/15/14, indicated licensed practical nurse (LPN)-A entered R46's room and found the resident in tears. R46 had requested a certain nursing assistant (NA) to not provide cares to her anymore. R46 reported to LPN-A the NA had made a "snappy remark" to her, had not assisted her with the transfer onto the toilet, and R46 stood up and fell back into her chair (wheelchair). R46 stated upon transfer off the toilet, she requested to be assisted into her recliner, however, R46 stated the NA left the room without assisting the resident into the recliner. R46 also informed LPN-A she was very worried about "repercussions," from the named NA. The Concern Form indicated LPN-A talked to the NA and discussed the need for her to help the resident, and asked the NA to stay away from R46 for the remainder of the day. During interview on 1/08/15, at 8:53 a.m. LPN-A stated she had completed the Concern Form and thought she had given the form to either the director of nursing (DON) or the nurse manager. LPN-A stated she thought someone met with the employee, however, she had never heard any more about the incident. LPN-A stated the NA had been emotionally abusive to R46, and the NA had a history of being "nasty" to residents. LPN-A stated she had other residents complain to her of how the NA treated them during cares. During interview on 1/8/15, at 9:33 a.m. DON stated the state agency had not been informed of the allegation on 8/15/14, and also had no evidence of the administrator being notified until 9/2/14, when the administrator signed the	F 226	abuse neglect or maltreatment by the director of social services weekly for one month, monthly for 3 months and quarterly thereafter. Findings will be reported to the QAPI committee for further follow-up.	

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Concern Form. The DON stated she did not feel the incident rose to the level of mistreatment which needed to be reported to the state agency, and felt it was a communication issue between the NA and R46. DON stated she met with R46 and the NA on the day of the incident, and felt the problem had been addressed. DON stated the NA accused of the rough treatment is no longer employed by the facility. No further investigation was conducted.

During interview on 1/8/15, at 10:15 a.m. R46 stated on 8/5/14, the NA who assisted her was, "rough" and was, "grouchy a lot of the time." R46 stated the NA would not listen to her and would leave the room without completing her requests. R46 stated she had heard other residents complain about the same issues with the NA. R46 stated she did not want to complain too much about the NA because she was afraid staff would get back at her.

During interview on 1/8/15, at 10:17 a.m. R46's family member (FM)-A stated R46 frequently complained about the NA, and often family would visit R46 and would find her in tears. FM-A stated R46 would blame herself for the way the NA was treating her and would say, "I made [NA] mad." FM-A reported R46 would tell her family the NA was "rough," with her and spoke to her in a rough tone. FM-A stated staff were aware of their concerns regarding the rough treatment as she had complained to the staff at least three times about the NA's rough treatment of R46. FM-A stated she was hesitant to report the rough treatment too often and was also fearful of staff retaliation.

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F 226	Continued From page 12	F 226		

R101's quarterly MDS dated 10/16/14, identified R101 had severe cognitive impairment, had no episodes of delirium or psychosis, and required extensive physical assistance from staff for transferring, toileting, and personal hygiene.
A Concern Form dated 10/17/14, which was completed by the administrator, described R101 had reported to her the employee who had gotten her up that morning was rough. R101 didn't recall the name of the employee, but was able to give a partial physical description of the employee and details about how many children the employee had. The Concern Form indicated R101 stated if staff didn't like their job, they should get another job. A note on the front of the Concern Form indicated it was forwarded to the social worker for interview.

Review of R101's medical record was completed and lacked any documentation of the incident on 10/17/14.

