DEPARTMENT OF HEAL			D CERTIFIC	ATION	CENTERS FOR MI AND TRANSMITTAL	EDICARE & MEDICAID SERVICES		
					TE SURVEY AGENCY	Facility ID: 00146		
MEDICARE/MEDICAID PROVI (L1) 245403 2.STATE VENDOR OR MEDICAID (L2) 150518100		 NAME AND AD (L3) GOOD SAM (L4) 105 GLENHA (L5) BATTLE LA 	ARITAN SOCI AVEN DRIVE		TTLE LAKE (L6) 56515	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE O	OWNEDSHID			DV	<u>02</u> (L7)	7. On-Site Visit 9. Other		
(L9)	OWNERSHIP	7. PROVIDER/SUI 01 Hospital	05 HHA	69 ESRD	<u>13 PTIP</u> 22 CLIA	8. Full Survey After Complaint		
	9/25/2017 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Oth		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICATI	ON	10.THE FACILITY	IS CERTIFIED AS	:				
From (a):		X A. In Complian			And/Or Approved Waivers Of Th			
To (b) :			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit		
		1 4	Acceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SNF	 7. Medical Director 8. Patient Room Size 		
12.Total Facility Beds	55 ^(L18)		leceptuble 1 OC		5. Life Safety Code	9. Beds/Room		
13.Total Certified Beds	55 (L17)		npliance with Prog and/or Applied Wa		* Code: A *	(L12)		
14. LTC CERTIFIED BED BREAK	DOWN	·			15. FACILITY MEETS			
18 SNF 18/19 SI	NF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
55								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICABL	E SHOW LTC CANCE	ELLATION DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:		
Gail Anderson, Unit Su	Ipervisor	1	0/12/2017	(L19)	Anne Peterson, Enforcement Specialist 10/16/2017			
	PART II - TO BI	E COMPLETED	BY HCFA RI	EGIONA	L OFFICE OR SINGLE ST.	ATE AGENCY		
19. DETERMINATION OF ELIGIB _X_ 1. Facility is Eligible	to Participate		IPLIANCE WITH GHTS ACT:	CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Elig	gible (L21)							
22. ORIGINAL DATE	23. LTC AGREEM		4. LTC AGREEM		26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	E	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure			
12/01/1986	7 .40				02-Dissatisfaction W/ Reimburseme	05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement		
(L24)	(L41) 27. ALTERNATI		(L25)		03-Risk of Involuntary Termination			
25. LTC EXTENSION DATE:		n of Admissions:			04-Other Reason for Withdrawal	OTHER 07-Provider Status Change		
	F		(L44)			00-Active		
(L27)	B. Rescind Sus	spension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARKS			
		00140						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL D	ATE				
		10/05/2017						

(L33)

DETERMINATION APPROVAL

(L32)



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 Retension -

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



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 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 Retension -

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



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 Retenson_

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

DEPARTMENT OF HEALTH			D CERTIFIC	CATION A	CENTERS FOR MEI AND TRANSMITTAL	DICARE & MEDICAID SERVICES ID: C912
					TE SURVEY AGENCY	Facility ID: 00146
1. MEDICARE/MEDICAID PROVIDE (L1) 245403 2.STATE VENDOR OR MEDICAID N (L2) 150518100		3. NAME AND AI (L3) GOOD SAM (L4) 105 GLENH (L5) BATTLE L 4	IARITAN SOC IAVEN DRIVE	CIETY - BA	ATTLE LAKE (L6) 56515	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
 EFFECTIVE DATE CHANGE OF C (L9) DATE OF SURVEY 08/10/ ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 1 Other 		7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	<u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds	55 (L18)	Compliance		AS:	2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN	 7. Medical Director VF) 8. Patient Room Size
13.Total Certified Beds	55 (L17)	X B. Not in Con	· ·	·	5. Life Safety Code	9. Beds/Room
14. LTC CERTIFIED BED BREAKDOV	ŴŇ	Requirements	and/or Applied V	valvers:	* Code: B * 15. FACILITY MEETS	(L12)
18 SNF 18/19 SNF 55	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
 STATE SURVEY AGENCY REMA SURVEYOR SIGNATURE 	ARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):	18. STATE SURVEY AGENCY	APPROVAL Date:
Christina Martinson, HF	E NEII	0	09/12/2017	(L19)	Mark Meath, 1	Enforcement Specialist _ 10/04/2017 (L20)
PAR	AT II - TO BE (COMPLETED I	BY HCFA RE	GIONAL	OFFICE OR SINGLE S	TATE AGENCY
 DETERMINATION OF ELIGIBILI <u>X</u> 1. Facility is Eligible to Pa <u>2</u>. Facility is not Eligible 			IPLIANCE WITH HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	IENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION 12/01/1986	BEGINNING	DATE	ENDING DAT	ГЕ	VOLUNTARY 00 01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involuntary Terminatie 04-Other Reason for Withdrawal	on <u>OTHER</u> 07-Provider Status Change 00-Active
(L27)	B. Rescind Su	spension Date:	(L11)			
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS	
		00140				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APP	ROVAL



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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.

Good Samaritan Society - Battle Lake August 25, 2017 Page 4

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

Good Samaritan Society - Battle Lake August 25, 2017 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Good Samaritan Society - Battle Lake August 25, 2017 Page 6

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

Feel free to contact me if you have questions.

Sincerely,

Kumala 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED							
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			B NO. 093	-	
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X	(3) DATE SU COMPLET		
		245403	B. WING		08/10/2	2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- BATTI F I AKF		105 GLENHAVEN DRIVE			
0.002.01				BATTLE LAKE, MN 56515			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) MPLETION DATE	
F 000	INITIAL COMMENT	S	F 000	ט			
	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve f compliance upon the otance. Because you are your signature is not required first page of the CMS-2567 nic submission of the POC will ion of compliance.					
F 282 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with RVICES BY QUALIFIED ARE PLAN	F 28	2	9/1	3/17	
		ive Care Plans led or arranged by the facility, omprehensive care plan,					
	care.	qualified persons in ch resident's written plan of NT is not met as evidenced					
	Based on observat review the facility fa intervention for repor- residents (R6, R44) pressure ulcer. In a implement care pla pressure relieving b	ion, interview and record iled to implement care plan ositioning schedule for 2 of 2 with a current unstageable ddition, the facility failed to n intervention for use of a boot for 1 of 2 residents (R6) igeable pressure ulcer.		 R6 and R44 are being repositione care planned intervention. Heel boot being placed on R6 left foot as directed care plan. All residents requiring assistance w repositioning or pressure relieving de will be reviewed by DNS or designee ensure the plan of care is being follow The DON or designee will provide re-education for CNA's and nurses or 9/12/17 and 9/13/17 regarding facility 	t is ed by with evices to wed. n		
LABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6)	DATE	

Electronically Signed

08/31/2017

PRINTED: 09/01/2017

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.

UD PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245403 B. WING 06/10/2017. WARE OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, 2P CODE 06/10/2017. GOOD SAMARTAN SOCIETY - BATTLE LAKE ITSREET ADDRESS, CITY, STATE, 2P CODE 06/10/2017. PREX INCOMPLETED INFUNDING INFORMATION, ID PREVIDER OR SUPPLAN OF CORRECTION INFORMATION, ID PREX INCOMPLETE INFORMATION, INFORMATION, ID PREVIDENCE TO THE APPROPRIATE OPELENCY, F 282 Continued From page 1 F F F F F F F Continued From page 1 F F F F F F Continued From page 1 F	STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION	(X3) DATE	0938-039 SURVEY
WAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - BATTLE LAKE ISTREET ADDRESS, CITY, STATE, ZIP CODE CH, ID, RAMARY STATEMENT OF DEPICENCIES IDE THE LLAKE, MN 56515 CH, ID, RAMDERY, STATEMENT OF DEPICENCIES PROVIDERS PLAN OF CORRECTIVE ACTION SHOLD BE Refer X, TAG Refer X, MS 5615 F 282 Continued From page 1 Pressure alcore to the left Refer X, Carlot C, Continued From page 1 F 282 F 685 care plan revised 8/3/17, identified R6 had a current unstageable pressure alcore to the left pressure releaving devices with review of assesses ing the resident is cardox and using facility processes for documenting on CNA Tig City and Parkinson's disease. R6's care plan directed staff to assist to turin/reposition at least every two hours when sitting, avoid positioning feet on bed, at all times, float heles with his bed, provide Prevalon boot on his right toot and black Prevalan boot (pressure releaved to back) F 282 On 8/8/17, at 2/48 p.m. R6 was seated in his wheelchair. F 332 p.m. nursing assistant (NA)-A propelled R6 him from his rom too the unit day room. The black Prevalan boot on his right foot and his left stocking covered foor tested directly on the bed. At 3:32 p.m. nursing assistant (NA)-B approached R6 and knet mest to his wheelchair. At 3:30 p.m. nursing assistant (NA)-B approached R6 and knet mest to his wheelchair. R6's represond the black Prevalan boot on the bedial of the wheelchair.	ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COM	PLETED
105 GLEHAVEN DRIVE BATLE LAKE, MN 56515 Continued From page 1 Resultation of the pressure ulcer to the left active parkinsors' disease. RFS 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 or pressure reduction boot to left foot, and Photo cushion when in wheelchair. RF wheel, Head a black Prevalon boot on his right foot without a sock present. Both feet/heels rested direction the unit and ablack Prevalon boot or nested directly on the pedal of the wheelchair. RF wheelchair. At 3:30 p.m. nursing assistant (NA)-B approached RF approximation and the left coord stretches to his right log, with RFS left theel resting directly on the black Prevalon boot form RFS right foot and exited the area. 106 actemption the section is concerned by the performed the pedal of the wheelchair. RF wore a vellow and white non-skid sock on the six right foot and his left socking the left heel or to the pedal of the wheelchair. RF wore a vellow and white non-skid sock on the six right foot and his left socking the left heel or the pedal of the wheelchair. NA-B removed the black Prevalon boot on the six right foot and his left socking the left heel or the black and result on the heelchair. NA-B removed the black Prevalon boot rested directly on the pedal of the wheelchair. NA-B removed the black Prevalon boot rested directly on the pedal of the wheelchair. NA-B removed the black Prevalon boot to RFS right foot and his left socking the left heel or to be wheelchair. NA-B removed the black Prevalon boot to RFS right foot and his left socking the left heel and bas the result on the wheelchair. NA-B removed the black Prevalon boot to RFS right foot an derived the area. Section S			245403	B. WING			08/1	0/2017
GOOD SAMARTIAN SOCIETY - BATTLE LAKE BATTLE LAKE, MN 56515 (X4) ID PREEX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE REFECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) 000 (EACH CORRECTVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) 000 (EACH CORRECTVE ACTION SHOULD BE CROSS REFERENCED TAG F 282 Continued From page 1 Refs care plan revised 8/3/17, identified R6 had a current unstageable pressure licer to the left heel, related to the need for mobility assistance and Parkinson's disease. R6's care plan directed staff to assist to turrivreposition 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 Rohc usbin when in wheelchair. R6 wore a yellow and white non-skid sock 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 his best to ching covered foor R6 and R44 and random other residents by the DON/designee weekly times 3. Audit results will be reported to the monthy QA meeting for further recommendation. 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 rested directly on the pedal of the wheelchair. NA-B removed the black Prevalon boot to rested directly on the pedal of the wheelchair. NA-B removed the black Prevalon boot to rested directly of left toot, pressing the left heel resting directly on the wheelchair. NA-B removed the black Prevalon boot Torm R6's rig	NAME OF F	PROVIDER OR SUPPLIER						
PHEERX TAG IEACH DEPICENCY MUST BE PRECEDED BY FULL PERCENCE TO TAG PHEERX TAG IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO TAIL SATURDARY OR LSC IDENTIFYING INFORMATION) Construction	GOOD S	AMARITAN SOCIETY	- BATTLE LAKE					
 R6's care plan revised 8/3/17, identified R6 had a current unstageable pressure uicer 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 B/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 and white go to 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 rested directly on top pol left foot, pressing the left heel onto the pedal of the wheelchair. At 3:30 p.m. nursing assistant (NA)-B approached R6 and knett next to his wheelchair. At 3:30 p.m. nursing assistant (NA)-B approached R6 and knett next to his wheelchair. At 3:30 p.m. nursing assistant (NA)-B approached R6 and knett next to his wheelchair. At 3:30 p.m. nursing assistant (NA)-B approached R6 and knett next to his wheelchair. At 3:30 p.m. nursing assistant (NA)-B approached R6 and knett next to his wheelchair. At 3:30 p.m. nursing assistant (NA)-B approached R6 and knett next to his wheelchair. At 3:30 p.m. nursing assistant (NA)-B approached R6 and knett next to his wheelchair. At 3:30 p.m. nursing assistant (NA)-B approached R6 and knett next to his wheelchair. At 3:30 p.m. nursing assistant (NA)-B approached R6 and knett next to his wheelchair. At 3:30 p.m. nursing assistant (NA)-B approached R6 and knett next to his wheelchair. At 3:30 p.m. nursing assistant (NA)-B approached R6 and knett next to h	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETIC
At 3:38 p.m. R6 remained seated in his	F 282	R6's care plan revis current unstageable heel, related to the and Parkinson's dis staff to assist to tur hours when sitting, at all times, float he provide Prevalon be to left foot, and Rof On 8/8/17, at 2:48 p room, lying on his be closed. He had a p chin which exposed R6 wore a yellow a foot and a black Pr without a sock press directly on the bed. At 3:24 p.m. R6 wa and trained medicat him from his room black Prevalon boo and his left stocking on the pedal of the crossed and his rig of left foot, pressing the wheelchair. At 3:30 p.m. nursin approached R6 and NA-B removed the right foot and perfo stretches to his rig resting directly on t p.m. NA-B replaced right foot and exited	sed 8/3/17, identified R6 had a e pressure ulcer to the left need for mobility assistance sease. R6's care plan directed n/reposition at least every two avoid positioning feet on bed eels with pillow while in bed, oot (pressure reduction boot) no cushion when in wheelchair. p.m. R6 was observed in his back in his bed with his eyes laid blanket pulled up to his d his feet and legs to mid-shin. and white non-skid sock on left evalon boot on his right foot sent. Both feet/heels rested as seated in his wheelchair tion aid (TMA)-A propelled R6 to the unit day room. The tremained on R6's right foot g covered foot rested directly wheelchair. R6's legs were ht boot rested directly on top g the left heel onto the pedal of g assistant (NA)-B d knelt next to his wheelchair. black Prevalon boot from R6's rmed hamstring and heel cord at leg, with R6's left heel he wheelchair pedal. At 3:37 d the Prevalon boot to R6's d the area.	F 2	82	 plan repositioning times and applying pressure releiving devices with reversion assessing the resident's Kardex are facility process for documenting or "list" when resident is positioned to they know when next repositioning due. 4. To monitor compliance of reposition and correct application of pressure relieving devices, random observation audits will be performed R6 and R44 and random other results by the DON/designee weekly times then monthly times 3. Audit results reported to the monthly QA meeting 	ng iew of nd using n CNA ensure time is tioning of n ed for idents s 4, and s will be	
		At 3:38 p.m. R6 rer	nained seated in his					

