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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C9I2

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00146

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245403**

2.STATE VENDOR OR MEDICAID NO.
(L2) **150518100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BATTLE LAKE**
(L4) **105 GLENHAVEN DRIVE**
(L5) **BATTLE LAKE, MN** (L6) **56515**

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 **09/25/2017** (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 **55** (L18)
13.Total Certified Beds **55** (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 |
|---|---|---|---|---|
| | **55** | | | |
| (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 :
Gail Anderson, Unit Supervisor 10/12/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 10/16/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**12/01/1986**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**00140**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**10/05/2017**
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

CMS Certification Number (CCN): 245403 October 12, 2017

Mr. James Wolf, Administrator
Good Samaritan Society Battle Lake
105 Glenhaven Drive
Battle Lake, MN 56515

Dear Mr. Wolf:

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 September 29, 2017 the above facility is recommended for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 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 related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered October 12, 2017

Mr. James Wolf, Administrator
Good Samaritan Society Battle Lake
105 Glenhaven Drive
Battle Lake, MN 56515

RE: Project Number S5403026

Dear Mr. Wolf:

On August 25, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 10, 2017. 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 September 25, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 2, 2017 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 August 10, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 29, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 10, 2017, effective September 29, 2017 and therefore remedies outlined in our letter to you dated August 25, 2017, will not be imposed.

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

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

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

October 12, 2017

Mr. James Wolf, Administrator
Good Samaritan Society Battle Lake
105 Glenhaven Drive
Battle Lake, MN 56515

Re: Reinspection Results - Project Number S5403026

Dear Mr. Wolf:

On September 25, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 25, 2017 with orders received by you on August 28, 2017. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: C9I2

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

Facility ID: 00146

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245403**
2.STATE VENDOR OR MEDICAID NO.
(L2) **150518100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BATTLE LAKE**
(L4) **105 GLENHAVEN DRIVE**
(L5) **BATTLE LAKE, MN** (L6) **56515**

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 **08/10/2017** (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 **55** (L18)
13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 55 | | | |
| (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 :
Christina Martinson, HFE NEII 09/12/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/04/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**12/01/1986**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**00140**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 25, 2017

Mr. James Wolf, Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, MN 56515

RE: Project Number S5403026

Dear Mr. Wolf:

On August 10, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

DEPARTMENT CONTACT

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

**Gail Anderson, Unit Supervisor**
**Fergus Falls Survey Team**
**Licensing and Certification Program**
**Health Regulation Division**
**Minnesota Department of Health**
**1505 Pebble Lake Road, Suite 300**
**Fergus Falls, Minnesota 56537-3858**
**Email: gail.anderson@state.mn.us**
**Phone: (218) 332-5140**
**Fax: (218) 332-5196**

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 September 19, 2017, 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 September 19, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

### Original deficiencies not corrected

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

### Original deficiencies not corrected and new deficiencies found during the revisit

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

### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 10, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 10, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

**Mr. Tom Linhoff, Fire Safety Supervisor**
**Health Care Fire Inspections**
**Minnesota Department of Public Safety**
**State Fire Marshal Division**
**445 Minnesota Street, Suite 145**
**St. Paul, Minnesota 55101-5145**

**Email: tom.linhoff@state.mn.us**
**Telephone: (651) 430-3012**
**Fax: (651) 215-0525**

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

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 |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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<br><br>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.<br><br>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 282 SS=D | 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review the facility failed to implement care plan intervention for repositioning schedule for 2 of 2 residents (R6, R44) with a current unstageable pressure ulcer. In addition, the facility failed to implement care plan intervention for use of a pressure relieving boot for 1 of 2 residents (R6) with a current unstageable pressure ulcer.<br><br>Findings include: | F 282 | 1. R6 and R44 are being repositioned per care planned intervention. Heel boot is being placed on R6 left foot as directed by care plan.<br>2. All residents requiring assistance with repositioning or pressure relieving devices will be reviewed by DNS or designee to ensure the plan of care is being followed.<br>3. The DON or designee will provide re-education for CNA's and nurses on 9/12/17 and 9/13/17 regarding facility | 9/13/17 |

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

Electronically Signed | 08/31/2017

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 282 | Continued From page 1<br>R6's care plan revised 8/3/17, identified R6 had a current unstageable pressure ulcer to the left heel, related to the need for mobility assistance and Parkinson's disease. R6's care plan directed staff to assist to turn/reposition at least every two hours when sitting, avoid positioning feet on bed at all times, float heels with pillow while in bed, provide Prevalon boot (pressure reduction boot) to left foot, and Roho cushion when in wheelchair.<br><br>On 8/8/17, at 2:48 p.m. R6 was observed in his room, lying on his back in his bed with his eyes closed. He had a plaid blanket pulled up to his chin which exposed his feet and legs to mid-shin. R6 wore a yellow and white non-skid sock on left foot and a black Prevalon boot on his right foot without a sock present. Both feet/heels rested directly on the bed.<br><br>At 3:24 p.m. R6 was seated in his wheelchair and trained medication aid (TMA)-A propelled R6 him from his room to the unit day room. The black Prevalon boot remained on R6's right foot and his left stocking covered foot rested directly on the pedal of the wheelchair. R6's legs were crossed and his right boot rested directly on top of left foot, pressing the left heel onto the pedal of the wheelchair.<br><br>At 3:30 p.m. nursing assistant (NA)-B approached R6 and knelt next to his wheelchair. NA-B removed the black Prevalon boot from R6's right foot and performed hamstring and heel cord stretches to his right leg, with R6's left heel resting directly on the wheelchair pedal. At 3:37 p.m. NA-B replaced the Prevalon boot to R6's right foot and exited the area.<br><br>At 3:38 p.m. R6 remained seated in his | F 282 | policy and procedure for following care plan repositioning times and applying pressure releiving devices with review of assessing the resident's Kardex and using facility process for documenting on CNA "list" when resident is positioned to ensure they know when next repositioning time is due.<br>4. To monitor compliance of repositioning schedules and correct application of pressure relieving devices, random observation audits will be performed for R6 and R44 and random other residents by the DON/designee weekly times 4, and then monthly times 3. Audit results will be reported to the monthly QA meeting for further recommendation. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 282 | Continued From page 2 | F 282 | | |

wheelchair with black Prevalon boot to right foot, with his left foot covered with a yellow and white sock resting directly on the wheelchair pedal. Director of nursing (DON) visualized R6's feet with surveyor and confirmed R6's Prevalon boot was on the right foot and his left heel rested directly on the pedal of the wheelchair. She confirmed R6 had a current unstageable pressure ulcer to his left heel and confirmed the Prevalon boot was to be applied to R6's left foot, not his right foot. DON then left the area.

At 3:46 p.m. R6 remained in the same position when TMA-A and NA-A approached R6 and propelled him to his room to transfer from wheelchair to his bed. DON and clinical manager (CM)-A entered the room and CM-A removed R6's yellow and white non-skid sock from his left foot. CM-A visualized R6's pressure ulcer and indicated it had hard edges with granular tissue (pink-red moist tissue that fills an open wound, when it starts to heal) in the base and eschar present. CM-A stated R6 had an unstageable pressure ulcer on the left heel.

On 8/8/17 at 3:51 p.m. during interview with CM-A and DON, CM-A confirmed R6's Prevalon boot was on the incorrect foot. She indicated R6 had a pressure reduction mattress, protein supplement (for wound healing), pressure reduction boot to left foot to keep his heel floated at all times. CM-A stated she would expect the interventions to be followed. DON stated she would expect staff to follow R6's care plan.

On 8/9/17, at 7:47 a.m. registered nurse (RN)-A completed wound care on R6's left heel unstageable pressure ulcer. RN-A stated R6's ulcer measurements were 1 centimeter (cm) x 2

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 282 | Continued From page 3 | F 282 | | |

cm x 0.2 cm and had a 0.4 x 0.7 cm open area with granulation, stiff edges, four percent eschar, no slough and 96 percent epithelium (the outside layer of cells that covers all the free, open surfaces of the body including the skin). She stated interventions in place for R6's left heel ulcer included to elevate left heel off bed, reposition every two hours while sitting, and a protein supplement. RN-A stated she had seen R6 the previous day with the Prevalon boot on his left foot and indicated she was unaware what time the boot had been placed on the wrong foot.

On 8/9/17, at 9:49 a.m. NA-C stated R6 was dependent on staff for all cares and required a mechanical lift for transfers. She indicated interventions to relieve pressure included pressure reduction boot to left foot, pressure reduction cushion in wheelchair and staff were to place a pillow under his legs while lying in bed.

On 8/10/17, at 10:50 a.m. nurse practitioner (NP)-A stated if a resident had a pressure ulcer on the heel she would expect that a pillow or boot would be used to relieve pressure from the area at all times.

On 8/9/17, at 6:48 a.m. R6 was observed seated in his wheelchair next to two recliner in the middle of the dayroom, facing the television. R6 wore street clothes with a white sock on his right foot and a black Prevalon boot on his left foot. Continuous observations were conducted from 7:03 a.m. to 9:18 a.m. At 7:03 a.m. R6 remained seated in his wheelchair in the middle of the main dayroom facing the television. At 7:41 a.m., R6 remained seated in his wheelchair in the dayroom. R6 reached down and moved the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 282 | Continued From page 4 | F 282 | | |

wheels of his wheelchair, propelling himself forward until he bumped his feet into a nearby armchair. At 7:45 am RN-A entered the dayroom, approached R6 and propelled his wheelchair to his room. RN-A completed wound care to his left foot while R6 remained seated in his wheelchair. At 7:53 a.m. RN-A assisted R6 to propel his wheelchair from his room to the dining room and positioned his wheelchair at a table. At 8:06 a.m. licensed practical nurse (LPN)-A approached R6 at the table and assisted R6 to take medications with a spoon and immediately walked away. At 8:22 a.m. NA-D brought R6's breakfast items and sat next to R6 and assisted him to eat breakfast. At 8:50 a.m. R6 remained seated in his wheelchair, independently drinking coffee. At 9:00 NA-D approached R6 and wheeled him out of dining room to the dayroom and walked out of the area. R6 remained seated in his wheelchair until 9:18 a.m. when NA-D entered the area and assisted R6 to propel his wheelchair from the dayroom to his room and assisted him from his wheelchair to bed. R6 had not been repositioned from 6:45 a.m. to 9:18 am, a total of 2 hours and 33 minutes.