During interview on 1/8/14, at 5:20 p.m. social worker (SW)-A stated she recalled the incident and stated she had received the Concern Form report from the administrator in which R101 had complained of rough treatment. SW-A stated she went to interview R101 to get more details about the incident in order to determine if it was abuse or not prior to reporting the allegation. SW-A stated R101 had identified an employee had grabbed her by the arm while providing cares that morning, however, R101 was not able to identify the employee, and there was no investigation completed to determine who the employee was. SW-A stated she did not feel the incident was abuse because R101 stated she felt safe at the facility and did not have any bruising, therefore, the incident was not reported to the SA. The

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F 226	Continued From page 13 DON was also a part of the interview at this time and stated there was no further investigation of R101's allegation of rough treatment, and the facility did not determine who had assisted R101 in cares earlier that morning. DON stated all staff were given a verbal reminder to slow down and be more careful when assisting residents. The facility policy titled Abuse and Neglect dated 9/13, indicated alleged or suspected violations involving any mistreatment, neglect, or abuse would be reported immediately to officials in accordance with state law.	F 226		
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 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		2/9/15

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F 329	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 5 residents (R103) reviewed for unnecessary medications had adequate indications for use of psychoactive medications and was experiencing sedation from multiple narcotics, antihistamine and anxiolytic medications. Findings include: R103's quarterly Minimum Data Set dated 11/19/14, revealed a Brief Interview for Mental Status (BIMS) score of seven indicating severe cognitive impairment. The MDS identified R103 had verbal and other behavioral symptoms one to three days during the lookback period. R103's physician's orders dated 12/1/14, revealed an admission date of 5/20/14, and current diagnoses of anxiety, depression, psoriasis and unspecified dementia. The orders also identified R103 was admitted to hospice on 5/20/14, for terminal cancer and included the following active medications: -Ativan (an anxiolytic) one milligram (mg) at bedtime for agitation/restlessness and one mg by mouth every one hours as needed for Unknown. An additional handwritten order from R103's nurse practitioner, dated 12/5/14, directed an additional one mg of Ativan to be given every day at 10:00 a.m. -Diphenhydramine HCL elixir (an antihistamine) 25 mg four times a day for itch. The start date for	F 329	Consultant Pharmacist completed a Medication review of R103 on 1/18/15 and made recommendation to MD/NP to consider discontinuation of the diphenhydramine and clarify the lorazepam orders to provide additional documentation if more than 2mg/day of lorazepam are indicated. Orders to discontinue the diphenhydramine were received on 1/21/15. Order to clarify lorazapam was received on 1/30/15. Care team monitoring for changes in alertness, mood and itching. All residents receiving psychoactive medications had a medication regiman review by Consultant Pharmacist on 1-18-15. All Pharmacist recommentations are currently being reviewed by MD/NP□s. Orders will be revised as indicated to ensure adequate indications of use for psychoactive medications. Licensed Nurses will be inserviced 1/21/15 - 2/09/15 on facility policy and procedures for psychopharm □ acological medications. Random Audits of residents receiving psychopharmacological medications will be completed to ensure adequate indication for use. These audits will be done weekly for 1 month, monthly for 3	

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F 329	Continued From page 15 the order was 11/13/14. -Fentanyl patch (a narcotic pain medication) 25 micrograms (mcg) every three days for pain -Oxycodone HCL (a narcotic pain medication) five mg give two tablets by mouth every four hours for pain (a total dose of 60 mg/day) which was scheduled and had a start date of 12/29/14. R103's care plan dated 1/8/15, revealed she had impaired thought process and cognitive function as well as hallucinations and delusions. The care plan additionally identified R103 had behavioral symptoms of calling out and scratching herself, and to monitor for side effects of antianxiety drugs such as drowsiness as well as impulsive behavior, dizziness, lightheadedness, confusion and disorientation. R103's physician progress notes dated 10/10/14, revealed her daughter wanted her to be comfortable and happy, but would prefer not to use meds to fix everything (related to mood/behavioral issues). A physician progress note dated 12/10/14, revealed R103's skin had not been examined and questioned GDR (gradual dose reduction) of Benadryl (brand name for diphenhydramine) and a secondary progress note on 12/12/14, revealed to utilize Ativan or Oxycodone for agitation or pain and continue to monitor labile emotions. A hospice registered nurse (RN) progress note dated 12/21/14, revealed R103 was drowsy and eating well. An additional hospice RN progress note dated 11/5/14, revealed R103 had to be awakened at night in order to receive Benadryl. Review of R103's nursing progress notes over the past three months revealed R103 had	F 329	months and quarterly thereafter by the consultant pharmacist and/or Nurse Manager with changes implemented as needed. Findings will be reported to the QAPI committee for further evaluation and recommendations.	