If continuation sheet Page 2 of 25

TATEMEN	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
				JG		
		245403	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	08/	10/2017
	PROVIDER OR SUPPLIER	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 282	wheelchair with bla with his left foot cov sock resting directl Director of nursing with surveyor and cov was on the right food directly on the peda confirmed R6 had a ulcer to his left hee boot was to be app right foot. DON the At 3:46 p.m. R6 re when TMA-A and N propelled him to his wheelchair to his bo (CM)-A entered the R6's yellow and wh foot. CM-A visualize indicated it had har (pink-red moist tiss when it starts to he present. CM-A state pressure ulcer on to On 8/8/17 at 3:51 p and DON, CM-A cov was on the incorrect pressure reduction (for wound healing) left foot to keep his stated she would e followed. DON stat follow R6's care pla On 8/9/17, at 7:47 a completed wound ou	ck Prevalon boot to right foot, vered with a yellow and white y on the wheelchair pedal. (DON) visualized R6's feet confirmed R6's Prevalon boot of and his left heel rested al of the wheelchair. She a current unstageable pressure I and confirmed the Prevalon lied to R6's left foot, not his n left the area. mained in the same position IA-A approached R6 and s room to transfer from ed. DON and clinical manager e room and CM-A removed ite non-skid sock from his left ed R6's pressure ulcer and d edges with granular tissue ue that fills an open wound, al) in the base and eschar ed R6 had an unstageable he left heel. o.m. during interview with CM-A onfirmed R6's Prevalon boot ct foot. She indicated R6 had a mattress, protein supplement of heel floated at all times. CM-A xpect the interventions to be ed she would expect staff to	F 28	32		

Facility ID: 00146

If continuation sheet Page 3 of 25

STATEMEN	FOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION		E SURVEY
		IDENTIFICATION NUMBER.	A. BUILDI	NG	CON	nr le i ev
		245403	B. WING _		08/	/10/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIO(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		D BE	(X5) COMPLETIO DATE	
F 282	cm x 0.2 cm and ha with granulation, st no slough and 96 p layer of cells that co surfaces of the boo stated interventions ulcer included to el reposition every two protein supplement R6 the previous da left foot and indicat time the boot had b On 8/9/17, at 9:49 a dependent on staff mechanical lift for t interventions to reli pressure reduction reduction cushion i place a pillow unde On 8/10/17, at 10:5 (NP)-A stated if a re on the heel she wo would be used to re at all times. On 8/9/17, at 6:48 a in his wheelchair ne of the dayroom, fac street clothes with a and a black Prevale Continuous observ 7:03 a.m. to 9:18 a seated in his wheel dayroom facing the remained seated in	age 3 ad a 0.4 x 0.7 cm open area iff edges, four percent eschar, bercent epithelium (the outside overs all the free, open dy including the skin). She is in place for R6's left heel evate left heel off bed, o hours while sitting, and a t. RN-A stated she had seen y with the Prevalon boot on his ed she was unaware what been placed on the wrong foot. a.m. NA-C stated R6 was for all cares and required a ransfers. She indicated eve pressure included boot to left foot, pressure n wheelchair and staff were to er his legs while lying in bed. 50 a.m. nurse practitioner esident had a pressure ulcer uld expect that a pillow or boot elieve pressure from the area a.m. R6 was observed seated ext to two recliner in the middle cing the television. R6 wore a white sock on his right foot on boot on his left foot. ations were conducted from .m. At 7:03 a.m. R6 remained lchair in the middle of the main e television. At 7:41 a.m., R6 his wheelchair in the ned down and moved the	F 28			

If continuation sheet Page 4 of 25

	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	· · ·	E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B	COM	PLETED
		245403	B. WING		08/	10/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE		
GOOD S	AMARITAN SOCIETY	(- BATTLE LAKE		BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTION(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULDREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROF DEFICIENCY)		LD BE	(X5) COMPLETIOI DATE	
F 282	wheels of his wheel forward until he bu armchair. At 7:45 a approached R6 an his room. RN-A co foot while R6 rema At 7:53 a.m. RN-A wheelchair from his positioned his whe licensed practical r at the table and as with a spoon and in 8:22 a.m. NA-D bro sat next to R6 and At 8:50 a.m. R6 rem wheelchair, independent NA-D approached dining room to the area. R6 remained 9:18 a.m. when NA assisted R6 to proj dayroom to his roo wheelchair to bed. from 6:45 a.m. to 9 33 minutes. On 8/9/17, at 9:53 totally dependent of living (ADL). She in wear his boot (pres assisted to repositi	elchair, propelling himself imped his feet into a nearby am RN-A entered the dayroom, id propelled his wheelchair to mpleted wound care to his left ained seated in his wheelchair. assisted R6 to propel his s room to the dining room and elchair at a table. At 8:06 a.m. nurse (LPN)-A approached R6 isisted R6 to take medications mmediately walked away. At ought R6's breakfast items and assisted him to eat breakfast. mained seated in his endently drinking coffee. At 9:00 R6 and wheeled him out of dayroom and walked out of the d seated in his wheelchair until A-D entered the area and pel his wheelchair from the om and assisted him from his R6 had not been repositioned 0:18 am, a total of 2 hours and assure reduction) on his left foot, ion every two hours when mechanical lift with two staff to	F 282	2		

Facility ID: 00146

If continuation sheet Page 5 of 25

		AND HUMAN SERVICES				FORM	: 09/01/2017 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245403	B. WING			08/	10/2017
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE			105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	wheelchair at 6:45 R44 R44's care plan rev a current unstagea medial heel related dementia, and requ R6's care plan liste included reposition sitting, Roho cushic boot on left foot at a On 8/9/17, at 6:48 a in a wheelchair with television in the larg sleeve shirt and pla boot on his left foot were conducted fro 7:03 a.m R44 rema with his eyes closed RN-A entered the op propelled R44 in his 7:34 a.m. RN-A con evaluation of R44's R44 sat in the wheel propelled R44 in his back to the dayroot seated in his wheel entered the dayroot wheelchair from da room. At 8:22 a.m. nurse(LPN)-A brieft clothing protector a At 8:28 a.m. LPN-A assisted R44 to eat LPN-A left the table	A synchronia signal and a synchronia a synchr		282			

Facility ID: 00146

If continuation sheet Page 6 of 25

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245403	B. WING _		08/	/10/2017
	PROVIDER OR SUPPLIER	- BATTLE LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	D BE	(X5) COMPLETIO DATE
F 282	a.m. R44 remained the table with eyes headrest. At 9:02 a dining room and bar remained seated in when NA-D approa- his room. At 9:25 a mechanical lift to tr wheelchair to bed. incontinent brief an area was noted to b been repositioned a total of 2 hours and On 8/9/17, at 9:30 a area on R44's cocc she would notify LF NA-C indicated R4 on his left heel and two hours when se cushion in wheelch mattress. During fo NA-D stated she ha wheelchair at 6:45 On 8/9/17, at 12:59 had an current uns left medial heel. Sh repositioned every On 8/10/17, at 1:4 admission R44 was ulcers, but now a h CM-A confirmed R4 stated she would e reposition R44 eve On 8/10/17, at 2:0	A seated in his wheelchair at closed and head against the .m. NA-D propelled R44 out of ack into the dayroom. R44 his wheelchair until 9:22 a.m., iched him and propelled him to .m NA-C and NA-D utilized a ansfer R44 from his NA-C loosened R44's id R44's skin over his coccyx be bright red. R44 had not from 6:45 a.m. to 9:25 a.m., a 4 40 minutes. a.m. NA-C indicated the red cyx area was new and stated PN-A of this change for R44. 4 had a current pressure ulcer required repositioning every ated, pressure reduction air and pressure reduction allow up interview at 2:10 p.m. ad assisted R44 into his a.m. that morning. P.m. RN-A confirmed R44 tageable pressure ulcer on his is indicated R44 was to be	F 28	82		

If continuation sheet Page 7 of 25

		& MEDICAID SERVICES				0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· /	E SURVEY PLETED
		245403	B. WING		08/	10/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 314 SS=D	risk for developmer stated R44 had dev unstageable pressu on 7/2/17. She indid directions for repos when seated and e stated if R44 was n hours while seated, development of pre expected staff to fo indicated staff shout within 10-15 minute wheelchair. Review of facility po 11/16, indicated res reflect the care curr resident based on t assessment. The p care plans would b change of condition 483.25(b)(1) TREA PREVENT/HEAL P (b) Skin Integrity - (1) Pressure ulcers comprehensive ass facility must ensure (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that the (ii) A resident with p	The of pressure ulcers. DON veloped the current ure ulcer on his left medial heel cated R44's care plan included itioning R44 every two hours very four hours lying. DON ot repositioned every two , R44 would be at risk for essure ulcers. DON stated she llow R44's care plan and ald have repositioned R44 es of the two hours of sitting in oblicy titled, Care Plan, dated sidents plan of care would rently required/provided for the he comprehensive olicy also indicated resident be reviewed, updated with a n for the resident. TMENT/SVCS TO RESSURE SORES	F 2			9/13/17