On 8/9/17, at 9:53 a.m. NA-C stated R6 was totally dependent on staff for activities of daily living (ADL). She indicated R6 was supposed to wear his boot (pressure reduction) on his left foot, assisted to reposition every two hours when seated, and use a mechanical lift with two staff to transfer from wheelchair to bed. NA-C indicated R6 had been transferred from his bed to wheelchair "around 7:00 or so."

On 8/9/17 at 2:10 p.m. NA-D indicated she assisted R6 to transfer from bed to wheelchair in the early morning. She confirmed she had

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 282 | Continued From page 5<br>assisted R6 to transfer from his bed to his wheelchair at 6:45 a.m.<br><br>R44<br><br>R44's care plan revised 8/3/17, indicated R44 had a current unstageable pressure ulcer to left medial heel related to immobility, had advanced dementia, and required assistance with ADL's. R6's care plan listed various interventions which included reposition at least every two hours when sitting, Roho cushion in wheelchair and Prevalon boot on left foot at all times.<br><br>On 8/9/17, at 6:48 a.m. R44 was observed seated in a wheelchair with his eyes closed, facing the television in the large dayroom. R44 wore a long sleeve shirt and plaid pajama pants, and a blue boot on his left foot. Continuous observations were conducted from 7:03 a.m. to 9:25 a.m. At 7:03 a.m R44 remained seated in a wheelchair with his eyes closed in the dayroom. At 7:30 a.m. RN-A entered the dayroom, approached R44 and propelled R44 in his wheelchair to his room. At 7:34 a.m. RN-A completed a pressure ulcer evaluation of R44's left heel pressure ulcer, while R44 sat in the wheelchair. At 7:40 a.m. RN-A propelled R44 in his wheelchair from his room, back to the dayroom. At 8:01 a.m. R44 remained seated in his wheelchair in the dayroom, NA-D entered the dayroom and propelled R44's wheelchair from dayroom to a table in the dining room. At 8:22 a.m. licensed practical nurse(LPN)-A briefly approached R44, applied a clothing protector and immediately walked away. At 8:28 a.m. LPN-A sat down next to R44 and assisted R44 to eat breakfast. At 8:34 a.m. LPN-A left the table and NA-D sat down and continued to assist R44 to eat his meal. At 8:59 | F 282 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 282 | Continued From page 6 | F 282 | | |

a.m. R44 remained seated in his wheelchair at the table with eyes closed and head against the headrest. At 9:02 a.m. NA-D propelled R44 out of dining room and back into the dayroom. R44 remained seated in his wheelchair until 9:22 a.m., when NA-D approached him and propelled him to his room. At 9:25 a.m NA-C and NA-D utilized a mechanical lift to transfer R44 from his wheelchair to bed. NA-C loosened R44's incontinent brief and R44's skin over his coccyx area was noted to be bright red. R44 had not been repositioned from 6:45 a.m. to 9:25 a.m., a total of 2 hours and 40 minutes.

On 8/9/17, at 9:30 a.m. NA-C indicated the red area on R44's coccyx area was new and stated she would notify LPN-A of this change for R44. NA-C indicated R44 had a current pressure ulcer on his left heel and required repositioning every two hours when seated, pressure reduction cushion in wheelchair and pressure reduction mattress. During follow up interview at 2:10 p.m. NA-D stated she had assisted R44 into his wheelchair at 6:45 a.m. that morning.

On 8/9/17, at 12:59 p.m. RN-A confirmed R44 had an current unstageable pressure ulcer on his left medial heel. She indicated R44 was to be repositioned every two hours.

On 8/10/17, at 1:49 p.m. CM-A stated on admission R44 was a medium risk for pressure ulcers, but now a high risk due to his nutrition. CM-A confirmed R44's current care plan and stated she would expect nursing staff to reposition R44 every two hours while seated.

On 8/10/17, at 2:06 p.m. DON stated R44 was totally dependent on staff for all cares and was at

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 282 | Continued From page 7<br>risk for development of pressure ulcers. DON stated R44 had developed the current unstageable pressure ulcer on his left medial heel on 7/2/17. She indicated R44's care plan included directions for repositioning R44 every two hours when seated and every four hours lying. DON stated if R44 was not repositioned every two hours while seated, R44 would be at risk for development of pressure ulcers. DON stated she expected staff to follow R44's care plan and indicated staff should have repositioned R44 within 10-15 minutes of the two hours of sitting in wheelchair.<br><br>Review of facility policy titled, Care Plan, dated 11/16, indicated residents plan of care would reflect the care currently required/provided for the resident based on the comprehensive assessment. The policy also indicated resident care plans would be reviewed, updated with a change of condition for the resident. | F 282 | | |
| F 314 SS=D | 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>(b) Skin Integrity -<br><br>(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-<br><br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br><br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with | F 314 | | 9/13/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 314 | Continued From page 8<br>professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to implement repositioning schedule to prevent further development of pressure ulcers for 2 of 2 residents (R6, R44) with current unstageable pressure ulcers. In addition, the facility failed to implement the use of a pressure relieving boot to promote healing and prevent worsening for 1 of 2 residents (R6) with a current unstageable pressure ulcer.<br><br>Findings include:<br><br>R6's admission Minimum Data Set (MDS) dated 3/6/17, indicated R6 had diagnoses of Diabetes Mellitus, dementia, and Parkinson's disease. R6's MDS indicated he had severe cognitive impairment and was totally dependent on staff assistance for transfers. Further, the MDS indicated R6 required extensive assistance for bed mobility, toilet use, dressing and personal hygiene and did not ambulate. The MDS indicated R6 was at risk for the development of pressure ulcers and had no current pressure ulcers.<br><br>Review of R6's Care Area Assessment (CAA) dated 3/8/17, indicated R6's was dependent on staff for assistance with positioning, incontinent of bowel and bladder, had no known history of pressure ulcers, was at high risk of developing pressure ulcers and staff were to anticipate his needs. CAA listed various interventions put in place to prevent skin breakdown, which included | F 314 | 1. R6 and R44 are being repositioned per care planned intervention. Heel boot is being placed on R6 left foot as directed by care plan.<br>2. All residents with pressure areas will be reviewed by DNS or designee to ensure care plans are being followed for repositioning or application of pressure relieving devices.<br>3. The DON or designee will provide re-education for CNA's and nurses on 9/12/17 and 9/13/17 regarding facility policy and procedure for following care plan repositioning times and applying pressure relieving devices with review of assessing the resident's kardex, and using facility process for documenting on CNA "list" when resident is positioned to ensure they know when next repositioning time is due.<br>4. To monitor compliance of repositioning schedules and correct application of pressure relieving devices random observation audits will be performed for R6 and R44 and random other residents by the DON or designee weekly times 4 and monthly times 3. Audit results will be reported to the monthly QA meeting for further recommendation. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 314 | Continued From page 9<br>the use of a Roho cushion (pressure reduction cushion for sitting surfaces), alternating pro air mattress, scheduled repositioning, scheduled check and change for incontinence and nutritional supplement.<br><br>R6's quarterly MDS dated 6/5/17, indicated R6 had severe cognitive impairment and was totally dependent on staff for assistance with transfers. The MDS indicated R6 required extensive assistance for bed mobility, toilet use, dressing, personal hygiene and did not ambulate. R6's MDS indicated R6 had a current unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough (necrotic/avascular tissue in the process of separating from the viable portions of the body & is usually light colored, soft, moist, & stringy) and/or eschar (dead tissue) in the wound bed). R6's MDS indicated a risk for development of pressure ulcers and listed interventions in place to decrease this risk included: pressure reduction cushion in wheelchair, pressure reduction mattress, repositioning program, nutrition/hydration, and pressure ulcer treatment.<br><br>Review of R6's Wound Data Collection form dated 8/2/17, identified unstageable pressure ulcer to left heel. Length 0.6 cm, width 0.9 cm and unable to determine wound depth due to 50 percent of wound bed covered by slough. Wound bed percentages were 90% epithelialized, 5% granulation, 5% slough and no eschar. Wound Data Collection dated 8/9/17, identified pressure ulcer to left heel. Length 2 cm, width 1 cm and depth 0.2 cm. Wound bed percentages were 92% epithelialized, 4% granulation, no slough, and 4% eschar. | F 314 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 314 | Continued From page 10 | F 314 | | |

R6's care plan revised 8/3/17, identified R6 had a current unstageable pressure ulcer to the left heel, related to the need for mobility assistance and Parkinson's disease. R6's care plan directed staff to assist to turn/reposition at least every two hours when sitting, avoid positioning feet on bed at all times, float heels with pillow while in bed, provide Prevalon boot (pressure reduction boot) to left foot, and Roho cushion when in wheelchair.