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F 329	Continued From page 16	F 329		

intermittent confusion, agitation and experienced two falls within the last month. The progress notes also identified R103 had a rash on her back on 11/5/14, and nursing staff had begun scheduling Benadryl for her. A nursing progress note, dated 11/30/14, revealed R103 reported she was "not itching" and did not want her Benadryl. A hospice progress note, dated 12/12/14, revealed no skin or rash concerns were present and did not identify any current concerns with itching. A falls assessment, dated 12/5/14 also identified R103's medications as a potential risk factor for falls.

Review of R103's medication administration sheets revealed she had been receiving an average of 100 mg of Benadryl daily since 11/13/14, and an average of 1-2 mg of Ativan daily for the previous two months.

A PharMerica Note to Attending Physician/Prescriber dated 11/19/14, indicated diphenhydramine could cause confusion, urinary retention and sedation. The physician response section indicated the drug was being used for comfort care.

During observation on 1/6/15, at 2:09 p.m. R103 had difficulty talking and appeared very sedated.

During interview on 1/6/14, at 3:16 p.m. family (F)-B reported R103 had a baby doll she had provided that was effective for reducing R103's anxiety level. F-A reported hospice had tried some antipsychotic drugs for R103's behaviors that had not been as effective.

During observation on 1/7/15, at 12:41 p.m. R103 appeared very tired while seated at the dining

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room table and was not attempting to eat. R103 had her eyes closed but opened them when spoken too.

During interview on 1/7/15, at 1:02 p.m. RN-A stated she monitored resident behaviors and medication effectiveness by directly speaking with caregivers and her medical provider as well as observing residents. RN-A could not state if R103 was experiencing any medication side effects.

During observation on 1/7/15, at 2:46 p.m. R103 was sleeping in her wheelchair and was not able to watch TV in the day room.

During interview on 1/8/15, at 9:19 a.m. licensed practical nurse (LPN)-A stated R103 had been on the diphenhydramine for her psoriasis (a condition that causes thick patches of skin plaque buildup) for several months. LPN-A stated R103 was tired about half the time during the day and tried to get out of her bed at times. LPN-A stated R103's behaviors including itching were "better" at present.

During observation on 1/8/15, at 9:42 a.m. R103 was sleeping in her bed and had not been awakened for breakfast. Targeted observations of R103 from 1/6/14 through 1/8/14 revealed no signs of itching, anxiousness or pain symptoms.

During interview on 1/8/15, at 9:45 a.m. the consultant pharmacist (CP) stated he would not recommend diphenhydramine for long-term use for an elderly resident, and that R103's combination of narcotic, anxiolytic and antihistamine medications were a "definite concern." The CP further stated there were other antihistamine drugs that were less sedating that

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F 329	Continued From page 18 could be tried for R103's itching and that the Ativan orders required further clarification and dosing parameters. The CP indicated R103's current dosage of Ativan (2mg/day) was a "large dose" for an elderly resident. The CP indicated hospice had been ordering many of R103's medications including those for pain, anxiety and itching. During interview on 1/8/14, at 10:15 a.m. RN-B who was R103's hospice nurse indicated they could not recall trying any less-sedating antihistamines for R103 and that R103 had a lot of, "Elopements from her bed" and had been on the Ativan as a result. RN-B further stated R103's family had not been in agreement with adding medications to manage R103's behaviors, and that he would be open to a dose reduction of the diphenhydramine but thought the anxiolytic medications were necessary. The facility policy entitled Medication Regimen Review, dated 9/12 indicated the center would ensure that residents who have not used psychopharmacological medications and sedative/hypnotics are not given these unless this therapy is necessary to treat a specific condition, as diagnosed and documented in the medical record.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		2/9/15

