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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EQ1N

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00146

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

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

4. TYPE OF ACTION: 7 (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/03/2014** (L34)
09/04/2014

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 09/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/11/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00140 (L31)

30. REMARKS
Posted 09/24/2014 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
09/03/2014 (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245403

September 10, 2014

Mr. James Wolf, Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, Minnesota 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 3, 2014 the above facility is certified 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 t0o non-renewal or termination.

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

Sincerely,

Mark Meath

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

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 10, 2014

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

Project Number S5403023

Dear Mr. Wolf:

On July 31, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 17, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On September 3, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 4, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 3, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 17, 2014, effective September 3, 2014 and therefore remedies outlined in our letter to you dated July 31, 2014, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245403	A. Building B. Wing	9/3/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **08/26/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **08/26/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/26/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **08/26/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **08/26/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **08/26/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/mm	09/10/2014	28034	09/03/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/17/2014			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245403	A. Building / B. Wing: 01 - MAIN BUILDING 01	9/4/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix: Reg. # NFPA 101 LSC K0029	08/08/2014	ID Prefix: Reg. # NFPA 101 LSC K0056	09/03/2014	ID Prefix: Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/mm	**Date:** 09/10/2014	**Signature of Surveyor:** 27200	**Date:** 09/04/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/15/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245403	A. Building B. Wing 02 - 2007 CONNECTING LINK	9/4/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 09/03/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/mm	Date: 09/10/2014	Signature of Surveyor: 27200	Date: 09/04/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/15/2014	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EQ1N

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00146

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

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

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/17/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): **YES** (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NEII 08/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/02/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

July 31, 2014

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

RE: Project Number S5403023

Dear Mr. Wolf:

On July 17, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

<u>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;

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

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 August 26, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 17, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 17, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
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cc: Licensing and Certification File 5403s14epoc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to complete an assessment to determine safe self administration of medication for 1 of 1 resident(R78) observed receiving a nebulizer treatment. Findings include: R78's admission Minimum Data Set (MDS) dated 6/24/14, revealed R78 had diagnoses which included Asthma, Chronic Obstructive Pulmonary Disease (COPD) or Chronic Lung Disease and heart failure. The MDS identified R78 had	F 176	A. Resident #78 was assessed for self-administration and is able to self-administer nebulizer treatment independently once medication has been set up. B. All medical records of current residents with neb treatments were reviewed to ensure all had a current self-administration assessment completed. C. All residents admitted to this facility and those experiencing cognitive or physical changes that would impede	8/26/14

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

Electronically Signed | 08/07/2014

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F 176	Continued From page 1 moderate cognitive impairment, required extensive assistance with dressing, personal hygiene, toileting and transferring. R78's Care Area Assessment (CAA), dated 6/30/14, for cognitive loss/dementia identified R78 had confusion, disorientation, forgetfulness and identified heart failure and respiratory status could affect R78's cognition with the oxygen level. Review of R78's medication records from 6/18/14 to 7/15/14 revealed R78 received DuoNeb (combination medication used to treat bronchospasms with COPD) 0.5-2.5 milligrams per milliliter orally per nebulizer treatment three times daily since 6/17/14. R78 also received Symbicort Aerosol (combination of steroid and bronchodilator medications) 160-4.5 2 puffs orally two times daily since 6/17/14. On 7/14/14 at 7:48p.m., R78 was observing sitting on the edge of the bed, alone in his room. R78 held his hand to the steaming mask covering his nose and mouth which was connected to a nebulizer machine to the side of the bed. Licensed practice nurse (LPN)-B was observed walking down the hall by the main entrance of the facility, with several items of dirty linen in her left hand. She walked to a hamper in the hallway, placed the linen in the hamper and continued to walk down the hallway. LPN-B stopped in a resident's room near the main entrance, briefly talked to the resident and then returned to the hallway of the facility. At 7:52 p.m., R78 remained seated on the bed, holding the steaming mask covering his nose and mouth. During interview at that time, R78 stated he received nebulizer treatments daily and facility staff routinely left the room during the treatments.	F 176	proper administration of the medication will have a self-administration of medication assessment completed. Education was provided to all LPNs, RNs, and TMAs on 7/23/14, 8/4/14, and 8/5/14 regarding safe medication administration to ensure all nursing staff understand that nebulizer treatments must be observed unless self-administration order is in place. Nursing staff will be educated of this practice upon hire. D. Random observation audits of nebulizer treatments will be done weekly x4 and monthly x3 to ensure meds are being administered appropriately and to ensure self-administration of medication assessments have been completed. Results of these audits will be discussed and reviewed at QA meetings for further recommendations.	