On 8/8/17, at 2:48 p.m. R6 was observed in his room, lying on his back in his bed with his eyes closed. He had a plaid blanket pulled up to his chin which exposed his feet and legs to mid-shin. R6 wore a yellow and white non-skid sock on left foot and a black Prevalon boot on his right foot without a sock present. Both feet/heels rested directly on the bed.

At 3:24 p.m. R6 was seated in his wheelchair and trained medication aid (TMA)-A propelled R6 him from his room to the unit day room. The black Prevalon boot remained on R6's right foot and his left stocking covered foot rested directly on the pedal of the wheelchair. R6's legs were crossed and his right boot rested directly on top of left foot, pressing the left heel onto the pedal of the wheelchair.

At 3:30 p.m. nursing assistant (NA)-B approached R6 and knelt next to his wheelchair. NA-B removed the black Prevalon boot from R6's right foot and performed hamstring and heel cord stretches to his right leg, with R6's left heel resting directly on the wheelchair pedal. At 3:37 p.m. NA-B replaced the Prevalon boot to R6's right foot and exited the area.

At 3:38 p.m. R6 remained seated in his

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 314 | Continued From page 11 | F 314 | | |

wheelchair with black Prevalon boot to right foot, with his left foot covered with a yellow and white sock resting directly on the wheelchair pedal. Director of nursing (DON) visualized R6's feet with surveyor and confirmed R6's Prevalon boot was on the right foot and his left heel rested directly on the pedal of the wheelchair. She confirmed R6 had a current unstageable pressure ulcer to his left heel and confirmed the Prevalon boot was to be applied to R6's left foot, not his right foot. DON then left the area.

At 3:46 p.m. R6 remained in the same position when TMA-A and NA-A approached R6 and propelled him to his room to transfer from wheelchair to his bed. DON and clinical manager (CM)-A entered the room and CM-A removed R6's yellow and white non-skid sock from his left foot. CM-A visualized R6's pressure ulcer and indicated it had hard edges with granular tissue (pink-red moist tissue that fills an open wound, when it starts to heal) in the base and eschar present. CM-A stated R6 had an unstageable pressure ulcer on the left heel.

At 3:51 p.m. during interview with CM-A and DON, CM-A confirmed R6's Prevalon boot was on the incorrect foot. She indicated R6 had a pressure reduction mattress, protein supplement (for wound healing), pressure reduction boot to left foot to keep his heel floated at all times. CM-A stated she would expect the interventions to be followed. DON stated she would expect staff to follow R6's care plan.

On 8/9/17, at 7:47 a.m. registered nurse (RN)-A completed wound care on R6's left heel unstageable pressure ulcer. RN-A stated R6's ulcer measurements were 1 centimeter (cm) x 2

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 314 | Continued From page 12 | F 314 | | |

cm x 0.2 cm and had a 0.4 x 0.7 cm open area with granulation, stiff edges, four percent eschar, no slough and 96 percent epithelium (the outside layer of cells that covers all the free, open surfaces of the body including the skin). She stated interventions in place for R6's left heel ulcer included to elevate left heel off bed, reposition every two hours while sitting, and a protein supplement. RN-A stated she had seen R6 the previous day with the Prevalon boot on his left foot and indicated she was unaware what time the boot had been placed on the wrong foot.

On 8/9/17, at 9:49 a.m. NA-C stated R6 was dependent on staff for all cares and required a mechanical lift for transfers. She indicated interventions to relieve pressure included pressure reduction boot to left foot, pressure reduction cushion in wheelchair and staff were to place a pillow under his legs while lying in bed.

On 8/9/17, at 12:49 p.m. during a follow up interview, RN-A indicated R6's pressure ulcer measurements on 8/9/17 were larger than measurements on 8/2/17. RN-A stated the area of new eschar was not present in 8/2/17 when she had completed dressing change. RN-A stated she would expect the boot to be on the left foot at all times and would expect the pillow under his legs floating heels when in bed.

On 8/10/17, at 10:50 a.m. nurse practitioner (NP)-A stated if a resident had a pressure ulcer on the heel she would expect that a pillow or boot would be used to relieve pressure from the area at all times.

On 8/9/17, at 6:48 a.m. R6 was observed seated

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 314 | Continued From page 13 | F 314 | | |

in his wheelchair next to two recliner in the middle of the dayroom, facing the television. R6 wore street clothes with a white sock on his right foot and a black Prevalon boot on his left foot. Continuous observations were conducted from 7:03 a.m. to 9:18 a.m. At 7:03 a.m. R6 remained seated in his wheelchair in the middle of the main dayroom facing the television. At 7:41 a.m., R6 remained seated in his wheelchair in the dayroom. R6 reached down and moved the wheels of his wheelchair, propelling himself forward until he bumped his feet into a nearby armchair. At 7:45 am RN-A entered the dayroom, approached R6 and propelled his wheelchair to his room. RN-A completed wound care to his left foot while R6 remained seated in his wheelchair. At 7:53 a.m. RN-A assisted R6 to propel his wheelchair from his room to the dining room and positioned his wheelchair at a table. At 8:06 a.m. licensed practical nurse (LPN)-A approached R6 at the table and assisted R6 to take medications with a spoon and immediately walked away. At 8:22 a.m. NA-D brought R6's breakfast items and sat next to R6 and assisted him to eat breakfast. At 8:50 a.m. R6 remained seated in his wheelchair, independently drinking coffee. At 9:00 NA-D approached R6 and wheeled him out of dining room to the dayroom and walked out of the area. R6 remained seated in his wheelchair until 9:18 a.m. when NA-D entered the area and assisted R6 to propel his wheelchair from the dayroom to his room and assisted him from his wheelchair to bed. R6 had not been repositioned from 6:45 a.m. to 9:18 am, a total of 2 hours and 33 minutes.

On 8/9/17, at 9:53 a.m. NA-C stated R6 was totally dependent on staff for activities of daily living (ADL). She indicated R6 was supposed to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 314 | Continued From page 14 | F 314 | | |

wear his boot (pressure reduction) on his left foot, assisted to reposition every two hours when seated, and use a mechanical lift with two staff to transfer from wheelchair to bed. NA-C indicated R6 had been transferred from his bed to wheelchair "around 7:00 or so."

On 8/9/17 at 2:10 p.m. NA-D indicated she assisted R6 to transfer from bed to wheelchair in the early morning. She confirmed she had assisted R6 to transfer from his bed to his wheelchair at 6:45 a.m.

R44

R44's admission MDS dated 4/18/17, indicated R44 had diagnoses which included Alzheimer's disease, psychotic disorder, anxiety and depression. The MDS indicated R44 had both short and long term memory problems, and had severely impaired cognitive skills for daily decision making. The MDS indicated R44 was totally dependent on staff assistance for transfers, required extensive assistance with bed mobility, toileting, personal hygiene and did not ambulate. Further, the MDS identified R44 was at risk for pressure ulcer development and did not have current pressure ulcers.

R44's CAA dated 4/19/17, indicated R44 had rapidly progressing Alzheimer's disease, acute behavioral disturbance, required assistance with all ADLS, had declined in his abilities. The CAA indicated R44 required staff to assist with anticipation of needs due to trouble with communication, garbled speech and history of being hard of hearing. The CAA summary indicated pressure ulcers had triggered for R44 and would be addressed on R44's care plan.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 314 | Continued From page 15 | F 314 | | |

R44's quarterly MDS dated 7/12/17, indicated R44 had both short and long term memory problems, and had severely impaired cognitive skills for daily decision making. The MDS indicated R44 was totally dependent on staff assistance for transfers, required extensive assistance with bed mobility, toileting, personal hygiene and did not ambulate. The MDS identified R44 was at risk for pressure ulcer development and did not have current pressure ulcers.

Review of R44's Positioning Assessment & Evaluation dated 7/12/17, indicated "Resident is at risk for skin breakdown and is on scheduled repositioning plan for this. Pressure reduction mattress in place and has Roho cushion in w/c [wheelchair] as well. No pressure related open areas with these measures in place.

Review of R44's Progress Notes from 7/20/17 to 8/9/17 revealed a note dated 7/26/17, which identified R44 had developed a new unstageable pressure ulcer to left medial heel, with stable eschar and no drainage.

R44's care plan revised 8/3/17, indicated R44 had a current unstageable pressure ulcer to left medial heel related to immobility, had advanced dementia, and required assistance with ADL's. R6's care plan listed various interventions which included reposition at least every two hours when sitting, Roho cushion in wheelchair and Prevalon boot on left foot at all times.

On 8/9/17, at 6:48 a.m. R44 was observed seated in a wheelchair with his eyes closed, facing the television in the large dayroom. R44 wore a long

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 314 | Continued From page 16 | F 314 | | |

sleeve shirt and plaid pajama pants, and a blue boot on his left foot. Continuous observations were conducted from 7:03 a.m. to 9:25 a.m. At 7:03 a.m R44 remained seated in a wheelchair with his eyes closed in the dayroom. At 7:30 a.m. RN-A entered the dayroom, approached R44 and propelled R44 in his wheelchair to his room. At 7:34 a.m. RN-A completed a pressure ulcer evaluation of R44's left heel pressure ulcer, while R44 sat in the wheelchair. At 7:40 a.m. RN-A propelled R44 in his wheelchair from his room, back to the dayroom. At 8:01 a.m. R44 remained seated in his wheelchair in the dayroom, NA-D entered the dayroom and propelled R44's wheelchair from dayroom to a table in the dining room. At 8:22 a.m. licensed practical nurse(LPN)-A briefly approached R44, applied a clothing protector and immediately walked away. At 8:28 a.m. LPN-A sat down next to R44 and assisted R44 to eat breakfast. At 8:34 a.m. LPN-A left the table and NA-D sat down and continued to assist R44 to eat his meal. At 8:59 a.m. R44 remained seated in his wheelchair at the table with eyes closed and head against the headrest. At 9:02 a.m. NA-D propelled R44 out of dining room and back into the dayroom. R44 remained seated in his wheelchair until 9:22 a.m., when NA-D approached him and propelled him to his room. At 9:25 a.m NA-C and NA-D utilized a mechanical lift to transfer R44 from his wheelchair to bed. NA-C loosened R44's incontinent brief and R44's skin over his coccyx area was noted to be bright red. R44 had not been repositioned from 6:45 a.m. to 9:25 a.m., a total of 2 hours and 40 minutes.