If continuation sheet Page 8 of 25

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		C PLE CONSTRUCTION G	· · ·	E SURVEY PLETED
		245403	B. WING		08/1	10/2017
	PROVIDER OR SUPPLIER	- BATTLE LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 314	professional standa healing, prevent inf from developing. This REQUIREMEI by: Based on observar review, the facility f repositioning scheo development of pre- residents (R6, R44 pressure ulcers. In implement the use promote healing an residents (R6) with pressure ulcer. Findings include: R6's admission Mir 3/6/17, indicated R6 Mellitus, dementia, R6's MDS indicated impairment and wa assistance for trans indicated R6 requir bed mobility, toilet of hygiene and did no indicated R6 was a pressure ulcers and ulcers. Review of R6's Car dated 3/8/17, indicated bowel and bladder, pressure ulcers and needs. CAA listed of	ards of practice, to promote ection and prevent new ulcers NT is not met as evidenced tion, interview and document	F 31	 1. R6 and R44 are being repositions care planned intervention. Heel by being placed on R6 left foot as dir care plan. 2. All residents with pressure areas reviewed by DNS or designee to express are being followed for repositioning or application of preserelieving devices. 3. The DON or designee will provide re-education for CNA's and nurse 9/12/17 and 9/13/17 regarding fact policy and procedure for following plan repositioning times and apply pressure relieving devices with reassessing the resident's kardex, a using facility process for documer CNA "list" when resident is position ensure they know when next reportime is due. 4. To monitor compliance of reposes schedules and correct application pressure relieving devices random observation audits will be perform R6 and R44 and random other results reported to the monthly QA meeting further recommendation. 	oot is ected by as will be ensure ssure de s on ility care ring view of ind ting on ned to sitioning of n ed for sidents mes 4 s will be	

Facility ID: 00146

If continuation sheet Page 9 of 25

		AND HUMAN SERVICES				FORM	09/01/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245403	B. WING			08/-	10/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE			05 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	the use of a Roho of cushion for sitting s mattress, scheduled check and change f supplement. R6's quarterly MDS had severe cognitiv dependent on staff The MDS indicated assistance for bed of personal hygiene an MDS indicated R6 f pressure ulcer (full the base of the ulce (necrotic/avascular separating from the is usually light color and/or eschar (deat R6's MDS indicated pressure ulcers and to decrease this risil cushion in wheelchar mattress, reposition nutrition/hydration, a Review of R6's Woo dated 8/2/17, identified ulcer to left heel. Let unable to determine percent of wound b bed percentages we granulation, 5% slo Data Collection data ulcer to left heel. Let depth 0.2 cm. Wound	cushion (pressure reduction purfaces), alternating pro air d repositioning, scheduled for incontinence and nutritional d dated 6/5/17, indicated R6 re impairment and was totally for assistance with transfers. R6 required extensive mobility, toilet use, dressing, nd did not ambulate. R6's nad a current unstageable thickness tissue loss in which er is covered by slough tissue in the process of e viable portions of the body & red, soft, moist, & stringy) d tissue) in the wound bed). d a risk for development of d listed interventions in place k included: pressure reduction air, pressure reduction	F3	314			

If continuation sheet Page 10 of 25

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
		245403	B. WING			10/0017	
NAME OF	PROVIDER OR SUPPLIER	243403		STREET ADDRESS, CITY, STATE, ZIP C		/10/2017	
	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETIC DATE	
F 314	R6's care plan revis current unstageable heel, related to the and Parkinson's dis staff to assist to tur hours when sitting, at all times, float he provide Prevalon bo to left foot, and Rof On 8/8/17, at 2:48 p room, lying on his b closed. He had a pl chin which exposed R6 wore a yellow a foot and a black Pre- without a sock press directly on the bed. At 3:24 p.m. R6 wa and trained medica him from his room to black Prevalon boo and his left stocking on the pedal of the crossed and his rig of left foot, pressing the wheelchair. At 3:30 p.m. nursing approached R6 and NA-B removed the right foot and perfo stretches to his righ resting directly on th p.m. NA-B replaced right foot and exited	sed 8/3/17, identified R6 had a e pressure ulcer to the left need for mobility assistance ease. R6's care plan directed n/reposition at least every two avoid positioning feet on bed rels with pillow while in bed, bot (pressure reduction boot) to cushion when in wheelchair. co.m. R6 was observed in his rack in his bed with his eyes aid blanket pulled up to his d his feet and legs to mid-shin. and white non-skid sock on left evalon boot on his right foot ent. Both feet/heels rested as seated in his wheelchair tion aid (TMA)-A propelled R6 to the unit day room. The t remained on R6's right foot g covered foot rested directly wheelchair. R6's legs were ht boot rested directly on top g the left heel onto the pedal of g assistant (NA)-B d knelt next to his wheelchair. black Prevalon boot from R6's rmed hamstring and heel cord at leg, with R6's left heel ne wheelchair pedal. At 3:37 d the Prevalon boot to R6's		314			

If continuation sheet Page 11 of 25

STATEMENT	OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED
		245403	B. WING _		08/	10/2017
	PROVIDER OR SUPPLIER	- BATTLE LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	D BE	(X5) COMPLETIO DATE
F 314	with his left foot corsock resting directl Director of nursing with surveyor and corsock resting directly was on the right food directly on the peda confirmed R6 had a ulcer to his left hee boot was to be app right foot. DON the At 3:46 p.m. R6 re when TMA-A and N propelled him to his wheelchair to his b (CM)-A entered the R6's yellow and wh foot. CM-A visualize indicated it had har (pink-red moist tiss when it starts to he present. CM-A stat pressure ulcer on t At 3:51 p.m. during DON, CM-A confirm on the incorrect food pressure reduction (for wound healing) left foot to keep his stated she would e followed. DON stat follow R6's care pla	ick Prevalon boot to right foot, vered with a yellow and white y on the wheelchair pedal. (DON) visualized R6's feet confirmed R6's Prevalon boot of and his left heel rested al of the wheelchair. She a current unstageable pressure d and confirmed the Prevalon blied to R6's left foot, not his n left the area. mained in the same position NA-A approached R6 and s room to transfer from ed. DON and clinical manager e room and CM-A removed bite non-skid sock from his left ed R6's pressure ulcer and d edges with granular tissue sue that fills an open wound, al) in the base and eschar ed R6 had an unstageable he left heel. interview with CM-A and ned R6's Prevalon boot was ot. She indicated R6 had a mattress, protein supplement), pressure reduction boot to a heel floated at all times. CM-A xpect the interventions to be ed she would expect staff to	F 3			

Facility ID: 00146

If continuation sheet Page 12 of 25

		AND HUMAN SERVICES				FORM	: 09/01/2017 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245403	B. WING	i		08/	/10/2017
NAME OF	PROVIDER OR SUPPLIER	<u>.</u>	·	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	SAMARITAN SOCIETY	- BATTLE LAKE			05 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	cm x 0.2 cm and ha with granulation, sti no slough and 96 p layer of cells that co surfaces of the bod stated interventions ulcer included to ele reposition every two protein supplement R6 the previous day left foot and indicate time the boot had b On 8/9/17, at 9:49 a dependent on staff mechanical lift for tr interventions to relia pressure reduction reduction cushion in place a pillow unde On 8/9/17, at 12:49 interview, RN-A ind measurements on a of new eschar was she had completed she would expect th all times and would legs floating heels wo would be used to re at all times.	ad a 0.4 x 0.7 cm open area iff edges, four percent eschar, bercent epithelium (the outside overs all the free, open dy including the skin). She is in place for R6's left heel levate left heel off bed, to hours while sitting, and a t. RN-A stated she had seen by with the Prevalon boot on his ted she was unaware what been placed on the wrong foot. a.m. NA-C stated R6 was for all cares and required a transfers. She indicated ieve pressure included boot to left foot, pressure in wheelchair and staff were to er his legs while lying in bed. 0 p.m. during a follow up dicated R6's pressure ulcer 8/9/17 were larger than 8/2/17. RN-A stated the area not present in 8/2/17 when d dressing change. RN-A stated he boot to be on the left foot at d expect the pillow under his		314			

If continuation sheet Page 13 of 25

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY
		BERTI IO/TIOITION BETT	A. BUILDIN	IG	001	
		245403	B. WING _		08/	/10/2017
-	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 314	in his wheelchair ne of the dayroom, fac street clothes with a and a black Preval Continuous observa 7:03 a.m. to 9:18 a. seated in his wheel dayroom facing the remained seated in dayroom. R6 reach wheels of his wheel forward until he bun armchair. At 7:45 at approached R6 and his room. RN-A con foot while R6 remai At 7:53 a.m. RN-A a wheelchair from his positioned his wheel licensed practical n at the table and ass with a spoon and im 8:22 a.m. NA-D bro sat next to R6 and a At 8:50 a.m. R6 rem wheelchair, indeper NA-D approached F dining room to the c area. R6 remained 9:18 a.m. when NA assisted R6 to prop dayroom to his roor wheelchair to bed. F	ext to two recliner in the middle ing the television. R6 wore a white sock on his right foot on boot on his left foot. ations were conducted from m. At 7:03 a.m. R6 remained chair in the middle of the main television. At 7:41 a.m., R6 his wheelchair in the ed down and moved the chair, propelling himself nped his feet into a nearby m RN-A entered the dayroom, d propelled his wheelchair to npleted wound care to his left ned seated in his wheelchair. assisted R6 to propel his room to the dining room and elchair at a table. At 8:06 a.m. urse (LPN)-A approached R6 sisted R6 to take medications nediately walked away. At ught R6's breakfast items and assisted him to eat breakfast. nained seated in his ndently drinking coffee. At 9:00 R6 and wheeled him out of dayroom and walked out of the seated in his wheelchair until -D entered the area and el his wheelchair from the n and assisted him from his R6 had not been repositioned c18 am, a total of 2 hours and	F 31	4		

If continuation sheet Page 14 of 25

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()	IPLE CONSTRUCTION	· · /	TE SURVEY MPLETED
		245403	B. WING _		08	/10/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 314	wear his boot (pres assisted to repositive seated, and use and transfer from whee R6 had been transfer wheelchair "around On 8/9/17 at 2:10 p assisted R6 to transfer the early morning. If assisted R6 to transfer wheelchair at 6:45 R44 R44's admission M R44 had diagnoses disease, psychotic depression. The Mill short and long term severely impaired of decision making. T totally dependent of required extensive toileting, personal h Further, the MDS id pressure ulcer deve current pressure ull R44's CAA dated 4 rapidly progressing behavioral disturba all ADLS, had decli indicated R44 required	ssure reduction) on his left foot, on every two hours when mechanical lift with two staff to lchair to bed. NA-C indicated ferred from his bed to 17:00 or so." o.m. NA-D indicated she sfer from bed to wheelchair in She confirmed she had sfer from his bed to his a.m. IDS dated 4/18/17, indicated s which included Alzheimer's disorder, anxiety and DS indicated R44 had both n memory problems, and had cognitive skills for daily 'he MDS indicated R44 was in staff assistance for transfers, assistance with bed mobility, nygiene and did not ambulate. dentified R44 was at risk for elopment and did not have	F 31			