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F 176	Continued From page 2 On 7/14/14, at 7:54 p.m., R78 remained seated on the bed, alone in his room with the steaming nebulizer mask to his face. LPN-B entered the room at that time and confirmed she had left R78's room after handing the mask to R78. LPN-B stated she routinely left R78's room after starting the nebulizer machine for the treatment. She stated she was not aware if R78 was able to self administer medications and stated "I let him give his own inhalers, so it must be ok." On 7/15/14, at 8:47 a.m. the assistant director of nursing (ADON) stated the usual facility practice included an assessment for the ability to safely self administer medication for the individual resident prior to allowing them to self administer medications. On 7/15/14, at 8:57 a.m. LPN-C confirmed R78 received nebulizer treatments and inhalers daily and stated R78 had not been assessed for the ability to safely self administer medications. LPN-C stated R78 was confused at times, especially in the evenings. She indicated R78 should not be left alone to self administer medications and confirmed the usual facility practice was to assess any resident for safe ability to self administer prior to allowing them to self medications in the facility. On 7/15/14, at 2:36 p.m. the director of nurses (DON) confirmed the current facility policy and indicated the assessment done prior to self administration of medication included assessment of the resident's knowledge of the purpose of the medications, possible side effects, and if they can properly set up and administer the medications. The DON confirmed R78 had	F 176		

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F 176	Continued From page 3 not been assessed for the ability to safely self administer medications and stated "he should of been." She stated when the assessment had not been completed, she would expect the nurse to stay with the resident during the entire medication administration. The DON indicated it was not acceptable to leave R78 alone during the nebulizer treatments and also indicated R78 should not be left alone to self administer inhaler medications. Review of the facility policy titled Resident Self-Administration of Medication, revised 7/14 revealed a assessment of a resident's ability to safely administer medication would be completed, and the interdisciplinary team (IDT) would determine whether each resident who expresses a desire to self-administer medications can do this successfully. The IDT team would determine if the resident had any educational needs or accommodation in order to self-administer medication and that determination must be documented in the medical record. The policy indicated the assessment and determination by the IDT team would be completed prior to the resident self-administering medications in the facility. In addition, a physician's order for the specific medication to be self-administered would be obtained prior to the resident self-administering the medications.	F 176		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		8/26/14

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F 241	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to enhance the dining experience for 5 of 18 residents (R51, R9, R13, R22, R82) during observation of the breakfast meal in the Heritage dining room. In addition, the facility failed to ensure a dignified dining experience for 3 of 3 residents (R23, R55, R63) who required assistance with eating during the supper meal observation on the Heritage unit. Findings include: During an observation on 7/14/14, at 5:30 p.m. R51 was seated in a stationary chair at a table in the heritage dining room. While R51 sat at the table in the dining room with 17 other residents, nursing assistant (NA)-B approached R51, reached over the small table and placed R51's upper denture, and then the lower denture into her mouth. Four residents were seated in direct view of R51 when her dentures were placed into her mouth at the dining room table. R13 sat directly across the table, R9 sat to the left, and R22 and R82 sat at the table to the right of R51. During interview on 7/14/14, at 7:10 p.m. NA-B confirmed he had brought R51's dentures to the dining room table and had placed them into R51's mouth at the table in view of the other residents. NA-B stated the "best thing" that staff could have done was to move R51 off to the side of the dining room to place the dentures in her mouth.	F 241	A. Resident #51 is having her dentures placed in her mouth in a private area prior to entering the dining room. Resident #9, #54, #63, and #23 are receiving assistance with eating according to their care plans. Any assistance needed will be done from a sitting position by the care-giver with appropriate hand washing done during the dining time. B. All residents requiring feeding assistance are receiving such assistance in a dignified manner with staff in a sitting position and eye-level with the resident. Education provided to all LPNs, RNs, and TMAs on 7/23/14, 8/4/14, and 8/5/14. Education provided to all CNAs on 8/6/14 regarding providing a dignified and enhanced dining experience. C. All residents requiring assistance with eating will receive it in a seated position and in a dignified matter. All nursing staff educated on dignity related to assistance with meals as well as providing privacy when giving residents personal care items. D. Social services and DNS or designee will conduct weekly observation audits x4 and monthly x3 to ensure that residents requiring assistance with eating are receiving assistance by staff who are sitting. Audits will also ensure that residents who require dentures will have them placed in a private setting before coming to the dining room. The finding of these audits will be discussed at the	

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F 241	Continued From page 5 During interview on 7/17/14, at 2:40 p.m. the director of nursing (DON) indicated it was not acceptable for staff to assist residents to place dentures in the dining room and confirmed she expected staff to take R51 to her room to put her dentures into her mouth. She stated R51's dentures should not have been taken to the dining table to be placed in R51's mouth. R55, R63 and R23 were not provided a dignified dining experience while facility staff assisted with eating the supper meal in the heritage dining room. R23's care plan (CP) revised 5/19/14, identified R23 had diagnoses which included dementia, memory loss, and diabetes. R23's CP identified R23 had impaired cognitive function, and required assistance from staff to complete all activities of daily living (ADL). Further review of the CP directed staff to give R23 cueing with occasional hands-on guidance and assistance with eating. R55's CP dated 5/20/14, identified R55 had diagnoses which included dementia, unstageable pressure ulcer, and depression. The CP identified R55 had impaired cognitive function, and required assistance from staff to complete all ADL's. Further review of the CP directed staff to assist R55 with eating. R63's CP dated 4/23/14, identified R63 had diagnoses which included Alzheimer disease, senile dementia, and depression. R63's CP identified R63 had impaired cognitive function,	F 241	monthly QA meetings fo further recommendations.	