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F 371	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure potentially hazardous foods were cooled in a manner to prevent foodborne illness. This had the potential to affect 78 out of 82 residents who consumed meals at the facility. Findings include: During observation on 1/5/15, at 6:34 p.m. three stainless steel steam table pan containers, approximately 10 inches long x 6 inches deep, containing chicken and rice soup, were noted in the central serving kitchen refrigerator. The containers were warm to the touch and dated 1/5/15. Cook-A stated the containers had just been put in the refrigerator (which occurred at approximately 5:30 p.m.) and the soup was leftover from supper. Cook-A further stated the soup should have been put on ice to cool it prior to being placed in the refrigerator, however, she had gotten busy and had not done this and was unable to state the facility procedure for cooling of leftover food items. Cook-A further stated there should be a log to record cooling temperatures, however, she was unable to find it. Observation on 1/5/15, at 8:52 p.m. with dietary aide (DA)-A revealed the soup containers had been transferred into a larger plastic container, approximately 12 inches wide x 8 inches deep.	F 371	Cooks have been educated about the procedures of proper cooling of food product and proper logging of cooling temperatures according to Good Samaritan Society Procedures on 1/16/15. Dietary Director will complete random audits for proper temperature compliance of cooling foods weekly for one month, monthly for 3 months and quarterly there after. Results and recommendations will be communicated in the QAPI meeting for further follow- up.	

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DA-A obtained the temperature of the chicken rice soup and measured it at 85 degrees Fahrenheit (F). DA-A stated he was unsure of what the temperature of the soup should be at this time and was unable to state the procedure for cooling leftover foods.

During interview on 1/5/15, at 9:12 p.m. the dietary manager (DM) stated he had just moved the chicken and rice soup to a new container a few minutes ago. The DM stated staff should be using a wide, shallow pan for cooling of foods and should be monitoring the cooling temperatures.

During interview on 1/6/15, at 11:45 a.m. DA-B stated the usual procedure for cooling foods would be to re-check the temperature when it returned to the kitchen to ensure it was under 145 degrees and then check the temperature four hours later. DA-B stated the temperatures would be recorded on a cooling log which she located in a three ring binder.

Review of the facility Cooling Temperature Log, revised 12/08 revealed 14 entries between 12/7/14 and 1/7/15. 13 of the 14 entries listed the two hour temperature at or above 135 degrees. Leftover food portions listed on the form included oats, pork, soup and eggs. The form had instructions at the bottom indicating sauces and soups should be transferred into two to four inch deep shallow pans and put on an ice water bath for quick cooling.

During interview on 1/8/15, 10:28 a.m. the DM confirmed that the cooling temperatures were not being recorded correctly by dietary staff. The facility registered dietician (RD) was also present during for the interview and indicated the current

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F 371	Continued From page 21 lack of proper temperature monitoring was a potential risk for foodborne illness, and that two hour temperatures should be recorded on the cooling temperature log after the food had cooled in a shallow pan for two hours, not when the food initially returned back to the kitchen from the units. The facility policy, entitled Food/Food Preparation Leftovers, dated 2/13 indicated leftover hot food should be cooled from 135 to 70 degrees F within the first two hours and shallow pans of no more than three inches deep should be used to cool broth or soup. If food was not cooled to 70 degrees F within two hours, the food should be reheated to 165 degrees F for 15 seconds.	F 371		
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: Based on interview and document review the consultant pharmacist failed to identify irregularities to the physician for 1 of 5 residents (R103) reviewed for unnecessary medications who was experiencing sedation and received	F 428	Consultant Pharmacist completed a Medication review of R103 on 1/18/15 and made recommendation to MD/NP to consider discontinuation of the diphenhydramine and clarify the	2/9/15