On 8/9/17, at 9:30 a.m. NA-C indicated the red area on R44's coccyx area was new and stated she would notify LPN-A of this change for R44.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 314 | Continued From page 17 | F 314 | | |

NA-C indicated R44 had a current pressure ulcer on his left heel and required repositioning every two hours when seated, pressure reduction cushion in wheelchair and pressure reduction mattress. During follow up interview at 2:10 p.m. NA-D stated she had assisted R44 into his wheelchair at 6:45 a.m. that morning.

On 8/9/17, at 12:59 p.m. RN-A confirmed R44 had an current unstageable pressure ulcer on his left medial heel. She indicated R44 was to be repositioned every two hours.

On 8/10/17, at 1:49 p.m. CM-A stated on admission R44 was a medium risk for pressure ulcers, but now a high risk due to his nutrition. CM-A confirmed R44's current care plan and stated she would expect nursing staff to reposition R44 every two hours while seated.

On 8/10/17, at 2:06 p.m. DON stated R44 was totally dependent on staff for all cares and was at risk for development of pressure ulcers. DON stated R44 had developed the current unstageable pressure ulcer on his left medial heel on 7/2/17. She indicated R44's care plan included directions for repositioning R44 every two hours when seated and every four hours lying. DON stated if R44 was not repositioned every two hours while seated, R44 would be at risk for development of pressure ulcers. DON stated she expected staff to follow R44's care plan and indicated staff should have repositioned R44 within 10-15 minutes of the two hours of sitting in wheelchair.

Review of the facility policy titled, Pressure Ulcer Practice Guidelines, revised 9/16, indicated a resident will be assessed and interventions

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 314 | Continued From page 18<br>implemented to address causative factors that contribute to the the resident's risk for skin breakdown. The policy indicated resident specific turning and positioning programs would be developed based on the individualized assessments.<br><br>Review of facility policy titled, Care Plan, dated 11/16, indicated residents plan of care would reflect the care currently required/provided for the resident based on the comprehensive assessment. The policy also indicated resident care plans would be reviewed, updated with a change of condition for the resident. | F 314 | | |
| F 431 SS=D | 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--<br><br>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and | F 431 | | 9/13/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 431 | Continued From page 19<br><br>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>(g) Labeling of Drugs and Biologicals.<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>(h) Storage of Drugs and Biologicals.<br>(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure the accurate labels with directions for use were on medications for 1 of 1 resident (R37) insulin pen observed during medication administration.<br><br>Findings include: | F 431 | 1. R37 Direction/order change sticker placed on insulin pen immediately upon being recognized by surveyor. Pharmacy was notified and a new and accurate label was ordered, received, and placed on the pen.<br>2. All residents receiving insulin via pen device were inspected by DNS on 8/7/17 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 431 | Continued From page 20<br>R37's Order Summary Report dated 8/8/17, indicated R37 had diagnoses which included Diabetes Mellitus, Alzheimer's disease and kidney failure. The report included an order for Novolog Solution 100 unit/ml (Insulin) 8 units injected subcutaneously once a day and 4 units once a day, ordered on 11/22/16.<br><br>On 8/7/17, at 6:45 p.m. registered nurse (RN)-B was observed standing next to the medication cart outside of R37's room. She opened the first drawer of the medication cart and removed a blue Insulin pen from the drawer, labeled with R37's name on the pen. RN-B primed the Insulin pen and set the dial of the pen for delivery of four units of insulin. The medication label on the insulin pen dated 8/4/17, directed staff to inject 8 units of Insulin at lunch and supper.<br><br>When interviewed at that time, RN-B confirmed R37's Insulin pen label was incorrectly labeled, and stated R37's current order was to administer 8 units at noon and 4 units in the evening. She stated R37's dose of Insulin had changed in the past, from 8 units each lunch and supper, to currently 8 units at noon and 4 units in the evening. RN-B indicated the Insulin pen should have had a sticker placed on it to reflect the current order, which had been ordered on 11/22/16.<br><br>On 8/8/17, at 3:06 p.m. the pharmacy consultant (PC) confirmed the usual facility practice, for when an order was changed, was to apply a label noting dose change or directing staff to electronic medical record for new dosage instructions to R37's insulin pen.<br><br>On 8/8/17, at 3:22 p.m. the director of nursing | F 431 | to ensure accurate identification/direction label was adhered to the pen.<br>3. DNS will provide re-education to all nurses on 9/12/17 and 9/13/17 regarding facility procedure for placing "change order stickers" on medications that have had a dose change and requesting new label from pharmacy. Medication carts will be stocked with change order stickers.<br>4. DNS or designee will perform random observational audits of medication order changes weekly times 4 and monthly times 2. All audit findings will be reported to the monthly QA meeting for further recommendation. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 431 | Continued From page 21<br>(DON) confirmed the current facility policy and stated a sticker should have been placed in the interim on R37's insulin pen when the order was changed and the pharmacy notified of that order change.<br><br>Review of the facility's policy titled Medication-Change of Direction Stickers dated 12/2015, directed staff to refuse or return inaccurately or improperly labeled medications to the dispensing pharmacy. In cases where prescriber's directions for use change, the policy allowed the nurse to place a change of order, check chart or similar sticker on the container to indicate changes in direction for use or dosages. | F 431 | | |
| F 441 SS=F | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: | F 441 | | 9/13/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 441 | Continued From page 22<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which 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; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. | F 441 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 441 | Continued From page 23<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to implement their infection control program policies to report a facility outbreak of influenza to the State agency (SA). This deficient practice had the potential to affect all 50 residents who resided in the facility.<br><br>Findings include:<br><br>Review of the facility form titled Monthly Report of Resident Infections in Center dated 2/17, indicated one positive influenza A culture on each of its three identified units (Heritage Lane, Fisherman's Cove and Cottonwood Grove). Fisherman's Cove also had three other residents with identified lower respiratory infections. Heritage Lane had three additional residents cultured for influenza. Cottonwood Grove had two additional residents with lower respiratory infections. Twelve residents were cultured for influenza.<br><br>During an interview on 8/10/17, at 3:09 p.m. the assistant director of nursing (ADON), who was the facility's infection control nurse, confirmed the above findings. ADON stated she was unsure if she had completed a influenza report form and indicated she would call SA to verify the report had been submitted. At 4:10 p.m. ADON confirmed the facility influenza outbreak had not been reported to the SA.<br><br>Review of facility procedure titled Infection | F 441 | 1. Positive influenza cultures were reported to the appropriate state agency by Facility Infection Preventionist on 8/10/17.<br>2. All residents in the facility were at risk for this deficient practice. No others demonstrated symptoms during that time frame.<br>3. DNS will provide re-education/reminders to Infection Preventionist on when to report per GSS procedure and MN Dept. of Health requirements on Sept. 5th, 2017.<br>4. DNS or designee will audit the infection control logs to determine if reporting was needed and completed as appropriate 1 time per month times 4 months. Results will be taken to QA meeting for further recommendations. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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 441 | Continued From page 24<br>Monitoring and Exposure Control Outbreaks/Epidemics/Seasonal Infectious Disease dated 3/16, indicated, "The local health department will be notified regarding the epidemic/outbreak if it is a reportable disease."<br><br>The Minnesota Department of Health form titled Long-Term Care Facility Influenza Report Form, 2016-2017 dated 9/2016, specified, "The definition of an outbreak is: Two residents with influenza-like illness (ILI) or one laboratory-confirmed influenza positive case along with other cases of respiratory infection in a unit." The form indicated submitting the report was sufficient for reporting an outbreak. | F 441 | | |

Electronically delivered
August 25, 2017

Mr. James Wolf, Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, MN 56515

Re: State Nursing Home Licensing Orders - Project Number S5403026

Dear Mr. Wolf:

The above facility was surveyed on August 7, 2017 through August 10, 2017 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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 contact Gail Anderson, Unit Supervisor at (218) 332-5140 or gail.anderson@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112  Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