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and required assistance from staff to complete all ADL's. Further review of the CP directed staff to assist R63 with guidance and cueing with assist of 1 at times with eating.

During continual observation of the supper meal on 7/14/14 at 5:42 p.m. R23, R55 and R63 were seated at a square table in the middle of Heritage dining room with various food items in front of them. Licensed practical nurse (LPN)-B was observed standing next to the table, in between R55 and R63, assisting R55 to eat food portions out of a maroon coffee cup. LPN-B put the cup on the table, turned to her right, picked up a spoon and assisted R63 to eat a bit of his supper, and proceeded to assist R63 to drink milk from a clear plastic glass. LPN-B continued to stand at the table, assisting R55 and R63 to eat food items until 5:49 p.m. At 5:49 p.m., LPN-B abruptly stopped assisting R55 and R63 with eating and walked across dining room to another table and approached another resident, asking her if she needed anything, then proceeded to get applesauce out of the refrigerator and brought the applesauce to the resident at the other table.

At 5:50 p.m. LPN-B walked back over to R55 and R63's table and proceeded to pick up the coffee cup and assisted R55 to drink from the coffee cup. She proceeded to offer R63 a spoonful of his coleslaw from his plate. LPN-A continued to stand next to table, between R55 and R63 as she assisted R55 and R63 to eat their supper. At 5:57 LPN-A walked to the other side of the table to R23 who was also seated at the table, stood next to R23 and proceeded to offer her a couple of spoonfuls of food. At 5:58 p.m. LPN-A left R23 and returned to R55 and R63 side of the table and again assisted R55 to eat from the maroon

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coffee cup, then turned to R63 and gave him a bite of his supper from a silver spoon. LPN-A continued to stand the entire time while assisting R23, R55, and R63 with eating their supper. At 6:09 LPN-A briefly sat down on the edge of a chair, visited with another staff member, while she continued to assist R55 and R63 to eat food items. At 6:11 p.m., LPN-A abruptly stood up and continued to assist R63 to eat more spoonfuls of his supper.

During interview on 7/14/14, at 7:50 p.m. LPN-A confirmed she stood the entire time while assisting R23, R55, and R63 with eating supper and stated "I ' m too short to sit down and feed the residents, so I stand it's more comfortable for me."

During interview on 7/16/14, at 12:21 p.m. the director of nursing (DON) confirmed staff should not stand while assisting residents to eat and indicated she expected staff to be seated at the same level of the resident while assisting them to eat. DON also confirmed staff should not be moving from table to table, interrupting eating, to assist residents to eat and indicated she expected staff to assist 1-2 residents at a time. The DON stated "this is definitely not dignified."

During interview on 7/16/14, at 12:58 p.m. registered nurse (RN)-B confirmed staff should be sitting when assisting residents with eating and stated "that's their meal time, its demeaning and they should be at eye level." RN-B verified this was not dignified to eat this way.

Review of the facility policy titled Dignity, revised 3/2004, indicated staff were to promote care for residents in a manner and in an environment that

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F 241	Continued From page 8 maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement fall interventions for 1 of 2 residents (R51) reviewed with a history of falls. Findings include: R51's care plan, revised 7/9/14 identified R51 was unaware of safety in environment, wandered, had poor judgement and decision making, macular degeneration, weakness, anxiety with delusions and a history of frequent falls. R51's care plan listed various interventions which included walker to be kept within reach when in bed and when in recliner to maximize resident safety, personal safety alarm when in bed and recliner to alert staff to resident's movement and to assist staff in monitoring movement and use of a body pillow to outside of bed when laying. During observation on 7/14/14, at 4:22 p.m. R51 was lying in bed in her room. R51 was lying on her left side facing the wall, with a body pillow	F 282	A. Fall interventions for resident #51 were reviewed and OT eval was completed. Care plan updated with new intervention of gray belt while in w/c to assist with fall prevention. Walker intervention remains part of the care-planned measures. B. All residents who have had falls one month prior to survey were reviewed to ensure that current interventions are in place and care plan is being followed. C. All newly admitted residents defined as being a fall risk or residents with new falls will be re-assessed and new interventions put in place. D. Education provided to nursing staff on 7/23/14, 8/4/14, and 8/5/14 to ensure that a fall risk assessment is completed with each fall at the time of the fall, adding new interventions at time of fall, and to ensure that current interventions are being carried out to assist with preventing further falls. Observational audits of current residents who have had falls	8/26/14