If continuation sheet Page 15 of 25

		AND HUMAN SERVICES				FORM	APPROVED		
	<u>SFOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		וחיד	LE CONSTRUCTION				
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					E SURVEY IPLETED		
		245403	B. WING				10/2017		
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>		TREET ADDRESS, CITY, STATE, ZIP CODE	00/	10/2017		
			105 GLENHAVEN DRIVE						
GOOD SI	AMARITAN SOCIETY	- BAITLE LAKE		E	BATTLE LAKE, MN 56515				
(X4) ID			ID				(X5)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		CROSS-REFERENCED TO THE APPROP		DATE		
			<u> </u>		DEFICIENCY)				
F 314	Continued From pa	iae 15	F 3	14					
				• •					
		S dated 7/12/17, indicated					0938-0391 E SURVEY PLETED 10/2017		
		and long term memory severely impaired cognitive	BATTLE LAKE, MN 56515 L ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE red						
		sion making. The MDS							
	indicated R44 was t	totally dependent on staff							
		sfers, required extensive							
		d mobility, toileting, personal t ambulate. The MDS							
		at risk for pressure ulcer							
	development and d	lid not have current pressure							
	ulcers.								
	Review of R44's Pc	ositioning Assessment &							
	Evaluation dated 7/	/12/17, indicated "Resident is							
		kdown and is on scheduled							
		or this. Pressure reduction nd has Roho cushion in w/c							
	[wheelchair] as well	I. No pressure related open							
	areas with these me	easures in place.							
	Review of R44's Pr	ogress Notes from 7/20/17 to							
	8/9/17 revealed a n	ote dated 7/26/17, which							
		developed a new unstageable ft medial heel, with stable							
	eschar and no drair	-							
		-					SURVEY LETED 0/2017 (X5) COMPLETION		
		vised 8/3/17, indicated R44 had							
		ble pressure ulcer to left to immobility, had advanced							
		lired assistance with ADL's.							
		d various interventions which							
		at least every two hours when on in wheelchair and Prevalon							
	boot on left foot at a								
	On 9/0/17 at 6:49 (a m. D11 was abaarved asstad							
		a.m. R44 was observed seated n his eyes closed, facing the							
		ge dayroom. R44 wore a long							

Facility ID: 00146

If continuation sheet Page 16 of 25

PRINTED: 09/01/2017

		& MEDICAID SERVICES				. 0938-039
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · ·	E SURVEY IPLETED
		245403	B. WING		08/	/10/2017
	PROVIDER OR SUPPLIER	- BATTLE LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	boot on his left foot were conducted fro 7:03 a.m R44 rema with his eyes closed RN-A entered the d propelled R44 in his 7:34 a.m. RN-A cor evaluation of R44's R44 sat in the whee propelled R44 in his back to the dayroor seated in his wheel entered the dayroor wheelchair from da room. At 8:22 a.m. nurse(LPN)-A briefl clothing protector a At 8:28 a.m. LPN-A assisted R44 to eat LPN-A left the table continued to assist a.m. R44 remained the table with eyes headrest. At 9:02 a dining room and ba remained seated in when NA-D approa his room. At 9:25 a. mechanical lift to tra wheelchair to bed. I incontinent brief and area was noted to b been repositioned f total of 2 hours and On 8/9/17, at 9:30 a area on R44's cocc	id pajama pants, and a blue . Continuous observations m 7:03 a.m. to 9:25 a.m. At ined seated in a wheelchair d in the dayroom. At 7:30 a.m. layroom, approached R44 and s wheelchair to his room. At npleted a pressure ulcer left heel pressure ulcer left heel pressure ulcer, while elchair. At 7:40 a.m. RN-A s wheelchair from his room, m. At 8:01 a.m. R44 remained chair in the dayroom, NA-D m and propelled R44's yroom to a table in the dining licensed practical y approached R44, applied a nd immediately walked away. a sat down next to R44 and breakfast. At 8:34 a.m. e and NA-D sat down and R44 to eat his meal. At 8:59 seated in his wheelchair at closed and head against the .m. NA-D propelled R44 out of tck into the dayroom. R44 his wheelchair until 9:22 a.m., ched him and propelled him to .m NA-C and NA-D utilized a ansfer R44 from his NA-C loosened R44's d R44's skin over his coccyx be bright red. R44 had not rom 6:45 a.m. to 9:25 a.m., a	F 3			

If continuation sheet Page 17 of 25

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245403	B. WING _		08	/10/2017
				STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		BATTLE LAKE, MN 56515		_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 314	on his left heel and two hours when set cushion in wheelch mattress. During fo NA-D stated she ha wheelchair at 6:45 On 8/9/17, at 12:59 had an current unsi- left medial heel. Sh- repositioned every On 8/10/17, at 1:49 admission R44 was ulcers, but now a h CM-A confirmed R4 stated she would ex- reposition R44 ever On 8/10/17, at 2:00 totally dependent o- risk for development stated R44 had dev unstageable press on 7/2/17. She indid directions for repos when seated and e- stated if R44 was in hours while seated development of pre- expected staff to fo indicated staff shou- within 10-15 minute- wheelchair. Review of the facilit	 4 had a current pressure ulcer required repositioning every ated, pressure reduction air and pressure reduction on the pressure reduction on the pressure reduction on the pressure at 2:10 p.m. and assisted R44 into his a.m. that morning. 9 p.m. RN-A confirmed R44 tageable pressure ulcer on his the indicated R44 was to be two hours. 9 p.m. CM-A stated on a medium risk for pressure igh risk due to his nutrition. At's current care plan and the xpect nursing staff to ry two hours while seated. 6 p.m. DON stated R44 was at the top pressure ulcers. DON 	F 31			

If continuation sheet Page 18 of 25

		& MEDICAID SERVICES	Γ			0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · /	E SURVEY IPLETED
		245403	B. WING		08/10/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	contribute to the the breakdown. The po turning and position developed based o	dress causative factors that e resident's risk for skin licy indicated resident specific ning programs would be	F 314	4		
F 431 SS=D	11/16, indicated res reflect the care curr resident based on t assessment. The p care plans would b change of condition 483.45(b)(2)(3)(g)(I LABEL/STORE DR The facility must pr drugs and biologica them under an agre §483.70(g) of this p unlicensed personr law permits, but on	olicy also indicated resident be reviewed, updated with a n for the resident. n) DRUG RECORDS, UGS & BIOLOGICALS ovide routine and emergency als to its residents, or obtain beement described in part. The facility may permit hel to administer drugs if State by under the general	F 43	1		9/13/17
	pharmaceutical ser that assure the acc dispensing, and ad biologicals) to meet (b) Service Consult employ or obtain th	facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and t the needs of each resident. ation. The facility must e services of a licensed				
	disposition of all co	vstem of records of receipt and ntrolled drugs in sufficient accurate reconciliation; and				

If continuation sheet Page 19 of 25

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/01/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245403	B. WING _			08/-	10/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		-	05 GLENHAVEN DRIVE ATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	Continued From pa	ge 19	F 4	31			
	that an account of a	drug records are in order and all controlled drugs is iodically reconciled.					
	labeled in accordan professional princip appropriate access	als used in the facility must be ice with currently accepted iles, and include the					
	the facility must sto locked compartmer	vith State and Federal laws, re all drugs and biologicals in hts under proper temperature t only authorized personnel to					
	permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distri quantity stored is m be readily detected. This REQUIREMEN by: Based on observat review, the facility fa labels with direction	t provide separately locked, d compartments for storage of red in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can NT is not met as evidenced tion, interview, and document ailed to ensure the accurate is for use were on medications R37) insulin pen observed			1. R37 Direction/order change stick placed on insulin pen immediately u being recognized by surveyor. Pha was notified and a new and accurat	ipon rmacy	
	during medication a Findings include:				was ordered, received, and placed pen.2. All residents receiving insulin via device were inspected by DNS on 8	on the pen	

Facility ID: 00146

PRINTED: 09/01/2017

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245403	B. WING _		08/	10/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 431	R37's Order Summ indicated R37 had Diabetes Mellitus, <i>A</i> kidney failure. The Novolog Solution 10 injected subcutaned once a day, ordered On 8/7/17, at 6:45 p was observed stand cart outside of R37 drawer of the media Insulin pen from the name on the pen. F and set the dial of t units of insulin. The insulin pen dated 8/ units of Insulin at lu When interviewed R37's Insulin pen la and stated R37's cu 8 units at noon and stated R37's dose of past, from 8 units et currently 8 units at evening. RN-B india have had a sticker current order, which 11/22/16. On 8/8/17, at 3:06 p (PC) confirmed the when an order was noting dose change medical record for t R37's insulin pen.	hary Report dated 8/8/17, diagnoses which included Alzheimer's disease and report included an order for 00 unit/ml (Insulin) 8 units ously once a day and 4 units d on 11/22/16. b.m. registered nurse (RN)-B ding next to the medication 's room. She opened the first cation cart and removed a blue e drawer, labeled with R37's RN-B primed the Insulin pen he pen for delivery of four e medication label on the /4/17, directed staff to inject 8	F 43	to ensure accurate identification. label was adhered to the pen. 3. DNS will provide re-education nurses on 9/12/17 and 9/13/17 r facility procedure for placing "ch order stickers" on medications th had a dose change and requesti label from pharmacy. Medicatio will be stocked with change orde 4. DNS or designee will perform observational audits of medicatic changes weekly times 4 and mo times 2. All audit findings will be to the monthly QA meeting for fu- recommendation.	to all egarding ange nat have ng new n carts r stickers. random on order nthly reported	

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		0. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		IG		MPLETED
		245403	B. WING _		08	8/10/2017
NAME OF I	PROVIDER OR SUPPLIER		· [STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 431	stated a sticker sho	ne current facility policy and puld have been placed in the	F 43	1		
		sulin pen when the order was harmacy notified of that order				
F 441 SS=F	12/2015, directed s inaccurately or imp the dispensing pha prescriber's direction allowed the nurse to check chart or similiar	e of Direction Stickers dated staff to refuse or return roperly labeled medications to rmacy. In cases where ons for use change, the policy o place a change of order, lar sticker on the container to a direction for use or dosages. e)(f) INFECTION CONTROL,	F 44	.1		9/13/17
	(a) Infection prever	ntion and control program.				
		stablish an infection prevention m (IPCP) that must include, at lowing elements:				
	investigating, and c communicable dise volunteers, visitors providing services arrangement base conducted accordin	eventing, identifying, reporting, controlling infections and eases for all residents, staff, , and other individuals under a contractual d upon the facility assessment ng to §483.70(e) and following standards (facility assessment Phase 2);				
		ds, policies, and procedures nich must include, but are not				

If continuation sheet Page 22 of 25

CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0938-039 INTERMENT OF PROFENCIENCES (2) PROVEMENDATION NUMBER: (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONST	DEPART CENTER		FORM APPROVED OMB NO. 0938-0391					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - BATTLE LAKE ISTREET ADDRESS, CITY, STATE, ZIP CODE INVERTING SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCE) IP IP SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCE) IP IP SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCE) IP IP REGULATORY OR LSC DENTIFYING INFORMATION) IP IF 441 Continued From page 22 (1) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; IF 441 (ii) When and to whom possible incidents of communicable disease or infections; IF 441 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; IV (iv) When and how isolation should be used for a resident; including but not limited to: IV (i) A requirement that the isolation, depending upon the infectious agent or organism involved, and IV (ii) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact will reasing the disease; and IV (v) The hand hygine procedures to be followed by staff involved in direct resident contact. IV (i) A system for recording incidents identified under the facility: IPCP and the corrective actions taken by the tacility. IV (ii) Linens. Personnel must handle, store, process	STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		LE CONSTRUCTION	(X3) DATE SURVEY	
GOOD SAMARITAN SOCIETY - BATTLE LAKE 195 GLEHHAVEN DRIVE BATTLE LAKE, MN 56515 (X4) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MST BE PRECEDED BY FULL TAG D PREFX TAG PREFX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 00/05 DUE F 441 Continued From page 22 (i) A system of surveillance designed to identify possible communicable disease or infections before they can spread to other persons in the facility; F 441 F 441 (ii) When and to whom possible incidents of communicable disease or infections to be followed to prevent spread of infections; F 441 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; F 441 (iv) When and how isolation should be used for a resident; including but not limited to: F 441 (iv) When and how isolation should be used for a resident; including but not limited to: F 441 (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 cortact with residents or their food, if direct core			245403	B. WING			08 / [.]	10/2017
GOOD SAMARTIN SOCIETY - BATTLE LAKE BATTLE LAKE, MN 56515 (24) ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIGT REPECEPED BY PULL RESULATION OR LSC DENTIFYING INFORMATION) PROVIDENTS PLAN OF CORRECTION (EACH DEFICIENCY WIGT REPECEPED BY PULL RESULATION OR LSC DENTIFYING INFORMATION) PROVIDENTS PLAN OF CORRECTIVE ATTORN SHOULD BE CHOSS HEFEREDUCT OT THE APPROPRIATE DEFICIENCY COMPLETION (CHOSS HEFEREDUCT OT THE APPROPRIATE DEFICIENCY) COMPLETION (CHOSS HEFEREDUCT ON THE APPROPRIATE DEFICIENCY) COMPLETION (CHOSS HEFEREDUCT ON THE APPROPRIATE DEFICIENCY) COMPLETION (CHOSS HEFEREDUCT ON CHOSS HEFEREDUCT ON CHOSS HEFEREDUCT ON CHOSS HEFEREDUCT ON CHOSS HEFEREDUCT (I) A system of surveillance designed to identify cross and transmit the disease, and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. I) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. I) Linens. Personnel must handle, store, process, and tra	NAME OF F	PROVIDER OR SUPPLIER						
PREFix TAG CEACH CORRECTS ALLTS & PRECEDED BY FULL BEQUATION OR LSC IDENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTME ACTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DEFICIENCY F 441 Continued From page 22 (I) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; F 441 F 441 (II) When and to whom possible incidents of communicable disease or infections should be reported; F 441 (III) Standard and transmission-based precautions to be followed to prevent spread of infections; F 441 (W) When and how isolation should be used for a resident; including but not limited to: F 441 (W) When and how isolation should be used for a resident; including but not limited to: F 441 (W) The type and duration of the isolation, depending upon the infectious agent or organism involved, and F 441 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. F 441 (vi) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin leasions from direct contact with residents or their food, if direct contact with resident sort their toot, if direct contact with resident or thact. F 441 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. F 441 (e) Linens. Personnel must handle, store, process, and t	GOOD S	AMARITAN SOCIETY	- BATTLE LAKE					
 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances under which the facility must prohibit employees with a communicable disease; and (v) The circumstances under which the facility must prohibit employees to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the 	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
	F 441	 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the 			441			