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 |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 8/7-8/10/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. | 2 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Continued From page 1<br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance.<br><br>Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | 2 000 | | |
| 2 565 | MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use<br><br>Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review the facility failed to implement care plan intervention for repositioning schedule for 2 of 2 residents (R6, R44) with a current unstageable pressure ulcer. In addition, the facility failed to implement care plan intervention for use of a pressure relieving boot for 1 of 2 residents (R6) with a current unstageable pressure ulcer.<br><br>Findings include:<br><br>R6's care plan revised 8/3/17, identified R6 had a current unstageable pressure ulcer to the left heel, related to the need for mobility assistance and Parkinson's disease. R6's care plan directed staff to assist to turn/reposition at least every two hours when sitting, avoid positioning feet on bed | 2 565 | Corrected | 9/13/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 565 | Continued From page 2<br>at all times, float heels with pillow while in bed, provide Prevalon boot (pressure reduction boot) to left foot, and Roho cushion when in wheelchair.<br><br>On 8/8/17, at 2:48 p.m. R6 was observed in his room, lying on his back in his bed with his eyes closed. He had a plaid blanket pulled up to his chin which exposed his feet and legs to mid-shin. R6 wore a yellow and white non-skid sock on left foot and a black Prevalon boot on his right foot without a sock present. Both feet/heels rested directly on the bed.<br><br>At 3:24 p.m. R6 was seated in his wheelchair and trained medication aid (TMA)-A propelled R6 him from his room to the unit day room. The black Prevalon boot remained on R6's right foot and his left stocking covered foot rested directly on the pedal of the wheelchair. R6's legs were crossed and his right boot rested directly on top of left foot, pressing the left heel onto the pedal of the wheelchair.<br><br>At 3:30 p.m. nursing assistant (NA)-B approached R6 and knelt next to his wheelchair. NA-B removed the black Prevalon boot from R6's right foot and performed hamstring and heel cord stretches to his right leg, with R6's left heel resting directly on the wheelchair pedal. At 3:37 p.m. NA-B replaced the Prevalon boot to R6's right foot and exited the area.<br><br>At 3:38 p.m. R6 remained seated in his wheelchair with black Prevalon boot to right foot, with his left foot covered with a yellow and white sock resting directly on the wheelchair pedal. Director of nursing (DON) visualized R6's feet with surveyor and confirmed R6's Prevalon boot was on the right foot and his left heel rested directly on the pedal of the wheelchair. She | 2 565 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 565 | Continued From page 3 | 2 565 | | |

confirmed R6 had a current unstageable pressure ulcer to his left heel and confirmed the Prevalon boot was to be applied to R6's left foot, not his right foot. DON then left the area.

At 3:46 p.m. R6 remained in the same position when TMA-A and NA-A approached R6 and propelled him to his room to transfer from wheelchair to his bed. DON and clinical manager (CM)-A entered the room and CM-A removed R6's yellow and white non-skid sock from his left foot. CM-A visualized R6's pressure ulcer and indicated it had hard edges with granular tissue (pink-red moist tissue that fills an open wound, when it starts to heal) in the base and eschar present. CM-A stated R6 had an unstageable pressure ulcer on the left heel.

On 8/8/17 at 3:51 p.m. during interview with CM-A and DON, CM-A confirmed R6's Prevalon boot was on the incorrect foot. She indicated R6 had a pressure reduction mattress, protein supplement (for wound healing), pressure reduction boot to left foot to keep his heel floated at all times. CM-A stated she would expect the interventions to be followed. DON stated she would expect staff to follow R6's care plan.

On 8/9/17, at 7:47 a.m. registered nurse (RN)-A completed wound care on R6's left heel unstageable pressure ulcer. RN-A stated R6's ulcer measurements were 1 centimeter (cm) x 2 cm x 0.2 cm and had a 0.4 x 0.7 cm open area with granulation, stiff edges, four percent eschar, no slough and 96 percent epithelium (the outside layer of cells that covers all the free, open surfaces of the body including the skin). She stated interventions in place for R6's left heel ulcer included to elevate left heel off bed, reposition every two hours while sitting, and a