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F 282	Continued From page 9 behind her back and the tabs alarm (a fall monitoring system) clip attached to R51's shirt. The alarm monitor was secured to the grab bar closest to the door, on the side of the bed away from the wall, behind R51 ' s back. A wheel chair was next to the bed by the side rail, with the seat of the wheel chair facing the bed and a walker was placed at the foot of the bed. On 7/14/14, at 5:20 p.m. R51 was yelling "help, help, help" with both legs over the body pillow and pulling herself up with both hands on the grab bar. R51's body was partially over the top of the body pillow and top of grab bar with the personal safety alarm remaining mounted to the outside grab bar of the bed. R51 repeatedly leaned over the grab bar, and attempted to pull herself up out of bed. The personal safety alarm was not sounding. R51 continued to attempt to climb over the grab bar, with the personal safety alarm not sounding until 5:22 p.m. when the director of nursing (DON) entered the room in response to the call light activated by the surveyor. During an interview on 7/14/14, at 5:24 p.m. the DON confirmed the personal safety alarm was placed on the outside grab bar of R51's bed. She confirmed R51 was unable to exit the opposite side of the bed, with the bed up against the wall and confirmed the personal safety alarm mounting location was ineffective due to R51's climbing over the grab bar, not activating the alarm. She indicated the personal safety alarm should of been placed to allow for early activation to detect R51 attempting to self transfer to prevent further falls. During an interview on 7/14/14, at 7:10 p.m. NA-B confirmed R51 had a history of falls and indicated	F 282	within the month prior to survey will be done weekly x4 and monthly x3 by DNS or designee to ensure that care planned interventions are being implemented. Audits of residents who have had new falls will be reviewed to ensure new fall interventions have been put in place. These audits will be done by DNS or designee and will be done with each fall for the next month with results to QA for further recommendations.	

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R51 utilized a body pillow and tabs alarm in bed, tabs alarm in wheel chair and seat belt in wheel chair. NA-B stated the wheel chair was placed next to the bed in an attempt to prompt R51 "will sit in it" when she attempted self transferring. NA-B was unsure if the walker was to be placed next to the bed or recliner.

During an observation on 7/15/14, at 8:05 a.m. R51 was seated in the television area in a brown reclining chair with her feet elevated on the foot rest, a blanket covered her legs and a pillow behind her head. The personal safety alarm cord had been clipped to R51 ' s clothing and the alarm monitor fastened to the back of the wheel chair which was placed next to the right side of the reclining chair. A walker was not observed near R51's recliner at that time.

During a second observation on 7/15/14, at 2:10 p.m. R51 was in the recliner with her legs elevated on the foot rest, the clip of the personal safety alarm attached to her clothing and alarm box attached to the back of the wheelchair next to the right side of the recliner. A walker was not observed near R51's recliner at that time.

During an observation on 7/16/14, at 7:00 a.m. R 51 was alone, seated in the brown reclining chair with her legs elevated on the foot rest, in the television area near the main dining room. R51's wheel chair had been placed to the right of the reclining chair with the personal safety alarm attached on the back of the wheel chair and the cord clipped to R51's clothing. A walker was not near or in the area of R51'a recliner. At 7:17 a.m., R51 remained in the recliner with her legs elevated, a walker was observed approximately six feet in front of R51's recliner, in the middle of

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the television area. At 7:43 a.m., social worker (SW)-A walked through the television area, briefly stopped and moved the walker which remained approximately six feet away, to the left side of R51's recliner and immediately walked out of the area.

During an interview on 7/16/14, at 7:44 a.m. SW-A confirmed she had moved R51's walker and stated the reason for moving the walker was to move it " out of the way." SW-A confirmed she was not aware of care plan interventions related to the placement of the walker for R51.

During an observation on 7/16/14, at 1:06 p.m. R51 had been seated at the dining table in a stationary chair with no alarm, seatbelt, or walker in reach. R51 fidgeted, removed her sweat shirt, attempted to stand from the chair multiple times and at 1:07 p.m. stood from chair independently and held on to the table in front of her. Dietary aide (DA)-B approached R51 and assisted her to sit back down on the chair. DA-B attempted to assist R51 to reapply her sweat shirt, R51 refused the sweat shirt and DA-B proceeded to walk away from R51. At 1:10 p.m. R51 again self transferred from the chair to stand next to the table. A walker was not present. The DON entered the dining area and witnessed R51 self transferring and requested a facility staff member to bring R51's walker to her.