If continuation sheet Page 23 of 25

PRINTED: 09/01/2017

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245403		(X2) MULTIPLE CONSTRUCTION A. BUILDING			MB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		B. WING		08/10/2017		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
good s	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 441	Continued From pa	ige 23	F 44	1		
 (f) Annual review. The facility will condannual review of its IPCP and update the program, as necessary. This REQUIREMENT is not met as early: Based on interview and document review facility failed to implement their infection program policies to report a facility out influenza to the State agency (SA). The practice had the potential to affect all 5 who resided in the facility. Findings include: Review of the facility form titled Month Resident Infections in Center dated 2/indicated one positive influenza A cultuof its three identified units (Heritage La Fisherman's Cove and Cottonwood Grifisherman's Cove also had three other with identified lower respiratory infection Heritage Lane had three additional rescultured for influenza. Cottonwood Griadditional residents with lower respirations. Twelve residents were cultuinfluenza. During an interview on 8/10/17, at 3:09 assistant director of nursing (ADON), withe facility's infection control nurse, coabove findings. ADON stated she was she had completed a influenza report indicated she would call SA to verify the had been submitted. At 4:10 p.m. ADC confirmed the facility influenza outbread been reported to the SA. 		A IPCP and update their sary. NT is not met as evidenced and document review, the lement their infection control report a facility outbreak of te agency (SA). This deficient tential to affect all 50 residents facility. ty form titled Monthly Report of in Center dated 2/17, ive influenza A culture on each d units (Heritage Lane, and Cottonwood Grove). also had three other residents r respiratory infections. three additional residents za. Cottonwood Grove had two s with lower respiratory esidents were cultured for f on 8/10/17, at 3:09 p.m. the f nursing (ADON), who was in control nurse, confirmed the ON stated she was unsure if a influenza report form and d call SA to verify the report d. At 4:10 p.m. ADON ty influenza outbreak had not		 Positive influenza cultures were reported to the appropriate state a by Facility Infection Preventionist of 8/10/17. All residents in the facility were for this deficient practice. No othe demonstrated symptoms during the frame. DNS will provide re-education/reminders to Infection Preventionist on when to report pe procedure and MN Dept. of Health requirements on Sept. 5th, 2017. DNS or designee will audit the in control logs to determine if reportin needed and completed as appropri time per month times 4 months. F will be taken to QA meeting for fur recommendations. 	re agency on e at risk hers that time on ber GSS th infection ting was priate 1 Results	

If continuation sheet Page 24 of 25

		AND HUMAN SERVICES				FORM): 09/01/2017 APPROVED). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245403	B. WING	i		08	/10/2017
NAME OF I	PROVIDER OR SUPPLIER	·			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE			105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	Disease dated 3/16 department will be epidemic/outbreak The Minnesota Dep Long-Term Care Fa 2016-2017 dated 9 definition of an outb influenza-like illness laboratory-confirme along with other cas unit." The form indi	osure Control ics/Seasonal Infectious 6, indicated, "The local health notified regarding the if it is a reportable disease." oartment of Health form titled acility Influenza Report Form, /2016, specified, "The oreak is: Two residents with	F	441			

Facility ID: 00146

If continuation sheet Page 25 of 25


Protecting, Maintaining and Improving the Health of All Minnesotans

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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Good Samaritan Society - Battle Lake August 25, 2017 Page 2 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,

Kumala 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: <u>kamala.fiske-downing@state.mn.us</u>

cc: Licensing and Certification File

Minneso	ota Department of He	alth					
-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU		. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00146	1	B. WING		08/1	0/2017
NAME OF	PROVIDER OR SUPPLIER		STREET ADDF	RESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE	105 GLENH BATTLE LA				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORE	DER				
	144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation ha	issued tion, it is cited violation ordance rule of s been tag below. ure to sidered e upon rule will if the item				
	that may result fron orders provided tha the Department wit	hearing on any asse n non-compliance wi at a written request is hin 15 days of receip ent for non-compliance	th these made to ot of a				
	completed at your f Department of Hea was in compliance	tandard survey was acility by the Minnes Ith to determine if yo with requirements of 3, and Requirements	ur facility 42 CFR				
Minnesota D	epartment of Health						
	y DIRECTOR'S OR PROVID	JER/SUPPLIER REPRESEN	TATIVE'S SIGNA	AI UKE	TITLE		(X6) DATE 08/31/17

If continuation sheet 1 of 24

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		00146	B. WING		08/	08/10/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	' - RATTIFIAKE	NHAVEN DR LAKE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE	
2 000	Continued From pa	age 1	2 000				
	The facility's plan c	of correction (POC) will serve of compliance upon the					
	revisit of your facili validate that substa	acceptable POC, an on-site ty may be conducted to antial compliance with the en attained in accordance with					
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			9/13/17	
		omprehensive plan of care Il personnel involved in the t.					
	by: Based on observat review the facility fa intervention for rep residents (R6, R44 pressure ulcer. In a implement care pla pressure relieving l	ient is not met as evidenced ion, interview and record ailed to implement care plan ositioning schedule for 2 of 2) with a current unstageable addition, the facility failed to an intervention for use of a boot for 1 of 2 residents (R6) ageable pressure ulcer.		Corrected			
	current unstageabl heel, related to the and Parkinson's dis staff to assist to tur	sed 8/3/17, identified R6 had a e pressure ulcer to the left need for mobility assistance sease. R6's care plan directed m/reposition at least every two avoid positioning feet on bed					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00146	B. WING		08/	10/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- RATTIFIAKE	NHAVEN DRIV LAKE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 2	2 565			
	provide Prevalon b	eels with pillow while in bed, oot (pressure reduction boot) ho cushion when in wheelchair				
	room, lying on his t closed. He had a p chin which exposed R6 wore a yellow a foot and a black Pr	p.m. R6 was observed in his back in his bed with his eyes laid blanket pulled up to his d his feet and legs to mid-shin. and white non-skid sock on left evalon boot on his right foot sent. Both feet/heels rested				
	and trained medica him from his room black Prevalon boo and his left stocking on the pedal of the crossed and his rig	as seated in his wheelchair ation aid (TMA)-A propelled R6 to the unit day room. The ot remained on R6's right foot g covered foot rested directly wheelchair. R6's legs were ht boot rested directly on top g the left heel onto the pedal of	:			
	NA-B removed the right foot and perfo stretches to his right resting directly on t	d knelt next to his wheelchair. black Prevalon boot from R6's rrmed hamstring and heel cord nt leg, with R6's left heel he wheelchair pedal. At 3:37 d the Prevalon boot to R6's				
	wheelchair with bla with his left foot cor sock resting direct Director of nursing with surveyor and c was on the right foo	mained seated in his ick Prevalon boot to right foot, vered with a yellow and white y on the wheelchair pedal. (DON) visualized R6's feet confirmed R6's Prevalon boot ot and his left heel rested al of the wheelchair. She				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00146	B. WING		08/	08/10/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	•		
OOD S	AMARITAN SOCIET	Z - BATTIEIAKE	NHAVEN DRIV LAKE, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 565	Continued From p	age 3	2 565				
	ulcer to his left hee boot was to be app right foot. DON the At 3:46 p.m. R6 re when TMA-A and I propelled him to his wheelchair to his b (CM)-A entered the R6's yellow and wh foot. CM-A visualiz indicated it had ha (pink-red moist tiss when it starts to he	emained in the same position NA-A approached R6 and is room to transfer from bed. DON and clinical manager e room and CM-A removed hite non-skid sock from his left zed R6's pressure ulcer and rd edges with granular tissue sue that fills an open wound, eal) in the base and eschar ted R6 had an unstageable					
	and DON, CM-A c was on the incorre pressure reduction (for wound healing left foot to keep his stated she would e	p.m. during interview with CM-A onfirmed R6's Prevalon boot ect foot. She indicated R6 had a n mattress, protein supplement g), pressure reduction boot to s heel floated at all times. CM-A expect the interventions to be ted she would expect staff to an.					
	completed wound unstageable press ulcer measuremen cm x 0.2 cm and h with granulation, s no slough and 96 layer of cells that of surfaces of the boo stated intervention ulcer included to e	a.m. registered nurse (RN)-A care on R6's left heel sure ulcer. RN-A stated R6's nts were 1 centimeter (cm) x 2 nad a 0.4×0.7 cm open area tiff edges, four percent eschar, percent epithelium (the outside covers all the free, open dy including the skin). She is in place for R6's left heel levate left heel off bed, yo hours while sitting, and a					

	DIT DEPARTMENT OF HE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00146	B. WING		08/	10/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		NHAVEN DRIV LAKE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 4	2 565			
	R6 the previous da left foot and indicat time the boot had b On 8/9/17, at 9:49 dependent on staff mechanical lift for t interventions to reli pressure reduction reduction cushion i place a pillow unde On 8/10/17, at 10:5 (NP)-A stated if a re on the heel she wo	t. RN-A stated she had seen y with the Prevalon boot on his ed she was unaware what been placed on the wrong foot. a.m. NA-C stated R6 was for all cares and required a ransfers. She indicated eve pressure included boot to left foot, pressure n wheelchair and staff were to er his legs while lying in bed. 50 a.m. nurse practitioner esident had a pressure ulcer uld expect that a pillow or boot elieve pressure from the area				
	in his wheelchair ne of the dayroom, fac street clothes with and a black Preval Continuous observ 7:03 a.m. to 9:18 a seated in his wheel dayroom facing the remained seated in dayroom. R6 reach wheels of his wheel forward until he but armchair. At 7:45 a approached R6 and his room. RN-A con foot while R6 rema At 7:53 a.m. RN-A	a.m. R6 was observed seated ext to two recliner in the middle sing the television. R6 wore a white sock on his right foot on boot on his left foot. ations were conducted from .m. At 7:03 a.m. R6 remained lchair in the middle of the main e television. At 7:41 a.m., R6 n his wheelchair in the hed down and moved the lchair, propelling himself mped his feet into a nearby m RN-A entered the dayroom, d propelled his wheelchair to mpleted wound care to his left ined seated in his wheelchair. assisted R6 to propel his s room to the dining room and				