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 565 | Continued From page 4<br>protein supplement. RN-A stated she had seen R6 the previous day with the Prevalon boot on his left foot and indicated she was unaware what time the boot had been placed on the wrong foot.<br><br>On 8/9/17, at 9:49 a.m. NA-C stated R6 was dependent on staff for all cares and required a mechanical lift for transfers. She indicated interventions to relieve pressure included pressure reduction boot to left foot, pressure reduction cushion in wheelchair and staff were to place a pillow under his legs while lying in bed.<br><br>On 8/10/17, at 10:50 a.m. nurse practitioner (NP)-A stated if a resident had a pressure ulcer on the heel she would expect that a pillow or boot would be used to relieve pressure from the area at all times.<br><br>On 8/9/17, at 6:48 a.m. R6 was observed seated in his wheelchair next to two recliner in the middle of the dayroom, facing the television. R6 wore street clothes with a white sock on his right foot and a black Prevalon boot on his left foot. Continuous observations were conducted from 7:03 a.m. to 9:18 a.m. At 7:03 a.m. R6 remained seated in his wheelchair in the middle of the main dayroom facing the television. At 7:41 a.m., R6 remained seated in his wheelchair in the dayroom. R6 reached down and moved the wheels of his wheelchair, propelling himself forward until he bumped his feet into a nearby armchair. At 7:45 am RN-A entered the dayroom, approached R6 and propelled his wheelchair to his room. RN-A completed wound care to his left foot while R6 remained seated in his wheelchair. At 7:53 a.m. RN-A assisted R6 to propel his wheelchair from his room to the dining room and positioned his wheelchair at a table. At 8:06 a.m. | 2 565 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 565 | Continued From page 5<br><br>licensed practical nurse (LPN)-A approached R6 at the table and assisted R6 to take medications with a spoon and immediately walked away. At 8:22 a.m. NA-D brought R6's breakfast items and sat next to R6 and assisted him to eat breakfast. At 8:50 a.m. R6 remained seated in his wheelchair, independently drinking coffee. At 9:00 NA-D approached R6 and wheeled him out of dining room to the dayroom and walked out of the area. R6 remained seated in his wheelchair until 9:18 a.m. when NA-D entered the area and assisted R6 to propel his wheelchair from the dayroom to his room and assisted him from his wheelchair to bed. R6 had not been repositioned from 6:45 a.m. to 9:18 am, a total of 2 hours and 33 minutes.<br><br>On 8/9/17, at 9:53 a.m. NA-C stated R6 was totally dependent on staff for activities of daily living (ADL). She indicated R6 was supposed to wear his boot (pressure reduction) on his left foot, assisted to reposition every two hours when seated, and use a mechanical lift with two staff to transfer from wheelchair to bed. NA-C indicated R6 had been transferred from his bed to wheelchair "around 7:00 or so."<br><br>On 8/9/17 at 2:10 p.m. NA-D indicated she assisted R6 to transfer from bed to wheelchair in the early morning. She confirmed she had assisted R6 to transfer from his bed to his wheelchair at 6:45 a.m.<br><br>R44<br><br>R44's care plan revised 8/3/17, indicated R44 had a current unstageable pressure ulcer to left medial heel related to immobility, had advanced dementia, and required assistance with ADL's. R6's care plan listed various interventions which | 2 565 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 565 | Continued From page 6<br>included reposition at least every two hours when sitting, Roho cushion in wheelchair and Prevalon boot on left foot at all times.<br><br>On 8/9/17, at 6:48 a.m. R44 was observed seated in a wheelchair with his eyes closed, facing the television in the large dayroom. R44 wore a long sleeve shirt and plaid pajama pants, and a blue boot on his left foot. Continuous observations were conducted from 7:03 a.m. to 9:25 a.m. At 7:03 a.m R44 remained seated in a wheelchair with his eyes closed in the dayroom. At 7:30 a.m. RN-A entered the dayroom, approached R44 and propelled R44 in his wheelchair to his room. At 7:34 a.m. RN-A completed a pressure ulcer evaluation of R44's left heel pressure ulcer, while R44 sat in the wheelchair. At 7:40 a.m. RN-A propelled R44 in his wheelchair from his room, back to the dayroom. At 8:01 a.m. R44 remained seated in his wheelchair in the dayroom, NA-D entered the dayroom and propelled R44's wheelchair from dayroom to a table in the dining room. At 8:22 a.m. licensed practical nurse(LPN)-A briefly approached R44, applied a clothing protector and immediately walked away. At 8:28 a.m. LPN-A sat down next to R44 and assisted R44 to eat breakfast. At 8:34 a.m. LPN-A left the table and NA-D sat down and continued to assist R44 to eat his meal. At 8:59 a.m. R44 remained seated in his wheelchair at the table with eyes closed and head against the headrest. At 9:02 a.m. NA-D propelled R44 out of dining room and back into the dayroom. R44 remained seated in his wheelchair until 9:22 a.m., when NA-D approached him and propelled him to his room. At 9:25 a.m NA-C and NA-D utilized a mechanical lift to transfer R44 from his wheelchair to bed. NA-C loosened R44's incontinent brief and R44's skin over his coccyx area was noted to be bright red. R44 had not | 2 565 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 565 | Continued From page 7<br>been repositioned from 6:45 a.m. to 9:25 a.m., a total of 2 hours and 40 minutes.<br><br>On 8/9/17, at 9:30 a.m. NA-C indicated the red area on R44's coccyx area was new and stated she would notify LPN-A of this change for R44. NA-C indicated R44 had a current pressure ulcer on his left heel and required repositioning every two hours when seated, pressure reduction cushion in wheelchair and pressure reduction mattress. During follow up interview at 2:10 p.m. NA-D stated she had assisted R44 into his wheelchair at 6:45 a.m. that morning.<br><br>On 8/9/17, at 12:59 p.m. RN-A confirmed R44 had an current unstageable pressure ulcer on his left medial heel. She indicated R44 was to be repositioned every two hours.<br><br>On 8/10/17, at 1:49 p.m. CM-A stated on admission R44 was a medium risk for pressure ulcers, but now a high risk due to his nutrition. CM-A confirmed R44's current care plan and stated she would expect nursing staff to reposition R44 every two hours while seated.<br><br>On 8/10/17, at 2:06 p.m. DON stated R44 was totally dependent on staff for all cares and was at risk for development of pressure ulcers. DON stated R44 had developed the current unstageable pressure ulcer on his left medial heel on 7/2/17. She indicated R44's care plan included directions for repositioning R44 every two hours when seated and every four hours lying. DON stated if R44 was not repositioned every two hours while seated, R44 would be at risk for development of pressure ulcers. DON stated she expected staff to follow R44's care plan and indicated staff should have repositioned R44 within 10-15 minutes of the two hours of sitting in | 2 565 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 565 | Continued From page 8<br>wheelchair.<br><br>Review of facility policy titled, Care Plan, dated 11/16, indicated residents plan of care would reflect the care currently required/provided for the resident based on the comprehensive assessment. The policy also indicated resident care plans would be reviewed, updated with a change of condition for the resident.<br><br>SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop systems to ensure implementation of the individualized resident plans of care. The DON or designee could educate all appropriate staff. The DON or designee could develop an auditing system to ensure ongoing compliance and report the results to the quality assurance committee.<br><br>TIME PERIOD FOR CORRECTION: Twenty (21) days. | 2 565 | | |
| 2 900 | MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers<br><br>Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:<br><br>A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and<br><br>B. a resident who has pressure sores receives necessary treatment and services to | 2 900 | | 9/13/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 900 | Continued From page 9<br>promote healing, prevent infection, and prevent new sores from developing.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to implement repositioning schedule to prevent further development of pressure ulcers for 2 of 2 residents (R6, R44) with current unstageable pressure ulcers. In addition, the facility failed to implement the use of a pressure relieving boot to promote healing and prevent worsening for 1 of 2 residents (R6) with a current unstageable pressure ulcer.<br><br>Findings include:<br><br>R6's admission Minimum Data Set (MDS) dated 3/6/17, indicated R6 had diagnoses of Diabetes Mellitus, dementia, and Parkinson's disease. R6's MDS indicated he had severe cognitive impairment and was totally dependent on staff assistance for transfers. Further, the MDS indicated R6 required extensive assistance for bed mobility, toilet use, dressing and personal hygiene and did not ambulate. The MDS indicated R6 was at risk for the development of pressure ulcers and had no current pressure ulcers.<br><br>Review of R6's Care Area Assessment (CAA) dated 3/8/17, indicated R6's was dependent on staff for assistance with positioning, incontinent of bowel and bladder, had no known history of pressure ulcers, was at high risk of developing pressure ulcers and staff were to anticipate his needs. CAA listed various interventions put in place to prevent skin breakdown, which included | 2 900 | Corrected | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 900 | Continued From page 10<br>the use of a Roho cushion (pressure reduction cushion for sitting surfaces), alternating pro air mattress, scheduled repositioning, scheduled check and change for incontinence and nutritional supplement.<br><br>R6's quarterly MDS dated 6/5/17, indicated R6 had severe cognitive impairment and was totally dependent on staff for assistance with transfers. The MDS indicated R6 required extensive assistance for bed mobility, toilet use, dressing, personal hygiene and did not ambulate. R6's MDS indicated R6 had a current unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough (necrotic/avascular tissue in the process of separating from the viable portions of the body & is usually light colored, soft, moist, & stringy) and/or eschar (dead tissue) in the wound bed). R6's MDS indicated a risk for development of pressure ulcers and listed interventions in place to decrease this risk included: pressure reduction cushion in wheelchair, pressure reduction mattress, repositioning program, nutrition/hydration, and pressure ulcer treatment.<br><br>Review of R6's Wound Data Collection form dated 8/2/17, identified unstageable pressure ulcer to left heel. Length 0.6 cm, width 0.9 cm and unable to determine wound depth due to 50 percent of wound bed covered by slough. Wound bed percentages were 90% epithelialized, 5% granulation, 5% slough and no eschar. Wound Data Collection dated 8/9/17, identified pressure ulcer to left heel. Length 2 cm, width 1 cm and depth 0.2 cm. Wound bed percentages were 92% epithelialized, 4% granulation, no slough, and 4% eschar.<br><br>R6's care plan revised 8/3/17, identified R6 had a | 2 900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 900 | Continued From page 11<br>current unstageable pressure ulcer to the left heel, related to the need for mobility assistance and Parkinson's disease. R6's care plan directed staff to assist to turn/reposition at least every two hours when sitting, avoid positioning feet on bed at all times, float heels with pillow while in bed, provide Prevalon boot (pressure reduction boot) to left foot, and Roho cushion when in wheelchair.<br><br>On 8/8/17, at 2:48 p.m. R6 was observed in his room, lying on his back in his bed with his eyes closed. He had a plaid blanket pulled up to his chin which exposed his feet and legs to mid-shin. R6 wore a yellow and white non-skid sock on left foot and a black Prevalon boot on his right foot without a sock present. Both feet/heels rested directly on the bed.<br><br>At 3:24 p.m. R6 was seated in his wheelchair and trained medication aid (TMA)-A propelled R6 him from his room to the unit day room. The black Prevalon boot remained on R6's right foot and his left stocking covered foot rested directly on the pedal of the wheelchair. R6's legs were crossed and his right boot rested directly on top of left foot, pressing the left heel onto the pedal of the wheelchair.<br><br>At 3:30 p.m. nursing assistant (NA)-B approached R6 and knelt next to his wheelchair. NA-B removed the black Prevalon boot from R6's right foot and performed hamstring and heel cord stretches to his right leg, with R6's left heel resting directly on the wheelchair pedal. At 3:37 p.m. NA-B replaced the Prevalon boot to R6's right foot and exited the area.<br><br>At 3:38 p.m. R6 remained seated in his wheelchair with black Prevalon boot to right foot, with his left foot covered with a yellow and white | 2 900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 900 | Continued From page 12<br>sock resting directly on the wheelchair pedal. Director of nursing (DON) visualized R6's feet with surveyor and confirmed R6's Prevalon boot was on the right foot and his left heel rested directly on the pedal of the wheelchair. She confirmed R6 had a current unstageable pressure ulcer to his left heel and confirmed the Prevalon boot was to be applied to R6's left foot, not his right foot. DON then left the area.<br><br>At 3:46 p.m. R6 remained in the same position when TMA-A and NA-A approached R6 and propelled him to his room to transfer from wheelchair to his bed. DON and clinical manager (CM)-A entered the room and CM-A removed R6's yellow and white non-skid sock from his left foot. CM-A visualized R6's pressure ulcer and indicated it had hard edges with granular tissue (pink-red moist tissue that fills an open wound, when it starts to heal) in the base and eschar present. CM-A stated R6 had an unstageable pressure ulcer on the left heel.<br><br>At 3:51 p.m. during interview with CM-A and DON, CM-A confirmed R6's Prevalon boot was on the incorrect foot. She indicated R6 had a pressure reduction mattress, protein supplement (for wound healing), pressure reduction boot to left foot to keep his heel floated at all times. CM-A stated she would expect the interventions to be followed. DON stated she would expect staff to follow R6's care plan.<br><br>On 8/9/17, at 7:47 a.m. registered nurse (RN)-A completed wound care on R6's left heel unstageable pressure ulcer. RN-A stated R6's ulcer measurements were 1 centimeter (cm) x 2 cm x 0.2 cm and had a 0.4 x 0.7 cm open area with granulation, stiff edges, four percent eschar, no slough and 96 percent epithelium (the outside | 2 900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 900 | Continued From page 13<br>layer of cells that covers all the free, open surfaces of the body including the skin). She stated interventions in place for R6's left heel ulcer included to elevate left heel off bed, reposition every two hours while sitting, and a protein supplement. RN-A stated she had seen R6 the previous day with the Prevalon boot on his left foot and indicated she was unaware what time the boot had been placed on the wrong foot.<br><br>On 8/9/17, at 9:49 a.m. NA-C stated R6 was dependent on staff for all cares and required a mechanical lift for transfers. She indicated interventions to relieve pressure included pressure reduction boot to left foot, pressure reduction cushion in wheelchair and staff were to place a pillow under his legs while lying in bed.<br><br>On 8/9/17, at 12:49 p.m. during a follow up interview, RN-A indicated R6's pressure ulcer measurements on 8/9/17 were larger than measurements on 8/2/17. RN-A stated the area of new eschar was not present in 8/2/17 when she had completed dressing change. RN-A stated she would expect the boot to be on the left foot at all times and would expect the pillow under his legs floating heels when in bed.<br><br>On 8/10/17, at 10:50 a.m. nurse practitioner (NP)-A stated if a resident had a pressure ulcer on the heel she would expect that a pillow or boot would be used to relieve pressure from the area at all times.<br><br>On 8/9/17, at 6:48 a.m. R6 was observed seated in his wheelchair next to two recliner in the middle of the dayroom, facing the television. R6 wore street clothes with a white sock on his right foot and a black Prevalon boot on his left foot. | 2 900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 900 | Continued From page 14<br><br>Continuous observations were conducted from 7:03 a.m. to 9:18 a.m. At 7:03 a.m. R6 remained seated in his wheelchair in the middle of the main dayroom facing the television. At 7:41 a.m., R6 remained seated in his wheelchair in the dayroom. R6 reached down and moved the wheels of his wheelchair, propelling himself forward until he bumped his feet into a nearby armchair. At 7:45 am RN-A entered the dayroom, approached R6 and propelled his wheelchair to his room. RN-A completed wound care to his left foot while R6 remained seated in his wheelchair. At 7:53 a.m. RN-A assisted R6 to propel his wheelchair from his room to the dining room and positioned his wheelchair at a table. At 8:06 a.m. licensed practical nurse (LPN)-A approached R6 at the table and assisted R6 to take medications with a spoon and immediately walked away. At 8:22 a.m. NA-D brought R6's breakfast items and sat next to R6 and assisted him to eat breakfast. At 8:50 a.m. R6 remained seated in his wheelchair, independently drinking coffee. At 9:00 NA-D approached R6 and wheeled him out of dining room to the dayroom and walked out of the area. R6 remained seated in his wheelchair until 9:18 a.m. when NA-D entered the area and assisted R6 to propel his wheelchair from the dayroom to his room and assisted him from his wheelchair to bed. R6 had not been repositioned from 6:45 a.m. to 9:18 am, a total of 2 hours and 33 minutes.<br><br>On 8/9/17, at 9:53 a.m. NA-C stated R6 was totally dependent on staff for activities of daily living (ADL). She indicated R6 was supposed to wear his boot (pressure reduction) on his left foot, assisted to reposition every two hours when seated, and use a mechanical lift with two staff to transfer from wheelchair to bed. NA-C indicated R6 had been transferred from his bed to | 2 900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 900 | Continued From page 15<br>wheelchair "around 7:00 or so."<br><br>On 8/9/17 at 2:10 p.m. NA-D indicated she assisted R6 to transfer from bed to wheelchair in the early morning. She confirmed she had assisted R6 to transfer from his bed to his wheelchair at 6:45 a.m.<br><br>R44<br><br>R44's admission MDS dated 4/18/17, indicated R44 had diagnoses which included Alzheimer's disease, psychotic disorder, anxiety and depression. The MDS indicated R44 had both short and long term memory problems, and had severely impaired cognitive skills for daily decision making. The MDS indicated R44 was totally dependent on staff assistance for transfers, required extensive assistance with bed mobility, toileting, personal hygiene and did not ambulate. Further, the MDS identified R44 was at risk for pressure ulcer development and did not have current pressure ulcers.<br><br>R44's CAA dated 4/19/17, indicated R44 had rapidly progressing Alzheimer's disease, acute behavioral disturbance, required assistance with all ADLS, had declined in his abilities. The CAA indicated R44 required staff to assist with anticipation of needs due to trouble with communication, garbled speech and history of being hard of hearing. The CAA summary indicated pressure ulcers had triggered for R44 and would be addressed on R44's care plan.<br><br>R44's quarterly MDS dated 7/12/17, indicated R44 had both short and long term memory problems, and had severely impaired cognitive skills for daily decision making. The MDS indicated R44 was totally dependent on staff | 2 900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 900 | Continued From page 16 | 2 900 | | |