During an interview on 7/16/14, at 1:19 p.m. the director of nursing (DON) confirmed R51 had been in the dining room seated in a stationary chair without an alarm in place, her walker had not been within reach. The DON confirmed it would not be appropriate to have R51 seated in a chair without any of these interventions in place.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 12 The DON also confirmed R51 ' s walker should be within reach at all times to prompt her to use the walker if she were to attempt to self transfer. During an interview on 7/17/14, at 2:18 p.m. licensed practical nurse (LPN)C confirmed R51 ' s was at risk for falls. LPN-C confirmed R51 was unpredictable and could stand at any time, from any surface without warning. LPN-C stated R51 should have the personal safety alarm on if staff were not present with her and stated she understood R51 was to utilize a personal safety alarm when seated in a stationary chair.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation interview and document review the facility failed to comprehensively asses to prevent further falls for 1 of 2 residents (R51) reviewed with a history of falls and failed to consistently implement care plan interventions to minimize the risk of further falls for 1 of 2 residents (R51) reviewed with a history falls. In addition the facility failed to ensure safe use of a front wheeled walker for 1 of 1 resident (R15) who received therapy services.	F 323	A. Resident #51 interventions were reviewed and new intevention put in place on 7/22/14. Walker remains within resident's reach at all times. Personal safety alarm remains in place at all times. Physical therapist was immediately educated regarding safe transportation of resident #15 in relation to using front wheeled walker. Therapy staff now brings wheelchair along with resident to and from therapy so it can be used to sit in when	8/26/14

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F 323	Continued From page 13 Findings include: The significant change Minimum Data Set (MDS) dated 12/10/13, identified R51 had diagnoses including Alzheimer's disease, had moderately impaired cognitive skills for daily decision making, made poor decisions, and required cues and supervision. Further the MDS identified R51 required extensive assistance with bed mobility, transfers, ambulation in her room and in hallways, was not steady, and only able to stabilize with human assistance with walking, transfers, moving from seated to standing position. The MDS identified since the prior assessment R51 had experienced two or more falls with no injury and two or more falls with injury. R51's falls Care Area Assessment (CAA) with assessment reference date 12/10/13, identified R51 had diagnoses which included Alzheimer's disease, anxiety, depression congestive heart failure, osteoporosis, visual and hearing impairment, incontinence, and had difficulty maintaining sitting balance, impaired balance during transitions. However, the CAA lacked documentation if R51 had experienced previous falls, analysis of the data and lacked documentation if the care plan interventions would be implemented and the goal for any interventions implemented. R51's quarterly MDS dated 5/27/14 identified R51 had both short and long term memory problems, severely impaired cognitive skills for daily decision making, and rarely/never made decisions. Further the MDS identified R51 required extensive assistance with bed mobility, transfers, ambulation in her room and in hallways, was not steady, and only able to stabilize with	F 323	resident gets too tired to ambulate. B. All residents who use walkers and are at risk for falls have the potential of being affected by this deficient practice. C. Nursing staff educated on 7/23/14, 8/4/14, and 8/5/14 regarding safe transportation of residents who use front wheeled walkers. Therapist also educated immediately upon exit survey. Nursing staff instructed to add immediate interventions to the care plan at the time of incident report followed by on-the-spot education of CNAs regarding the specific implementation to ensure compliance and optimal safety of the resident. D. Random observation audits are being completed weekly x4 and monthly x3 by DNS and designees to ensure that no resident (if using independently) or staff member (if assisting a resident with ambulation) uses seated walker in an unsafe manner, and to ensure that all care planned interventions are being followed by all nursing staff. Report of random audits will be brought to QA meetings for analysis.	

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human assistance with walking, transfers, moving from seated to standing position. The MDS identified since the prior assessment period R51 had experienced two or more falls with no injury and one fall with injury.

R51's care plan revised 7/9/14, identified R51 was unaware of safety in environment, wandered, had poor judgement and decision making, macular degeneration, weakness, anxiety with delusions and a history of frequent falls. R51's care plan listed various interventions which included walker to be kept within reach when in bed and when in recliner to maximize resident safety, personal safety alarm when in bed and recliner to alert staff to resident's movement and to assist staff in monitoring movement and use of a body pillow to outside of bed when laying.

During observation on 7/14/14, at 4:22 p.m. R51 was lying in bed in her room. R51 was lying on her left side facing the wall, with a body pillow behind her back and the tabs alarm (a fall monitoring system) clip attached to R51's shirt. The alarm monitor was secured to the grab bar closest to the door, on the side of the bed away from the wall, behind R51 ' s back. A wheel chair was next to the bed by the side rail, with the seat of the wheel chair facing the bed and a walker was placed at the foot of the bed.

On 7/14/14, at 5:20 p.m. R51 was yelling "help, help, help" with both legs over the body pillow and pulling herself up with both hands on the grab bar. R51's body was partially over the top of the body pillow and top of grab bar with the personal safety alarm remaining mounted to the outside grab bar of the bed. R51 repeatedly leaned over the grab bar, and attempted to pull herself up out

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of bed. The personal safety alarm was not sounding. R51 continued to attempt to climb over the grab bar, with the personal safety alarm not sounding until 5:22 p.m. when the director of nursing (DON) entered the room in response to the call light activated by the surveyor.

During an interview on 7/14/14, at 5:24 p.m. the DON confirmed the personal safety alarm was placed on the outside grab bar of R51's bed. She confirmed R51 was unable to exit the opposite side of the bed, with the bed up against the wall and confirmed the personal safety alarm mounting location was ineffective due to R51's climbing over the grab bar, not activating the alarm. She indicated the personal safety alarm should of been placed to allow for early activation to detect R51 attempting to self transfer to prevent further falls.