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·····	COM	PLETED
		00146	B. WING		08/	10/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		NHAVEN DRIV LAKE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	ge 5	2 565			
	at the table and ass with a spoon and in 8:22 a.m. NA-D bro sat next to R6 and a At 8:50 a.m. R6 ren wheelchair, indepen NA-D approached I dining room to the o area. R6 remained 9:18 a.m. when NA assisted R6 to prop dayroom to his roor wheelchair to bed. I from 6:45 a.m. to 9 33 minutes.	urse (LPN)-A approached R6 sisted R6 to take medications nmediately walked away. At bught R6's breakfast items and assisted him to eat breakfast. nained seated in his ndently drinking coffee. At 9:00 R6 and wheeled him out of dayroom and walked out of the seated in his wheelchair until -D entered the area and bel his wheelchair from the m and assisted him from his R6 had not been repositioned :18 am, a total of 2 hours and				
	totally dependent of living (ADL). She in wear his boot (pres assisted to reposition seated, and use a re transfer from wheel	a.m. NA-C stated R6 was n staff for activities of daily dicated R6 was supposed to sure reduction) on his left foot on every two hours when mechanical lift with two staff to lchair to bed. NA-C indicated erred from his bed to 7:00 or so."	,			
	assisted R6 to trans the early morning.	.m. NA-D indicated she sfer from bed to wheelchair in She confirmed she had sfer from his bed to his a.m.				
	R44					
	a current unstageal medial heel related dementia, and requ	rised 8/3/17, indicated R44 had ble pressure ulcer to left to immobility, had advanced lired assistance with ADL's. d various interventions which	ł			

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		E SURVEY PLETED
		IDENTIFICATION NOWIDEN.	A. BUILDING:			
		00146	B. WING	B. WING		10/2017
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
GOOD S	AMARITAN SOCIETY	- 84111 - 146 -	NHAVEN DRI\ LAKE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 6	2 565		,	
	included reposition	at least every two hours when on in wheelchair and Prevalon				
	in a wheelchair with television in the lar sleeve shirt and pla boot on his left foot were conducted fro 7:03 a.m R44 rema with his eyes close RN-A entered the co propelled R44 in hi 7:34 a.m. RN-A con evaluation of R44's R44 sat in the whe propelled R44 in hi back to the dayroou seated in his whee entered the dayroou seated in his whee entered the dayroou wheelchair from da room. At 8:22 a.m. nurse(LPN)-A brief clothing protector a At 8:28 a.m. LPN-A assisted R44 to ea LPN-A left the table continued to assist a.m. R44 remained the table with eyes headrest. At 9:02 a	a.m. R44 was observed seated h his eyes closed, facing the ge dayroom. R44 wore a long aid pajama pants, and a blue t. Continuous observations om 7:03 a.m. to 9:25 a.m. At ained seated in a wheelchair d in the dayroom. At 7:30 a.m. dayroom, approached R44 and s wheelchair to his room. At mpleted a pressure ulcer s left heel pressure ulcer, while elchair. At 7:40 a.m. RN-A s wheelchair from his room, m. At 8:01 a.m. R44 remained lchair in the dayroom, NA-D m and propelled R44's ayroom to a table in the dining licensed practical ly approached R44, applied a and immediately walked away. A sat down next to R44 and t breakfast. At 8:34 a.m. e and NA-D sat down and R44 to eat his meal. At 8:59 d seated in his wheelchair at closed and head against the a.m. NA-D propelled R44 out of ack into the dayroom. R44				
	his room. At 9:25 a mechanical lift to tr wheelchair to bed. incontinent brief an	ached him and propelled him to u.m NA-C and NA-D utilized a ransfer R44 from his NA-C loosened R44's nd R44's skin over his coccyx be bright red. R44 had not				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00146	B. WING		08/	08/10/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	•		
	AMARITAN SOCIETY	BATTLELAKE 105 GLE	NHAVEN DRIV	'E			
GOOD 5	AMARITAN SOCIETY	- BATTLE LAKE BATTLE	LAKE, MN 56	515			
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 565	Continued From pa	age 7	2 565				
	been repositioned total of 2 hours and	from 6:45 a.m. to 9:25 a.m., a 4 40 minutes.					
	area on R44's cocc she would notify LF NA-C indicated R4 on his left heel and two hours when se cushion in wheelch mattress. During fo NA-D stated she ha wheelchair at 6:45 On 8/9/17, at 12:59 had an current uns left medial heel. Sh repositioned every On 8/10/17, at 1:4 admission R44 was ulcers, but now a h CM-A confirmed R4	 p.m. RN-A confirmed R44 tageable pressure ulcer on his ie indicated R44 was to be two hours. 9 p.m. CM-A stated on s a medium risk for pressure igh risk due to his nutrition. 44's current care plan and 					
	reposition R44 eve On 8/10/17, at 2:0 totally dependent o risk for development stated R44 had dev	xpect nursing staff to ry two hours while seated. 6 p.m. DON stated R44 was n staff for all cares and was at nt of pressure ulcers. DON veloped the current ure ulcer on his left medial hee					
	directions for repose when seated and e stated if R44 was n hours while seated development of pre expected staff to for	cated R44's care plan included sitioning R44 every two hours every four hours lying. DON not repositioned every two , R44 would be at risk for essure ulcers. DON stated she illow R44's care plan and uld have repositioned R44					

Minneso	ta Department of He	alth			FORM	APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00146	B. WING	B. WING		
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		NHAVEN DRI\ LAKE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 8	2 565			
	wheelchair.					
	11/16, indicated res reflect the care curr resident based on t assessment. The p	olicy also indicated resident reviewed, updated with a				
	The director of nurs develop systems to individualized reside designee could edu DON or designee c system to ensure o	THOD FOR CORRECTION: sing (DON) or designee could ensure implementation of the ent plans of care. The DON or licate all appropriate staff. The ould develop an auditing ngoing compliance and report uality assurance committee.				
	TIME PERIOD FOR days.	R CORRECTION: Twenty (21)				
2 900	MN Rule 4658.0529 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			9/13/17
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
		ho has pressure sores y treatment and services to				

STATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED	
		00146	B. WING		08/	08/10/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE				
GOODS	AMARITAN SOCIETY		NHAVEN DR LAKE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	age 9	2 900				
	promote healing, p new sores from de	revent infection, and prevent veloping.					
	by:	ent is not met as evidenced ion, interview and document		Corrected			
	review, the facility for repositioning scheor development of pre- residents (R6, R44 pressure ulcers. In implement the use promote healing ar	Failed to implement dule to prevent further essure ulcers for 2 of 2) with current unstageable addition, the facility failed to of a pressure relieving boot to nd prevent worsening for 1 of 2 a current unstageable					
	Findings include:						
	3/6/17, indicated R Mellitus, dementia, R6's MDS indicated impairment and wa assistance for trans indicated R6 requir bed mobility, toilet hygiene and did no indicated R6 was a	himum Data Set (MDS) dated 6 had diagnoses of Diabetes and Parkinson's disease. d he had severe cognitive as totally dependent on staff sfers. Further, the MDS red extensive assistance for use, dressing and personal t ambulate. The MDS tt risk for the development of d had no current pressure					
	dated 3/8/17, indica staff for assistance bowel and bladder, pressure ulcers, wa pressure ulcers an needs. CAA listed w	re Area Assessment (CAA) ated R6's was dependent on with positioning, incontinent of had no known history of as at high risk of developing d staff were to anticipate his various interventions put in in breakdown, which included	f				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00146	B. WING	B. WING		08/10/2017	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
OOD S	AMARITAN SOCIETY	- RATTIFIAKE	NHAVEN DRIV LAKE, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 900	Continued From pa	age 10	2 900				
	cushion for sitting s mattress, schedule	cushion (pressure reduction surfaces), alternating pro air d repositioning, scheduled for incontinence and nutritiona	I				
	had severe cognitive dependent on staff The MDS indicated assistance for bed personal hygiene a MDS indicated R6 pressure ulcer (full the base of the ulce (necrotic/avascular separating from the is usually light colo and/or eschar (dea R6's MDS indicate pressure ulcers and to decrease this ris cushion in wheelch mattress, reposition nutrition/hydration, Review of R6's Wo dated 8/2/17, ident	and pressure ulcer treatment. ound Data Collection form ified unstageable pressure ength 0.6 cm, width 0.9 cm and					
	percent of wound b bed percentages w granulation, 5% slo Data Collection dat ulcer to left heel. Le depth 0.2 cm. Wou	e wound depth due to 50 bed covered by slough. Wound vere 90% epithelialized, 5% bugh and no eschar. Wound ted 8/9/17, identified pressure ength 2 cm, width 1 cm and and bed percentages were 92% granulation, no slough, and 4%					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED	
		00146	B. WING	B. WING		08/10/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- RAIII FIAKF	NHAVEN DRIV LAKE, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	age 11	2 900				
	heel, related to the and Parkinson's dis staff to assist to tur hours when sitting, at all times, float he provide Prevalon b to left foot, and Rol On 8/8/17, at 2:48 room, lying on his b closed. He had a p chin which exposed R6 wore a yellow a foot and a black Pr	e pressure ulcer to the left need for mobility assistance sease. R6's care plan directed in/reposition at least every two avoid positioning feet on bed eels with pillow while in bed, oot (pressure reduction boot) no cushion when in wheelchair p.m. R6 was observed in his back in his bed with his eyes laid blanket pulled up to his d his feet and legs to mid-shin. and white non-skid sock on left evalon boot on his right foot sent. Both feet/heels rested					
	and trained medica him from his room black Prevalon boc and his left stocking on the pedal of the crossed and his rig	as seated in his wheelchair ttion aid (TMA)-A propelled R6 to the unit day room. The of remained on R6's right foot g covered foot rested directly wheelchair. R6's legs were ht boot rested directly on top g the left heel onto the pedal of					
	NA-B removed the right foot and perfo stretches to his right resting directly on t	d knelt next to his wheelchair. black Prevalon boot from R6's rmed hamstring and heel cord nt leg, with R6's left heel he wheelchair pedal. At 3:37 d the Prevalon boot to R6's					
	wheelchair with bla	mained seated in his ck Prevalon boot to right foot, vered with a yellow and white					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
				A. BUILDING:			
		00146	B. WING		08/	10/2017	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
GOOD S	AMARITAN SOCIETY		NHAVEN DRIV LAKE, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 900	Continued From pa	age 12	2 900				
	Director of nursing with surveyor and of was on the right for directly on the peda confirmed R6 had a ulcer to his left hee boot was to be app right foot. DON the At 3:46 p.m. R6 re when TMA-A and N propelled him to his wheelchair to his b (CM)-A entered the R6's yellow and wh foot. CM-A visualize indicated it had har (pink-red moist tiss when it starts to he	mained in the same position NA-A approached R6 and s room to transfer from ed. DON and clinical manager e room and CM-A removed hite non-skid sock from his left ed R6's pressure ulcer and rd edges with granular tissue sue that fills an open wound, al) in the base and eschar ed R6 had an unstageable					
	DON, CM-A confirm on the incorrect foo pressure reduction (for wound healing) left foot to keep his stated she would e followed. DON stat follow R6's care pla		N				
	completed wound o unstageable press ulcer measuremen cm x 0.2 cm and ha with granulation, st	a.m. registered nurse (RN)-A care on R6's left heel ure ulcer. RN-A stated R6's ts were 1 centimeter (cm) x 2 ad a 0.4 x 0.7 cm open area iff edges, four percent eschar, percent epithelium (the outside					

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00146	B. WING		08/10/2017	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S		00/10/2011	
	AMARITAN SOCIETY	A BATTIELAKE 105 GLE	NHAVEN DRIV	'E		
.000.0/		BAIILE	LAKE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 13	2 900			
	surfaces of the boo stated interventions ulcer included to el reposition every two protein supplement R6 the previous da left foot and indicat time the boot had b On 8/9/17, at 9:49 a dependent on staff mechanical lift for t interventions to reli pressure reduction reduction cushion i place a pillow unde On 8/9/17, at 12:49 interview, RN-A ind measurements on of new eschar was she had completed she would expect th all times and would legs floating heels of On 8/10/17, at 10:5 (NP)-A stated if a re on the heel she wo would be used to re at all times.	overs all the free, open dy including the skin). She is in place for R6's left heel evate left heel off bed, o hours while sitting, and a t. RN-A stated she had seen by with the Prevalon boot on his ted she was unaware what been placed on the wrong foot. a.m. NA-C stated R6 was for all cares and required a transfers. She indicated ieve pressure included boot to left foot, pressure in wheelchair and staff were to er his legs while lying in bed. 9 p.m. during a follow up dicated R6's pressure ulcer 8/9/17 were larger than 8/2/17. RN-A stated the area not present in 8/2/17 when d dressing change. RN-A stated he boot to be on the left foot at d expect the pillow under his when in bed. 50 a.m. nurse practitioner esident had a pressure ulcer ould expect that a pillow or boot elieve pressure from the area	1			
	street clothes with	a white sock on his right foot on boot on his left foot.				