assistance for transfers, required extensive assistance with bed mobility, toileting, personal hygiene and did not ambulate. The MDS identified R44 was at risk for pressure ulcer development and did not have current pressure ulcers.

Review of R44's Positioning Assessment & Evaluation dated 7/12/17, indicated "Resident is at risk for skin breakdown and is on scheduled repositioning plan for this. Pressure reduction mattress in place and has Roho cushion in w/c [wheelchair] as well. No pressure related open areas with these measures in place.

Review of R44's Progress Notes from 7/20/17 to 8/9/17 revealed a note dated 7/26/17, which identified R44 had developed a new unstageable pressure ulcer to left medial heel, with stable eschar and no drainage.

R44's care plan revised 8/3/17, indicated R44 had a current unstageable pressure ulcer to left medial heel related to immobility, had advanced dementia, and required assistance with ADL's. R6's care plan listed various interventions which included reposition at least every two hours when sitting, Roho cushion in wheelchair and Prevalon boot on left foot at all times.

On 8/9/17, at 6:48 a.m. R44 was observed seated in a wheelchair with his eyes closed, facing the television in the large dayroom. R44 wore a long sleeve shirt and plaid pajama pants, and a blue boot on his left foot. Continuous observations were conducted from 7:03 a.m. to 9:25 a.m. At 7:03 a.m R44 remained seated in a wheelchair with his eyes closed in the dayroom. At 7:30 a.m. RN-A entered the dayroom, approached R44 and propelled R44 in his wheelchair to his room. At