During an interview on 7/14/14, at 7:10 p.m. NA-B confirmed R51 had a history of falls and indicated R51 utilized a body pillow and tabs alarm in bed, tabs alarm in wheel chair and seat belt in wheel chair. NA-B stated the wheel chair was placed next to the bed in an attempt to prompt R51 "will sit in it" when she attempted self transferring. NA-B was unsure if the walker was to be placed next to the bed or recliner.

During an observation on 7/15/14, at 8:05 a.m. R51 was seated in the television area in a brown reclining chair with her feet elevated on the foot rest, a blanket covered her legs and a pillow behind her head. The personal safety alarm cord had been clipped to R51 ' s clothing and the alarm monitor fastened to the back of the wheel chair which was placed next to the right side of the reclining chair. A walker was not observed

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F 323	Continued From page 16 near R51's recliner at that time. During a second observation on 7/15/14, at 2:10 p.m. R51 was in the recliner with her legs elevated on the foot rest, the clip of the personal safety alarm attached to her clothing and alarm box attached to the back of the wheelchair next to the right side of the recliner. A walker was not observed near R51's recliner at that time. During an observation on 7/16/14, at 7:00 a.m. R 51 was alone, seated in the brown reclining chair with her legs elevated on the foot rest, in the television area near the main dining room. R51's wheel chair had been placed to the right of the reclining chair with the personal safety alarm attached on the back of the wheel chair and the cord clipped to R51's clothing. A walker was not near or in the area of R51's recliner. At 7:17 a.m., R51 remained in the recliner with her legs elevated, a walker was observed approximately six feet in front of R51's recliner, in the middle of the television area. At 7:43 a.m., social worker (SW)-A walked through the television area, briefly stopped and moved the walker which remained approximately six feet away, to the left side of R51's recliner and immediately walked out of the area. During an interview on 7/16/14, at 7:44 a.m. SW-A confirmed she had moved R51's walker and stated the reason for moving the walker was to move it " out of the way." SW-A confirmed she was not aware of care plan interventions related to the placement of the walker for R51. During an observation on 7/16/14, at 1:06 p.m. R51 had been seated at the dining table in a stationary chair with no alarm, seatbelt, or walker	F 323		

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in reach. R51 fidgeted, removed her sweat shirt, attempted to stand from the chair multiple times and at 1:07 p.m. stood from chair independently and held on to the table in front of her. Dietary aide (DA)-B approached R51 and assisted her to sit back down on the chair. DA-B attempted to assist R51 to reapply her sweat shirt, R51 refused the sweat shirt and DA-B proceeded to walk away from R51. At 1:10 p.m. R51 again self transferred from the chair to stand next to the table. A walker was not present. The DON entered the dining area and witnessed R51 self transferring and requested a facility staff member to bring R51's walker to her.

During an interview on 7/16/14, at 1:19 p.m. the director of nursing (DON) confirmed R51 had been in the dining room seated in a stationary chair without an alarm in place, her walker had not been within reach. The DON confirmed it would not be appropriate to have R51 seated in a chair without any of these interventions in place. The DON also confirmed R51's walker should be within reach at all times to prompt her to use the walker if she were to attempt to self transfer.

During an interview on 7/17/14, at 2:18 p.m. licensed practical nurse (LPN)C confirmed R51 was at risk for falls. LPN-C confirmed R51 was unpredictable and could stand at any time, from any surface without warning. LPN-C stated R51 should have the personal safety alarm on if staff were not present with her and stated she understood R51 was to utilize a personal safety alarm when seated in a stationary chair.

Review of R51's incident reports from 5/1/14 to 7/12/14 revealed the following:

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F 323	Continued From page 18 -5/1/14 at 3:45 p.m., unwitnessed fall to floor in living room, had self transferred from the recliner -5/15/14 at 10:10 p.m., unwitnessed fall in room, found on floor, scooting towards the outside door -5/18/14 at 6:40 a.m., unwitnessed fall in room, found laying on her back on the floor -5/21/14 at 3:16 a.m., unwitnessed fall in hallway, found on floor sitting on her buttocks -5/26/14 at 12:30 p.m., unwitnessed fall, found sitting on the floor in the doorway to her room -6/4/14 at 12:06 a.m., unwitnessed fall, found sitting in front of recliner in day room -6/6/14 at 6:25 a.m., unwitnessed fall, found sitting on floor in hallway by her door -6/12/14 at 9:00 a.m., unwitnessed fall, found siting on floor of her room -6/20/14 at 1:00 a.m., unwitnessed fall, found sitting on floor in front of doorway -7/10/14 at 7:15 p.m., unwitnessed by facility staff, fall from recliner in day room -7/12/14 at 11:45 a.m., unwitnessed fall, found seated on floor in dining room Review of R51's Falls Data Collection Tool form from 1/14/14 to 5/16/14 and Fall Risk Evaluation forms from 5/21/14 to 7/16/14 revealed R51 continued to be identified at high risk for further falls. During an interview on 7/17/14, at 1:41 p.m. the DON confirmed R51 had frequent falls in the recent past and continued to be at risk for further falls. She stated the usual practice was to assess each resident for risk of falls on admission, annually and after each fall. She confirmed R51 frequently self transferred and confirmed R51's current care plan interventions to attempt to prevent further falls. The DON stated she would expect all staff to follow the fall prevention	F 323		