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00146	B. WING		08/	10/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S			
GOOD S	AMARITAN SOCIETY	- RATTLE LAKE	NHAVEN DRIV LAKE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	lge 14	2 900		.,	
	Continuous observa 7:03 a.m. to 9:18 a. seated in his wheel dayroom facing the remained seated in dayroom. R6 reach wheels of his whee forward until he bur armchair. At 7:45 a approached R6 and his room. RN-A cor foot while R6 remain At 7:53 a.m. RN-A wheelchair from his positioned his whee licensed practical in at the table and ass with a spoon and in 8:22 a.m. NA-D bro sat next to R6 and At 8:50 a.m. R6 rer wheelchair, indepen NA-D approached I dining room to the of area. R6 remained 9:18 a.m. when NA assisted R6 to prop dayroom to his roon wheelchair to bed. from 6:45 a.m. to 9 33 minutes. On 8/9/17, at 9:53 totally dependent o living (ADL). She in wear his boot (pres assisted to reposition seated, and use a rest of the seated.	ations were conducted from .m. At 7:03 a.m. R6 remained chair in the middle of the main television. At 7:41 a.m., R6 his wheelchair in the ed down and moved the lchair, propelling himself mped his feet into a nearby m RN-A entered the dayroom, d propelled his wheelchair to mpleted wound care to his left ined seated in his wheelchair. assisted R6 to propel his s room to the dining room and elchair at a table. At 8:06 a.m. urse (LPN)-A approached R6 sisted R6 to take medications nmediately walked away. At bught R6's breakfast items and assisted him to eat breakfast. nained seated in his ndently drinking coffee. At 9:00 R6 and wheeled him out of dayroom and walked out of the seated in his wheelchair until -D entered the area and bel his wheelchair from the m and assisted him from his R6 had not been repositioned :18 am, a total of 2 hours and a.m. NA-C stated R6 was n staff for activities of daily dicated R6 was supposed to sure reduction) on his left foot, on every two hours when mechanical lift with two staff to lchair to bed. NA-C indicated				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00146	B. WING		08/10/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		NHAVEN DRIV LAKE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 15	2 900			
	wheelchair "around	7:00 or so."				
	assisted R6 to tran the early morning. assisted R6 to tran wheelchair at 6:45	b.m. NA-D indicated she sfer from bed to wheelchair in She confirmed she had sfer from his bed to his a.m.				
	R44					
	R44 had diagnoses disease, psychotic depression. The M short and long term severely impaired of decision making. T totally dependent of required extensive toileting, personal h Further, the MDS is	IDS dated 4/18/17, indicated s which included Alzheimer's disorder, anxiety and DS indicated R44 had both n memory problems, and had cognitive skills for daily he MDS indicated R44 was in staff assistance for transfers assistance with bed mobility, hygiene and did not ambulate. dentified R44 was at risk for elopment and did not have cers.	i,			
	rapidly progressing behavioral disturba all ADLS, had decli indicated R44 requ anticipation of need communication, ga being hard of heari indicated pressure	/19/17, indicated R44 had Alzheimer's disease, acute ince, required assistance with ned in his abilities. The CAA ired staff to assist with ds due to trouble with urbled speech and history of ng. The CAA summary ulcers had triggered for R44 essed on R44's care plan.				
	R44 had both short problems, and had skills for daily decis	OS dated 7/12/17, indicated t and long term memory severely impaired cognitive sion making. The MDS totally dependent on staff				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00146	B. WING		08/	08/10/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	1		
OOD S	AMARITAN SOCIETY	' - BATTIEIAKE	NHAVEN DRIV LAKE, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE	(X5) COMPLE DATE	
0.000	0 11 15			DEFICIENC			
2 900		•	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.						
	Evaluation dated 7 at risk for skin brea repositioning plan mattress in place a	ositioning Assessment & /12/17, indicated "Resident is akdown and is on scheduled for this. Pressure reduction and has Roho cushion in w/c II. No pressure related open neasures in place.					
	8/9/17 revealed a r identified R44 had	rogress Notes from 7/20/17 to note dated 7/26/17, which developed a new unstageable oft medial heel, with stable nage.					
	a current unstagea medial heel related dementia, and req R6's care plan liste included reposition	vised 8/3/17, indicated R44 had ble pressure ulcer to left to immobility, had advanced uired assistance with ADL's. ed various interventions which at least every two hours wher on in wheelchair and Prevalon all times.					
	in a wheelchair wit television in the lar sleeve shirt and pla boot on his left foo were conducted fro 7:03 a.m R44 rema with his eyes close RN-A entered the o	a.m. R44 was observed seated h his eyes closed, facing the ge dayroom. R44 wore a long aid pajama pants, and a blue t. Continuous observations om 7:03 a.m. to 9:25 a.m. At ained seated in a wheelchair d in the dayroom. At 7:30 a.m. dayroom, approached R44 and is wheelchair to his room. At					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- RATTIFIAKE	NHAVEN DRIN LAKE, MN 56			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	i i	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	age 17	2 900			
	evaluation of R44's R44 sat in the whee propelled R44 in his back to the dayroor seated in his wheel entered the dayroo wheelchair from da room. At 8:22 a.m. nurse(LPN)-A brieff clothing protector a At 8:28 a.m. LPN-A assisted R44 to eat LPN-A left the table continued to assist a.m. R44 remained the table with eyes headrest. At 9:02 a dining room and ba remained seated in when NA-D approa his room. At 9:25 a mechanical lift to tr wheelchair to bed. incontinent brief an area was noted to b been repositioned f total of 2 hours and On 8/9/17, at 9:30 a area on R44's cocc she would notify LF NA-C indicated R44 on his left heel and two hours when sec cushion in wheelch mattress. During for	ly approached R44, applied a and immediately walked away. A sat down next to R44 and t breakfast. At 8:34 a.m. e and NA-D sat down and R44 to eat his meal. At 8:59 I seated in his wheelchair at closed and head against the .m. NA-D propelled R44 out of ack into the dayroom. R44 his wheelchair until 9:22 a.m., iched him and propelled him to .m NA-C and NA-D utilized a ansfer R44 from his NA-C loosened R44's d R44's skin over his coccyx be bright red. R44 had not from 6:45 a.m. to 9:25 a.m., a 40 minutes. a.m. NA-C indicated the red cyx area was new and stated 2N-A of this change for R44. 4 had a current pressure ulcer required repositioning every ated, pressure reduction air and pressure reduction illow up interview at 2:10 p.m. ad assisted R44 into his				

Minnesc	ta Department of He	ealth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00146	B. WING		08/1	0/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		NHAVEN DRI LAKE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	On 8/9/17, at 12:59 had an current uns left medial heel. Sh repositioned every On 8/10/17, at 1:4 admission R44 wa ulcers, but now a h CM-A confirmed R stated she would e reposition R44 eve On 8/10/17, at 2:0 totally dependent of risk for developme stated R44 had de unstageable press on 7/2/17. She indi directions for repose when seated and e stated if R44 was r hours while seated development of pre expected staff to for indicated staff show within 10-15 minute wheelchair. Review of the facilit Practice Guidelines resident will be as implemented to ad contribute to the th breakdown. The po- turning and position developed based of assessments. Review of facility p	p.m. RN-A confirmed R44 tageable pressure ulcer on his ine indicated R44 was to be				
STATE FOR			6899	C9I211	If continuatio	n sheet 19 of 24

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00146	B. WING		08/10/2017		
AME OF F	PROVIDER OR SUPPLIER	STREET AI	ADDRESS, CITY, STATE, ZIP CODE				
OOD S	AMARITAN SOCIETY						
(X4) ID	SUMMARY ST		LAKE, MN 56	PROVIDER'S PLAN OF	COBRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLE DATE	
2 900	Continued From pa	age 19	2 900				
	resident based on t assessment. The p care plans would b change of condition SUGGESTED MET The director of nurs implement policies ensuring staff comp routinely monitor al until resolved and p ulcers. The quality assess	oolicy also indicated resident be reviewed, updated with a in for the resident. THOD FOR CORRECTION: sing (DON) or designee could and procedures related to oblete appropriate interventions, I pressure ulcers for healing prevention of new pressure ment and assurance erform random audits to					
21375	days.	R CORRECTION: Twenty (21)	21375			9/13/17	
	Program		2.070			0/10/17	
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.					
	by: Based on interview facility failed to imp program policies to influenza to the Sta	ent is not met as evidenced and document review, the lement their infection control report a facility outbreak of te agency (SA). This deficient tential to affect all 50 residents facility.	;	Corrected			

C9I211

If continuation sheet 20 of 24

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00146	B. WING		08/10/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	/ - 84111 - 146 -	NHAVEN DRIV LAKE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
21375	Continued From pa	age 20	21375			
	Findings include:					
	Resident Infections indicated one positi of its three identifie Fisherman's Cove Fisherman's Cove with identified lowe Heritage Lane had cultured for influen additional residents	ity form titled Monthly Report of s in Center dated 2/17, tive influenza A culture on each and Cottonwood Grove). also had three other residents er respiratory infections. three additional residents za. Cottonwood Grove had two s with lower respiratory residents were cultured for				
	assistant director of the facility's infection above findings. AD she had completed indicated she woul had been submitte	v on 8/10/17, at 3:09 p.m. the of nursing (ADON), who was on control nurse, confirmed the OON stated she was unsure if d a influenza report form and d call SA to verify the report d. At 4:10 p.m. ADON ity influenza outbreak had not ne SA.				
	Monitoring and Ex Outbreaks/Epidem Disease dated 3/10 department will be	rocedure titled Infection posure Control ics/Seasonal Infectious 6, indicated, "The local health notified regarding the if it is a reportable disease."				
	Long-Term Care F 2016-2017 dated 9 definition of an out influenza-like illnes laboratory-confirm along with other ca	partment of Health form titled acility Influenza Report Form, 0/2016, specified, "The break is: Two residents with ss (ILI) or one ed influenza positive case ases of respiratory infection in a icated submitting the report	ı			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00146	B. WING		08/	08/10/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- RATTIFIAKE	ENHAVEN DRIN LAKE, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21375	Continued From pa	ge 21	21375				
	was sufficient for re	porting an outbreak.					
	The director of nurs develop and impler related to reporting reportable infection spread of illness. In designee, could de and procedures rela- and ensure the faci completed and revi designee could edu the quality assessm	HOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures to the state agency incidence s in the facility to minimize the n addition, the DON or velop and implement policies ated to Legionnaires' disease lity risk assessment is ewed periodically. The DON of acate staff on the policies and nent and assurance committee om audits to ensure	s e or				
	(21) days.	R CORRECTION: Twenty-one					
21620	MN Rule 4658.134	5 Labeling of Drugs	21620			9/13/17	
	Drugs used in the r in accordance with	nursing home must be labeled part 6800.6300.					
	by: Based on observative review, the facility for labels with direction for 1 of 1 resident (during medication and Findings include: R37's Order Summer	ent is not met as evidenced ion, interview, and document ailed to ensure the accurate is for use were on medication R37) insulin pen observed administration.	S	Corrected			