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F 428	Continued From page 22 multiple antihistamine, anxiolytic and narcotic medications. Findings include: R103's quarterly Minimum Data Set dated 11/19/14, revealed a Brief Interview for Mental Status (BIMS) score of seven indicating severe cognitive impairment. The MDS identified R103 had verbal and other behavioral symptoms one to three days during the lookback period. R103's physician's orders dated 12/1/14, revealed an admission date of 5/20/14, and current diagnoses of anxiety, depression, psoriasis and unspecified dementia. The orders also identified R103 was admitted to hospice on 5/20/14, for terminal cancer and included the following active medications: -Ativan (an anxiolytic) one milligram (mg) at bedtime for agitation/restlessness and one mg by mouth every one hours as needed for Unknown. An additional handwritten order from R103's nurse practitioner, dated 12/5/14, directed an additional one mg of Ativan to be given every day at 10:00 a.m. -Diphenhydramine HCL elixir (an antihistamine) 25 mg four times a day for itch. The start date for the order was 11/13/14. -Fentanyl patch (a narcotic pain medication) 25 micrograms (mcg) every three days for pain -Oxycodone HCL (a narcotic pain medication) five mg give two tablets by mouth every four hours for pain (a total dose of 60 mg/day) which was scheduled and had a start date of 12/29/14. R103's care plan dated 1/8/15, revealed she had impaired thought process and cognitive function as well as hallucinations and delusions. The care	F 428	lorazepam orders to provide additional documentation if more that 2mg/day of lorazepam is indicated. Orders to discontinue the diphenhydramine were received on 1/21/15. Order to clarify lorazapam were received on 1/30/15. 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 1/18/15 to review policy and procedure of monthly chart reviews. Licensed Nurses will be inserviced 1/21/15 - 2/09/15 on facility policy and procedures for pharmcist recommendations and communication to MD/NP 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 QAPI committee for further evaluation and recommendations.	

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plan additionally identified R103 had behavioral symptoms of calling out and scratching herself, and to monitor for side effects of antianxiety drugs such as drowsiness as well as impulsive behavior, dizziness, lightheadedness, confusion and disorientation.

R103's physician progress notes dated 10/10/14, revealed her daughter wanted her to be comfortable and happy, but would prefer not to use meds to fix everything (related to mood/behavioral issues). A physician progress note dated 12/10/14, revealed R103's skin had not been examined and questioned GDR (gradual dose reduction) of Benadryl (brand name for diphenhydramine) and a secondary progress note on 12/12/14, revealed to utilize Ativan or Oxycodone for agitation or pain and continue to monitor labile emotions.

A hospice registered nurse (RN) progress note dated 12/21/14, revealed R103 was drowsy and eating well. An additional hospice RN progress note dated 11/5/14, revealed R103 had to be awakened at night in order to receive Benadryl.

Review of R103's nursing progress notes over the past three months revealed R103 had intermittent confusion, agitation and experienced two falls within the last month. The progress notes also identified R103 had a rash on her back on 11/5/14, and nursing staff had begun scheduling Benadryl for her. A nursing progress note, dated 11/30/14, revealed R103 reported she was "not itching" and did not want her Benadryl. A hospice progress note, dated 12/12/14, revealed no skin or rash concerns were present and did not identify any current concerns with itching. A falls assessment, dated 12/5/14 also

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identified R103's medications as a potential risk factor for falls.

Review of R103's medication administration sheets revealed she had been receiving an average of 100 mg of Benadryl daily since 11/13/14, and an average of 1-2 mg of Ativan daily for the previous two months.

A PharMerica Note to Attending Physician/Prescriber dated 11/19/14, indicated diphenhydramine could cause confusion, urinary retention and sedation. The physician response section indicated the drug was being used for comfort care.

During observation on 1/6/15, at 2:09 p.m. R103 had difficulty talking and appeared very sedated.

During interview on 1/6/14, at 3:16 p.m. family (F)-B reported R103 had a baby doll she had provided that was effective for reducing R103's anxiety level. F-A reported hospice had tried some antipsychotic drugs for R103's behaviors that had not been as effective.

During observation on 1/7/15, at 12:41 p.m. R103 appeared very tired while seated at the dining room table and was not attempting to eat. R103 had her eyes closed but opened them when spoken too.

During interview on 1/7/15, at 1:02 p.m. RN-A stated she monitored resident behaviors and medication effectiveness by directly speaking with caregivers and her medical provider as well as observing residents. RN-A could not state if R103 was experiencing any medication side effects.