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interventions and confirmed she expected both the walker and wheelchair to be within reach for R51 at all times. She stated she "definitely" would expect both the walker and wheelchair to be within reach for R51 at all times since her cognition, and strength varied and R51 was difficult to predict which device she would use when she attempted to self transfer. She indicated R51 was severely confused, restless frequently and indicated R51's physical abilities varied frequently. She indicated R51 had been assessed for fall prevention in the past, however, after the most recent two falls the facility staff was unsure of what to do other than to deal with her immediate needs at the time of fall, such as to sit with her for a short time or offer her fluids.

The requested facility policy regarding fall prevention was not provided.

The provided facility form titled Personal Sentry Fall Monitoring System User Guide, under the heading How to Use the Personal Sentry Monitoring System, directed The length of the cord needs to be determined by how far you want the monitored person to be able to move before activating the alarm.

R15 was not assessed for safe use of the bench seat of a four-wheeled walker for mobility in the facility.
The care plan (CP) revised on 5/13/14, identified resident (R15) had diagnoses which included Hemiplegia affecting side, anxiety, and diabetes. The CP identified R15 had impaired cognitive function/dementia and required assistance from staff to complete all activities of daily living (ADL). Furthermore the CP identified R15 was potential

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risk for falls related to altered mental status, cerebral vascular accident and history of falls with impulsivity and various interventions which included to use a walker for mobility and a wheel chair for locomotion.
During observation on 7/14/14 at 11:57 a.m. R15 was in the middle of the hallway sitting on the bench of a black and red four-wheeled walker. While R15 is sitting on the bench of the four-wheeled walker, he was propelling himself with his feet in a walking motion to go forward down the hallway towards his room. The physical therapist (PT) walking on the right side of him was giving him verbal encouragement to keep going. While R15 was transporting himself back to his room he would stop occasionally and the PT would grab the handle of the four-wheeled walker with her left hand and pull R15 forward to get him to continue peddling his feet in a forward motion. After R15 peddled his feet approximately 40 feet down the hallway back to his room while sitting on the bench of his four-wheeled walker, the PT locked the brakes on the walker and assisted R15 to transfer from the bench of the walker to his wheel chair.
Review of occupational therapy notes dated 7/8/14 indicated R15's goal for wheelchair mobility was to efficiently propel wheelchair 100 feet using lower extremities with no assistance to increase independence in environment. R15's current level of function was efficiently propel wheelchair 30 feet using lower extremities, requiring verbal cues at times to put weight thru his lower extremities to the chair.
During an interview on 7/14/14 at 12:05 p.m., PT confirmed she had used the four-wheeled walker as a wheelchair to transport R15 back to his room and stated, "This is not what we want staff to do." PT stated that wheelchair mobility was part of

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F 323	Continued From page 21 R15's therapy program, so he could be safe with transfers and ambulation. During an interview on 7/14/14 at 12:22 p.m. registered nurse (RN)-C confirmed the PT was transporting R15 down the hallway while sitting on the bench of his four-wheeled walker propelling himself with his feet and stated " I have not seen him do this before today. " During an interview on 7/16/14 at 12:21 p.m. director of nursing (DON) confirmed that a four-wheeled walker should not be used as a device to transport residents and stated, "This is not even safe for him you're just asking for trouble." During an interview on 7/16/14 at 1:13 p.m. RN-B confirmed that a four-wheeled walker should not be used to transport resident on and stated,"It is unsafe and the walker should not be used in this manner." During an interview on 7/16/14 at 1:56 p.m. occupational therapist (OT) confirmed that a four-wheeled walker should not be used to transport residents and the PT should have got the wheelchair if it was part R15's therapy. Furthermore the OT stated, "This is not the intended use, they are to sit on and to rest." A policy was requested and none obtained from the facility. A Carex brand information sheet for rolling Walkers, undated, identified a roller walker as"...a light weight frame that is used to provide walking support, with the added advantages of swivel front wheels and seat." The information sheet also indicated "...before using the seat, activate the parking brake by pushing down on the handbrake." The instructions listed directions for utilizing the walker as a walking device, however lacked direction for safely using the four-wheeled walker as a temporary wheelchair.	F 323		

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F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the daily nurse staffing information was posted at the beginning of each shift, and failed to include the total hours	F 356	A. Daily staffing is posted at the beginning of the shift and all columns are filled in to include total hours worked. B. All residents in this facility, as well as	8/26/14