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 900 | Continued From page 17<br><br>7:34 a.m. RN-A completed a pressure ulcer evaluation of R44's left heel pressure ulcer, while R44 sat in the wheelchair. At 7:40 a.m. RN-A propelled R44 in his wheelchair from his room, back to the dayroom. At 8:01 a.m. R44 remained seated in his wheelchair in the dayroom, NA-D entered the dayroom and propelled R44's wheelchair from dayroom to a table in the dining room. At 8:22 a.m. licensed practical nurse(LPN)-A briefly approached R44, applied a clothing protector and immediately walked away. At 8:28 a.m. LPN-A sat down next to R44 and assisted R44 to eat breakfast. At 8:34 a.m. LPN-A left the table and NA-D sat down and continued to assist R44 to eat his meal. At 8:59 a.m. R44 remained seated in his wheelchair at the table with eyes closed and head against the headrest. At 9:02 a.m. NA-D propelled R44 out of dining room and back into the dayroom. R44 remained seated in his wheelchair until 9:22 a.m., when NA-D approached him and propelled him to his room. At 9:25 a.m NA-C and NA-D utilized a mechanical lift to transfer R44 from his wheelchair to bed. NA-C loosened R44's incontinent brief and R44's skin over his coccyx area was noted to be bright red. R44 had not been repositioned from 6:45 a.m. to 9:25 a.m., a total of 2 hours and 40 minutes.<br><br>On 8/9/17, at 9:30 a.m. NA-C indicated the red area on R44's coccyx area was new and stated she would notify LPN-A of this change for R44. NA-C indicated R44 had a current pressure ulcer on his left heel and required repositioning every two hours when seated, pressure reduction cushion in wheelchair and pressure reduction mattress. During follow up interview at 2:10 p.m. NA-D stated she had assisted R44 into his wheelchair at 6:45 a.m. that morning. | 2 900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 900 | Continued From page 18<br><br>On 8/9/17, at 12:59 p.m. RN-A confirmed R44 had an current unstageable pressure ulcer on his left medial heel. She indicated R44 was to be repositioned every two hours.<br><br>On 8/10/17, at 1:49 p.m. CM-A stated on admission R44 was a medium risk for pressure ulcers, but now a high risk due to his nutrition. CM-A confirmed R44's current care plan and stated she would expect nursing staff to reposition R44 every two hours while seated.<br><br>On 8/10/17, at 2:06 p.m. DON stated R44 was totally dependent on staff for all cares and was at risk for development of pressure ulcers. DON stated R44 had developed the current unstageable pressure ulcer on his left medial heel on 7/2/17. She indicated R44's care plan included directions for repositioning R44 every two hours when seated and every four hours lying. DON stated if R44 was not repositioned every two hours while seated, R44 would be at risk for development of pressure ulcers. DON stated she expected staff to follow R44's care plan and indicated staff should have repositioned R44 within 10-15 minutes of the two hours of sitting in wheelchair.<br><br>Review of the facility policy titled, Pressure Ulcer Practice Guidelines, revised 9/16, indicated a resident will be assessed and interventions implemented to address causative factors that contribute to the the resident's risk for skin breakdown. The policy indicated resident specific turning and positioning programs would be developed based on the individualized assessments.<br><br>Review of facility policy titled, Care Plan, dated 11/16, indicated residents plan of care would | 2 900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 900 | Continued From page 19<br>reflect the care currently required/provided for the resident based on the comprehensive assessment. The policy also indicated resident care plans would be reviewed, updated with a change of condition for the resident.<br><br>SUGGESTED METHOD FOR CORRECTION:<br>The director of nursing (DON) or designee could implement policies and procedures related to ensuring staff complete appropriate interventions, routinely monitor all pressure ulcers for healing until resolved and prevention of new pressure ulcers.<br>The quality assessment and assurance committee could perform random audits to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty (21) days. | 2 900 | | |
| 21375 | MN Rule 4658.0800 Subp. 1 Infection Control; Program<br><br>Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to implement their infection control program policies to report a facility outbreak of influenza to the State agency (SA). This deficient practice had the potential to affect all 50 residents who resided in the facility. | 21375 | Corrected | 9/13/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 21375 | Continued From page 20<br>Findings include:<br><br>Review of the facility form titled Monthly Report of Resident Infections in Center dated 2/17, indicated one positive influenza A culture on each of its three identified units (Heritage Lane, Fisherman's Cove and Cottonwood Grove). Fisherman's Cove also had three other residents with identified lower respiratory infections. Heritage Lane had three additional residents cultured for influenza. Cottonwood Grove had two additional residents with lower respiratory infections. Twelve residents were cultured for influenza.<br><br>During an interview on 8/10/17, at 3:09 p.m. the assistant director of nursing (ADON), who was the facility's infection control nurse, confirmed the above findings. ADON stated she was unsure if she had completed a influenza report form and indicated she would call SA to verify the report had been submitted. At 4:10 p.m. ADON confirmed the facility influenza outbreak had not been reported to the SA.<br><br>Review of facility procedure titled Infection Monitoring and Exposure Control Outbreaks/Epidemics/Seasonal Infectious Disease dated 3/16, indicated, "The local health department will be notified regarding the epidemic/outbreak if it is a reportable disease."<br><br>The Minnesota Department of Health form titled Long-Term Care Facility Influenza Report Form, 2016-2017 dated 9/2016, specified, "The definition of an outbreak is: Two residents with influenza-like illness (ILI) or one laboratory-confirmed influenza positive case along with other cases of respiratory infection in a unit." The form indicated submitting the report | 21375 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 21375 | Continued From page 21<br>was sufficient for reporting an outbreak.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of nursing (DON) or designee, could develop and implement policies and procedures related to reporting to the state agency incidences reportable infections in the facility to minimize the spread of illness. In addition, the DON or designee, could develop and implement policies and procedures related to Legionnaires' disease and ensure the facility risk assessment is completed and reviewed periodically. The DON or designee could educate staff on the policies and the quality assessment and assurance committee could perform random audits to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21375 | | |
| 21620 | MN Rule 4658.1345 Labeling of Drugs<br><br>Drugs used in the nursing home must be labeled in accordance with part 6800.6300.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure the accurate labels with directions for use were on medications for 1 of 1 resident (R37) insulin pen observed during medication administration.<br><br>Findings include:<br><br>R37's Order Summary Report dated 8/8/17, indicated R37 had diagnoses which included Diabetes Mellitus, Alzheimer's disease and | 21620 | Corrected | 9/13/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 21620 | Continued From page 22<br>kidney failure. The report included an order for Novolog Solution 100 unit/ml (Insulin) 8 units injected subcutaneously once a day and 4 units once a day, ordered on 11/22/16.<br><br>On 8/7/17, at 6:45 p.m. registered nurse (RN)-B was observed standing next to the medication cart outside of R37's room. She opened the first drawer of the medication cart and removed a blue Insulin pen from the drawer, labeled with R37's name on the pen. RN-B primed the Insulin pen and set the dial of the pen for delivery of four units of insulin. The medication label on the insulin pen dated 8/4/17, directed staff to inject 8 units of Insulin at lunch and supper.<br><br>When interviewed at that time, RN-B confirmed R37's Insulin pen label was incorrectly labeled, and stated R37's current order was to administer 8 units at noon and 4 units in the evening. She stated R37's dose of Insulin had changed in the past, from 8 units each lunch and supper, to currently 8 units at noon and 4 units in the evening. RN-B indicated the Insulin pen should have had a sticker placed on it to reflect the current order, which had been ordered on 11/22/16.<br><br>On 8/8/17, at 3:06 p.m. the pharmacy consultant (PC) confirmed the usual facility practice, for when an order was changed, was to apply a label noting dose change or directing staff to electronic medical record for new dosage instructions to R37's insulin pen.<br><br>On 8/8/17, at 3:22 p.m. the director of nursing (DON) confirmed the current facility policy and stated a sticker should have been placed in the interim on R37's insulin pen when the order was changed and the pharmacy notified of that order | 21620 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00146 | A. BUILDING: _____ B. WING _____ | 08/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - BATTLE LAKE | 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 21620 | Continued From page 23<br>change.<br><br>Review of the facility's policy titled Medication-Change of Direction Stickers dated 12/2015, directed staff to refuse or return inaccurately or improperly labeled medications to the dispensing pharmacy. In cases where prescriber's directions for use change, the policy allowed the nurse to place a change of order, check chart or similar sticker on the container to indicate changes in direction for use or dosages.<br><br>SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could develop and implement policies and procedures related to labeling medications when opened when necessary such as insulin. The quality assessment and assurance committee could perform random audits to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty (21) days. | 21620 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/09/2017** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOOD SAMARITAN SOCIETY - BATTLE LAKE** | **105 GLENHAVEN DRIVE**<br>**BATTLE LAKE, MN 56515** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>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.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety State Fire Marshal Division. At the time of this survey Good Samaritan Society Battle Lake, 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota Street, Suite 145 | K 000 | EPOC | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 08/31/2017 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/09/2017** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOOD SAMARITAN SOCIETY - BATTLE LAKE** | **105 GLENHAVEN DRIVE**<br>**BATTLE LAKE, MN 56515** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | Continued From page 1<br>St. Paul, MN 55101<br><br>Or by e-mail to:<br>Marian.Whitney@state.mn.us<br>and<br>Angela.Kappenman@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency<br><br>The Good Samaritan Society Battle Lake is a 1-story building, without a basement. The original building was built in 1973 and was determined to be Type II(000) construction. In 1994 additions to the south of the west wing and to the north of the north wing (Occupational and Physical Therapy - OT/PT) were constructed. The 1994 additions were determined to be Type V(111) construction. In 2004 a small vestibule was added to the west wing which included a walk in freezer, which is Type II (000) construction. In 2007 a connecting link, to the new assisted living apartments, was added to the south wing and was determined to be Type V (111). In 2010 an entrance addition was constructed to the north of the dining room which is 1-story, no basement and Type II (000) construction. In 2011 a 16 bed addition was added to the east of the north wing and was | K 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/09/2017** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOOD SAMARITAN SOCIETY - BATTLE LAKE** | **105 GLENHAVEN DRIVE**<br>**BATTLE LAKE, MN 56515** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | Continued From page 2<br>determined to be Type II (111) and a 8 bed addition was added to the east of the south east wing and was determined to be Type II (111) construction. The building is divided into 3 smoke compartments by 30 minute rated fire barriers.<br>Since all the different construction types were not separated by a 2 hour fire barrier, the building is considerd V(111) as per 8.2.1.3 of NFPA 101.<br><br>The entire building is sprinkler protected with a system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems . A fire alarm system with corridor smoke detection and smoke detection in common areas which was updated in 2010 in accordance with NFPA 72 "The National Fire Alarm Code" that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 55 beds with a census of 46 residents at the time of the inspection.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 131 SS=E | NFPA 101 Multiple Occupancies<br><br>Multiple Occupancies - Sections of Health Care Facilities<br>Sections of health care facilities classified as other occupancies meet all of the following:<br>* They are not intended to serve four or more inpatients.<br>* They are separated from areas of health care occupancies by construction having a minimum 2-hour fire resistance rating in accordance with | K 131 | | 8/31/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING **01 - MAIN BUILDING 01** B. WING _____ | **08/09/2017** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOOD SAMARITAN SOCIETY - BATTLE LAKE** | **105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 131 | Continued From page 3<br>Chapter 8.<br>* The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.<br>Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served.<br>18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623<br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to maintain the proper 2 hour fire resistive ratings for occupancies as described in the Life Safety Code (NFPA 101) 2012 edition section 19.1.3.3. This deficient practice could allow for the transfer of smoke or fire from another occupancy and affect 10 of the 46 residents and an undetermined amount of staff and visitors.<br><br>Findings include:<br><br>At 10:50 am on 08/09/2017 observations revealed a 1 1/2 inch penetration in the 2 hour fire barrier above the ceiling at the entrance door to the physical therapy room and there was unapproved fire stopping in a penetration of the 2 hour fire barrier above the ceiling at the entrance to the apartment link.<br><br>This deficient condition was confirmed by the Maintenance Engineer. | K 131 | The penetration in the 2 hour fire barrier has been sealed effective 8/31/17. Maintenance staff will make routine inspections following any service technicians providing services that may involve penetrations through fire barriers. | |
| K 324 SS=D | NFPA 101 Cooking Facilities<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control | K 324 | | 9/29/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/09/2017** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOOD SAMARITAN SOCIETY - BATTLE LAKE** | **105 GLENHAVEN DRIVE**<br>**BATTLE LAKE, MN 56515** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 324 | Continued From page 4<br>and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to provide supervision of the cooking equipment as stated in the Life Safety Code (NFPA 101) 2012 edition section 9.2.3 & NFPA 96 section 10.5.1.1 This deficient practice could prevent staff from extinguishing the fire causing evacuation affecting all residents, staff and visitors in the kitchen area.<br><br>Findings include:<br><br>At 11:20 am on 08/09/2017 observations revealed the ANSUL pull station was located approximately 2 feet from the stove, requirement is 10 feet minimum. | K 324 | The pull station will be relocated to meet applicable standards effective 9/29/17. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/09/2017** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOOD SAMARITAN SOCIETY - BATTLE LAKE** | **105 GLENHAVEN DRIVE**<br>**BATTLE LAKE, MN 56515** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 324 | Continued From page 5<br><br>This deficient condition was confirmed by the Maintenance Director. | K 324 | | |
| K 341 SS=F | NFPA 101 Fire Alarm System - Installation<br><br>Fire Alarm System - Installation<br>A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.<br>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect all of the 46 residents and an undetermined amount of staff and visitors.<br><br>Findings include:<br><br>During the facility tour on 08/09/2017 | K 341 | The smoke detectors identified in numbers 1 & 2 will be relocated to comply with applicable standards effective 9/29/17. | 9/29/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/09/2017** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOOD SAMARITAN SOCIETY - BATTLE LAKE** | **105 GLENHAVEN DRIVE**<br>**BATTLE LAKE, MN 56515** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 341 | Continued From page 6<br>observations revealed several locations had a smoke detector located within 3 feet of an HVAC diffuser.<br>1. At 11:35 am a storage room in the cottonwood wing.<br>2. At 11:36 am a soiled utility room in the cottonwood wing<br>3. At 11:56 am a storage room in the Fisherman's Cove wing.<br>4. At 12:07 pm in the laundry room in the Fisherman's Cove wing<br><br>This deficient conditions was confirmed by the Maintenance Director. | K 341 | | |
| K 372 SS=E | NFPA 101 Subdivision of Building Spaces - Smoke Barrie<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to maintain one of four smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another | K 372 | The penetration identified in this tag has been sealed effective 8/31/17.<br>Maintenance personnel will make routine inspections following any service technicians providing services that may involve penetrations through fire barriers. | 8/31/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245403 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/09/2017** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOOD SAMARITAN SOCIETY - BATTLE LAKE** | **105 GLENHAVEN DRIVE**<br>**BATTLE LAKE, MN 56515** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 372 | Continued From page 7<br>affecting the exiting of 10 of the 46 residents and an undetermined amount of staff and visitors.<br><br>Findings include:<br><br>At 10:45 am on 08/09/2017 observations revealed a penetration around a conduit and a cable bundle above the ceiling at the cross corridor doors of the Heritage Wing.<br><br>This deficient condition was confirmed by the Maintenance Engineer. | K 372 | | |