STATE FORM

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00146	B. WING		08/	10/2017
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S			
GOOD S	AMARITAN SOCIETY	'- RATTIEIAKE	NHAVEN DRIV LAKE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21620	Continued From pa	age 22	21620			
	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. On 8/7/17, at 6:45 p.m. registered nurse (RN)-B					
wa ca dra Ins na an un ins un W R3 an 8 u Sta pa cu ev ha cu 11 Or (P wh no mo	was observed stan cart outside of R37 drawer of the medi Insulin pen from th name on the pen. I and set the dial of	ding next to the medication "s room. She opened the first cation cart and removed a blue e drawer, labeled with R37's RN-B primed the Insulin pen the pen for delivery of four				
	insulin pen dated 8 units of Insulin at Iu	e medication label on the 3/4/17, directed staff to inject 8 unch and supper. at that time, RN-B confirmed				
	R37's Insulin pen la and stated R37's c 8 units at noon and stated R37's dose past, from 8 units e currently 8 units at evening. RN-B indi have had a sticker	abel was incorrectly labeled, urrent order was to administer d 4 units in the evening. She of Insulin had changed in the each lunch and supper, to noon and 4 units in the icated the Insulin pen should placed on it to reflect the h had been ordered on				
	(PC) confirmed the when an order was noting dose chang	p.m. the pharmacy consultant e usual facility practice, for s changed, was to apply a label e or directing staff to electronic new dosage instructions to				
magnetic D	(DON) confirmed t stated a sticker she interim on R37's in changed and the p	p.m. the director of nursing he current facility policy and ould have been placed in the sulin pen when the order was harmacy notified of that order				
innesota D TATE FORI	epartment of Health	harmacy notified of that order	6899 C	91211	If continuati	on sheet 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		DATE SURVEY	
		00146	B. WING		08/10/2017	
	PROVIDER OR SUPPLIER	A BATTIELAKE 105 GLE	DDRESS, CITY, STATI NHAVEN DRIVE LAKE, MN 56515	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE	
21620	change. Review of the facili Medication-Change 12/2015, directed s inaccurately or imp the dispensing pha prescriber's direction allowed the nurse to check chart or similindicate changes in SUGGESTED MET The director of nur implement policies labeling medication necessary such as assessment and as perform random au	-				

		AND HUMAN SERVICES & MEDICAID SERVICES			F51122222	FORM	: 09/13/2017 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		E CONSTRUCTION 01 - Main Building 01		E SURVEY IPLETED
		245403	B. WING			08/	09/2017
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	GOOD SAMARITAN SOCIETY - BATTLE LAKE				05 GLENHAVEN DRIVE ATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECT TAG CROSS-REFERENC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	КC	000			
	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.					
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm Marshal Division. A Samaritan Society I was found not in correquirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 10 Chapter 19 Existing edition of NFPA 99, PLEASE RETURN	articipation in at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), 9 Health Care and the 2012 Health Care Facilities Code THE PLAN OF R THE FIRE SAFETY TAGS) TO: spections Division			EPOC		
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	_	TITLE		(X6) DATE
	ically Signed						08/31/2017
Anudafiaiana	watatamant and inc with	an actoriale (*) denotes a deficiency wh	ich tha in:		on may be excused from correcting providing	tit is dete	armined that

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.

	OF DEFICIENCIES	& MEDICAID SERVICES				0. 0938-039 TE SURVEY	
	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01		COMPLETED	
		245403	B. WING		08/09/2017		
AME OF F	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	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE	
K 000	Continued From pa St. Paul, MN 5510	-	K 000	D			
	Or by e-mail to: Marian.Whitney@s and Angela.Kappenma						
		RRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION:					
	1. A description of to correct the defic	what has been, or will be, done iency.					
	2. The actual, or p	roposed, completion date.					
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency					
	1-story building, wi building was built in be Type II(000) con the south of the we north wing (Occup OT/PT) were cons were determined to In 2004 a small ve wing which include Type II (000) const link, to the new ass added to the south	an Society Battle Lake is a thout a basement. The original n 1973 and was determined to nstruction. In 1994 additions to est wing and to the north of the ational and Physical Therapy - tructed. The 1994 additions to be Type V(111) construction. stibule was added to the west ad a walk in freezer, which is ruction. In 2007 a connecting sisted living apartments, was wing and was determined to					
	was constructed to which is 1-story, no construction. In 20	2010 an entrance addition the north of the dining room basement and Type II (000) 11 a 16 bed addition was of the north wing and was					

Facility ID: 00146

If continuation sheet Page 2 of 8

				TIPLE CONSTRUCTION		0. 0938-039 TE SURVEY	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	DING 01 - MAIN BUILDING 01		MPLETED	
		245403	B. WING		08	/09/2017	
AME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		CODE		
OOD S	AMARITAN SOCIETY	- BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
K 000	Continued From pa	ge 2	к	000			
	addition was added wing and was deter construction. The smoke compartment barriers. Since all the differe separated by a 2 ho considerd V(111) as The entire building system installed in Standard for the Ins . A fire alarm system detection and smok which was updated NFPA 72 "The Nation monitored for autor notification.	ype II (111) and a 8 bed to the east of the south east mined to be Type II (111) building is divided into 3 hts by 30 minute rated fire nt construction types were not bur fire barrier, the building is sper 8.2.1.3 of NFPA 101. is sprinkler protected with a accordance with NFPA 13 stallation of Sprinkler Systems m with corridor smoke the detection in common areas in 2010 in accordance with onal Fire Alarm Code" that is natic fire department					
	inspection.	42 CFR, Subpart 483.70(a) is					
K 131 SS=E	NFPA 101 Multiple Multiple Occupanci Facilities Sections of health o other occupancies	Occupancies es - Sections of Health Care care facilities classified as meet all of the following:	K	131		8/31/17	
	inpatients. * They are separate occupancies by cor	nded to serve four or more ed from areas of health care nstruction having a minimum ce rating in accordance with					

Facility ID: 00146

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING	G 01 - MAIN BUILDING 01	COMPLETED 08/09/2017			
		245403	B. WING					
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
OOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515				
(X4) ID PREFIX T A G	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE		
K 131	Continued From pa	age 3	K 13	1				
	approved, supervision accordance with Hospital outpatient required to be class Care Occupancy repatients served. 18.1.3.3, 19.1.3.3, 485.623 This STANDARD Based on observat facility failed to ma resistive ratings for the Life Safety Cool section 19.1.3.3. T allow for the transf another occupancy	g is protected throughout by an sed automatic sprinkler system Section 9.7. surgical departments are sified as an Ambulatory Health egardless of the number of 42 CFR 482.41, 42 CFR is not met as evidenced by: tion and staff interview the intain the proper 2 hour fire occupancies as described in le (NFPA 101) 2012 edition his deficient practice could er of smoke or fire from and affect 10 of the 46 indetermined amount of staff		The penetration in the 2 hour fire has been sealed effective 8/31/17 Maintenance staff will make routin inspections following any service technicians providing services tha involve penetrations through fire b	e t may			
	Findings include:							
	revealed a 1 1/2 in barrier above the o the physical therap unapproved fire sto	/09/2017 observations ch penetration in the 2 hour fire ceiling at the entrance door to by room and there was opping in a penetration of the 2 ove the ceiling at the entrance nk.				,		
K 324	Maintenance Engi		К 32	4		9/29/17		
SS=D		t is protected in accordance ndard for Ventilation Control						

and the second stands of the	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATI	E SURVEY	
	FCORRECTION	IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01	СОМ	COMPLETED	
		245403	B, WING	STREET ADDRESS, CITY, STATE, ZIP CODE		09/2017	
AME OF F	PROVIDER OR SUPPLIER						
SOOD S	AMARITAN SOCIETY	- BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
K 324	Continued From pa	ae 4	K 324	4			
		of Commercial Cooking	I. UL				
	Operations, unless						
		g equipment (i.e., small					
		microwaves, hot plates, for food warming or limited					
		nce with 18.3.2.5.2, 19.3.2.5.2					
	* cooking facilities of	open to the corridor in smoke					
		30 or fewer patients comply					
	or	under 18.3.2.5.3, 19.3.2.5.3,					
		n smoke compartments with					
	30 or fewer patients	s comply with conditions under					
	18.3.2.5.4, 19.3.2.5	6.4. rotected according to NFPA 96					
		quired to be enclosed as					
		out shall not be open to the					
	corridor.			1			
	18.3.2.5.1 through 19.3.2.5.5, 9.2.3, T	18.3.2.5.4, 19.3.2.5.1 through					
	19.0.2.0.0, 9.2.0, 1	IN 12-2					
	This STANDARD	s not met as evidenced by:					
		tion and staff interview the		The pull station will be relocate			
		vide supervision of the cooking		applicable standards effective	9/29/17.	1	
		d in the Life Safety Code dition section 9.2.3 & NFPA 96					
		is deficient practice could					
	prevent staff from e	extinguishing the fire causing					
	evacuation affecting visitors in the kitche	g all residents, staff and en area.					
	Findings include:						
	the ANSUL pull sta	09/2017 observations revealed tion was located approximately ve, requirement is 10 feet					

Facility ID: 00146

If continuation sheet Page 5 of 8

STEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER		01 - MAIN BUILDING 01		COMPLETED	
		245403	B. WING		08/0	09/2017	
AME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
OOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
K 324	Continued From pa	age 5	K 324				
:	This deficient cond Maintenance Direc	lition was confirmed by the tor.					
K 3 41 SS=F		rm System - Installation	K 341			9/29/17	
	components appro accordance with N and NFPA 72, National provide effective w building. In areas n detection is installed unit. In new occupa at notification appli and supervising sta	n is installed with systems and ved for the purpose in FPA 70, National Electric Code onal Fire Alarm Code to arning of fire in any part of the not continuously occupied, ed at each fire alarm control ancy, detection is also installed ance circuit power extenders, ation transmitting equipment. wiring or other transmission ed for integrity.	,				
	Based on observa facility failed to inst accordance with N (2012) section 19.3 National Fire Alarm This deficient pract the alarm system to during a fire event	is not met as evidenced by: tions and staff interview the tall the smoke detection in FPA 101 Life Safety Code 3.4.1, 9.6.1.3 and NFPA 72 in Code (2010) section 17.7.4.1 tice could affect the ability of o sound in a timely manner which could affect all of the 46 undetermined amount of staff		The smoke detectors identified numbers 1 & 2 will be relocated with applicable standards effect 9/29/17.	to comply		
	Findings include:		1				

Event ID: C9I221

Facility ID: 00146

If continuation sheet Page 6 of 8

		& MEDICAID SERVICES			MB NO.	E SURVEY	
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		COMPLETED	
		245403	B. WING		08/09/2017		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
K 341	smoke detector loc diffuser. 1. At 11:35 am a st wing. 2. At 11:36 am a s cottonwood wing 3. At 11:56 am a s Fisherman's Cove	led several locations had a ated within 3 feet of an HVAC orage room in the cottonwood oiled utility room in the torage room in the wing. he laundry room in the	K 3	41			
	Maintenance Direc NFPA 101 Subdivis Smoke Barrie	itions was confirmed by the tor. sion of Building Spaces - ding Spaces - Smoke Barrier	К 3	72		8/31/17	
	fire resistance ratin be permitted to tern Smoke dampers an penetrations in fully an approved sprink smoke compartme barrier. 19.3.7.3, 8.6.7.1(1) Describe any mech in REMARKS. This STANDARD Based on observa facility failed to mail barriers as required	nanical smoke control system s not met as evidenced by: tion and staff interview the intain one of four smoke d by the 2012 Life Safety Code		The penetration identified in this been sealed effective 8/31/17. Maintenance personnel will make			
	barriers as required (NFPA 101) section deficient practice c			Maintenance personnel will make inspections following any service technicians providing services th involve penetrations through fire	at may		

ł

Facility ID: 00146

If continuation sheet Page 7 of 8

		AND HUMAN SERVICES				ORM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3)	DATE SURVEY COMPLETED
		245403	B. WING		_	08/09/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST.	ATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 565	515	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PL (EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIATI ICIENCY)	(X5) COMPLETION E DATE
	Continued From pa affecting the exiting an undetermined at Findings include: At 10:45 am on 08/ revealed a penetrat cable bundle above corridor doors of th	nge 7 g of 10 of the 46 residents and mount of staff and visitors. 09/2017 observations tion around a conduit and a e the ceiling at the cross e Heritage Wing. ition was confirmed by the	K 37		(CIENCY)	
FORM CMS-28	567(02-99) Previous Versions	Obsolete Event ID: C9I221	1	Facility ID: 00146	If continuatio	n sheet Page 8 of 8

PRINTED: 09/13/2017