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	245149	A. BUILDING _____ B. WING _____	01/08/2015

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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F 428	Continued From page 25	F 428		

During observation on 1/7/15, at 2:46 p.m. R103 was sleeping in her wheelchair and was not able to watch TV in the day room.

During interview on 1/8/15, at 9:19 a.m. licensed practical nurse (LPN)-A stated R103 had been on the diphenhydramine for her psoriasis (a condition that causes thick patches of skin plaque buildup) for several months. LPN-A stated R103 was tired about half the time during the day and tried to get out of her bed at times. LPN-A stated R103's behaviors including itching were "better" at present.

During observation on 1/8/15, at 9:42 a.m. R103 was sleeping in her bed and had not been awakened for breakfast. Targeted observations of R103 from 1/6/14 through 1/8/14 revealed no signs of itching, anxiousness or pain symptoms.

R103's pharmacy consultant reviews over the previous 10 months revealed the following:
-12/10/14 - Have Ativan dx [diagnosis] match and Celexa 20 mg at HS [hour of sleep]. Haldol - severe agitation. No new suggestions, Haldol - severe agitation
11/12/14 - Benadryl 150 mg /day, need dx for Ativan
10/14/14 - No new suggestions
9/5/14 - Ativan changed to HS, Sertraline increased to 50 mg per day, hospice
8/7/14 - No new suggestions

During interview on 1/8/15, at 9:45 a.m. the consultant pharmacist (CP) stated he would not recommend diphenhydramine for long-term use for an elderly resident, and that R103's combination of narcotic, anxiolytic and

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F 428	Continued From page 26 antihistamine medications were a "definite concern." The CP further stated there were other antihistamine drugs that were less sedating that could be tried for R103's itching and that the Ativan orders required further clarification and dosing parameters. The CP indicated R103's current dosage of Ativan (2mg/day) was a "large dose" for an elderly resident. The CP indicated hospice had been ordering many of R103's medications including those for pain, anxiety and itching. During interview on 1/8/14, at 10:15 a.m. RN-B who was R103's hospice nurse indicated they could not recall trying any less-sedating antihistamines for R103 and that R103 had a lot of, "Elopements from her bed" and had been on the Ativan as a result. RN-B further stated R103's family had not been in agreement with adding medications to manage R103's behaviors, and that he would be open to a dose reduction of the diphenhydramine but thought the anxiolytic medications were necessary. The facility policy entitled Medication Regimen Review, dated 9/12 indicated the center would ensure that residents who have not used psychopharmacological medications and sedative/hypnotics are not given these unless this therapy is necessary to treat a specific condition, as diagnosed and documented in the medical record.	F 428		
F 441 SS=D	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	F 441		2/9/15

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F 441	Continued From page 27 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 (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 observation, interview, and document review, the facility failed to ensure infection control protocols were used to prevent the spread	F 441	F441 NA-A retired from facility effective 1/20/15. Resident R59 is no longer in our facility.	

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F 441	Continued From page 28 of infection while giving personal cares for 2 of 6 residents (R59, R108) who were identified as having a influenza/respiratory illness. Findings include: On 1/6/15, at 9:33 a.m. nursing assistant (NA)-A was observed to enter R59's room to retrieve the resident's breakfast tray. NA-A had a face mask under his chin (not covering his mouth and nose) when he entered the room. R59 was lying on her bed. NA-A bent over the bed (face/nose uncovered) and spoke to R59. During the conversation, R59 coughed directly toward NA-A. R59 had a harsh, loose cough and her mouth was not covered. NA-A took her breakfast tray and put the tray on a cart outside the resident's room. NA-A then proceeded to retrieve R59's roommate's tray (R108) without completion of hand hygiene or proper placement of his face mask. NA-A spoke to R108 behind her privacy curtain and when he returned to the hallway, his face mask was properly placed on his face. An interview with NA-A was completed on 1/6/15, at 9:40 a.m. and he reported he was to wear the mask as the unit was "under quarantine" due to influenza. NA-A identified R59 had been diagnosed with Influenza A and also verified he had not worn his mask properly when interacting with R59. On 1/6/15, at 9:00 a.m. signs were posted on rooms 111, 114 (R59's and R108's room), 107, 106, and 103, that directed, "Respiratory Infection Etiquette." NA-A reported upon interview that the signs were a reminder to staff and visitors that the residents in these rooms had cold or flu symptoms and they were to adhere to infection	F 441	All residents in facility were reviewed for Respiratory Precautions and /or ILI on 1/28/2015. No active respiratory illness in facility at time of review. All staff will be inserviced by 2/9/15 on Infection Control Policy and Procedure for prevention of the spread of infection for residents with Influenza/ respiratory illness. Education included wearing masks upon entry to room that is identified as needing precautions and hand hygiene between residents in same room. Random audits to ensure Infection Control protocols are in place and properly followed for residents on respiratory / droplet precautions will be done done weekly for 1 month, monthly for 3 months, and quarterly thereafter as coordinated by the infection control Nurse. Results of audits will be reviewed and analyzed by infection control committee with changes implemented as needed. Findings will be reported to the QAPI committee for further evaluation and recommendations.	

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F 441	Continued From page 29	F 441		

control protocols. A posted sign on Room 114 indicated, "Droplet Precautions."

An interview with R59 was attempted but she declined to be interviewed as she reported she was, "Too sick to talk."

R59 was diagnosed with Influenza A on 1/4/15, and Tamiflu (an antiviral medication) 75 milligrams (mg) twice a day was ordered on that date.

An interview with R108 was completed on 1/6/15, at 9:50 a.m. She reported she was recovering from, "the bug," with body aches, cough and elevated body temperature.

On 1/6/15, at 9:30 a.m. registered nurse (RN)-C reported face masks were to be worn when providing all cares for R59. In addition, hand hygiene was to be performed when personal cares were provided.

An interview with the director of nurses (DON) was completed on 1/8/15, at 10:15 a.m. The DON reported face masks were to be worn when personal cares were provided to R59 and it was not acceptable to retrieve meal trays from the resident, without the use of a face mask. The DON also verified hand hygiene should have been completed between personal cares provided to the residents.

The facility's policy Droplet Precautions, last revised 11/14, directed staff to wear a mask upon entry into a resident's room or cubicle. In addition, the policy directed staff to perform hand hygiene between contact of a resident in the same room, regardless of whether one resident

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F 441	Continued From page 30 or both, were on droplet precautions. The facility did not follow their policy.	F 441		

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	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/12/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS 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. 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: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/02/2015

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K 000	Continued From page 1 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 has a capacity of 85 beds and had a census of 82 at time of the survey.	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		2/9/15

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K 029	Continued From page 2 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the hazardous areas are not maintained in accordance with NFPA 101-2000, Section 19.3.2.1. This deficient practice could affect some patients. Findings include: During facility tour between 9:30 AM and 11:00 PM on 01/12/2015, observation revealed that the E-12 kitchen door does not have a door closer. This deficient practice was verified by the maintenance at the time of the inspection.	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. Door Closer for E-12 kitchen will be installed by 2/9/2015. Maintenance Supervisor is responsible for ensuring door closures are in place as indicated. Any changes or modification will be reviewed in the safety committee for	

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K 029	Continued From page 3	K 029	further recommendation or follow-up.	
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility's fire alarm system is not maintained in conformance with NFPA 72, (99). This deficient practice could affect the residents. Findings include: On facility tour between 9:30 AM and 11:00 AM on 01/12/2015, observation revealed the the smoke detector in room E-8 is within 36" of the HVAC diffuser. This deficienct practice was verified by maintenance at the time of the inspection.	K 052	Diffuser in room E-8 was moved greater than 36" of the smoke detector on 1/28/2015. Maintenance Supervisor is responsible to monitor and ensure diffusers are outside of 36" of an HVAC diffuser.	2/9/15

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