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F 356	Continued From page 23 worked by each category of nursing staff. This had the potential to affect all 54 current residents, as well as any family or visitors who may choose to view this information. Findings include: During the initial tour on 7/14/14, at 11:35 a.m. the required posting of nurse staffing information was observed on the front desk in an acrylic stand. The posting dated 7/14/14 did not include the total hours worked for the night shift, and was completely blank for the day shift which had started at 6:00 a.m. on 7/14/14. At 2:30 p.m. the day shift information was documented, and at 5:40 p.m. the evening shift had been filled in. On 7/15/14, at 8:07 a.m. the posting included the information for the night and day shift, but lacked the total hours worked. At 4:20 p.m. the evening shift was completely blank. On 7/16/14, again the nurse staffing information failed to include the total hours worked. Reviewed the past 33 days of the Daily Nursing Staffing information postings, which indicated 31 postings lacked the total hours worked, and 4 postings lacked complete shift information. During interview on 7/16/14, at 11:33 a.m. the director of nursing (DON) stated each nurse is expected to fill out the required information on the posting at the beginning of each shift, as soon as the nurse gets a chance to do it. The DON then stated the assistant director of nursing and other nurses will also review it to ensure all of the columns are filled out. The DON confirmed the information is to be posted at the beginning of each shift and the total hours worked should be documented. The facility policy titled Nursing Staff Daily Posting Requirements dated September 2012, specified the total number of actual hours worked and other required information is to be posted at the	F 356	their families and any visitors have the potential of being affected by this deficient practice. C. Nursing education provided on 7/23/14, 8/4/14, and 8/5/14 regarding daily nursing staffing policy. Nurses reminded of the importance of filling out form GSS #160 in its entirety so accurate information is relayed to residents and families as to daily staffing. Nurses instructed to complete this task ASAP at the beginning of the shift. D. DNS has been completing daily audits since exit survey; DNS and designees will conduct weekly audits x4 to ensure this policy is being followed to standard. Results will be discussed and reviewed at QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	07/17/2014

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F 356	Continued From page 24 beginning of each shift.	F 356		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		8/26/14

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F 441	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide proper infection control practices during wound care to prevent the spread of infection for 1 of 1 resident (R53) noted to have Methicillin resistant staphylococcus aureus (MRSA). In addition, the facility failed to ensure proper infection control practices were implemented during the handling of soiled linen for 1 of 2 resident's (R4) observed while providing personal cares. This deficient practice had the potential to affect all 18 residents residing on the cottonwood unit in the facility. Findings Include: During observation on 7/14/14, at approximately 7:15 p.m. R53 was in the bedroom sitting in a recliner with both legs extended outward on the foot rest of the recliner located at the foot end of R53 bed. The license practical nurse (LPN)- A went into the bathroom and wet and soaped a clean white wash cloth. LPN-A came out of the bathroom with gloves on both hands with the washcloth and pulled up R53 shirt. LPN- A removed the dressing from R53's gastrostomy tube, checked the dressing for drainage and placed the soiled dressing in the garbage can. LPN-A cleansed the area around the gastrostomy tube and placed the washcloth at the foot end of the bed on the multi colored printed bedspread. LPN-A took the clean towel and dried the area around the gastronomy site and rolled the soiled washcloth inside the towel and placed it back on the bedspread towards the foot end of the bed.	F 441	A. Resident #53 has been discharged; no other residents with MRSA in this facility. Staff education regarding proper infection control procedures r/t dressing changes for those with MRSA as well as safe linen handling provided to RNs, LPNs, and TMAs on 7/23/14, 8/4/14,8/5/14 and CNAs on 8/6/14. B. All residents in this facility are at risk of being affected by this deficient practice. C. Proper infection control practices are being performed with all wound care. Linen is bagged upon leaving a resident's room and is not placed on the floor, furniture, or lifts. Moisture resistant bins are used to house soiled linen. D. Random observation audits will be done weekly x4 and monthly x3 by Staff Developement and Infection Control Coordinator to assess staff members understanding of infection control practices and correct linen handling during and after cares to ensure corrected deficient practices. Report of random audits will be brought to QA meetings for analysis.	

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F 441	Continued From page 26	F 441		

LPN-A applied a white dressing to the area around the gastrostomy tube site. LPN-A went into the bathroom, removed the gloves and washed hands. LPN-A picked up the soiled towel and wash cloth and went into the hallway to deposit the soiled linen to the soiled utility room.

On 7/14/14, at approximately 7:30 p.m. LPN-A verified the soiled wash cloth and towel on the bed should have been placed in a garbage bag and carried with a garbage bag.

On 7/17, at 1:42 p.m. registered nurse (RN) A said linen needs to be bagged when carried out of a resident's room. RN-A said if a wash cloth and towel was used to clean a site that had MRSA in it, it would need to be in a garbage bag and taken to the laundry. RN-A said the laundry treats everything as if it was infected. RN-A verified resident R53 had MRSA, and the site cleaned with a wash cloth and towel, laid on the bed and then taken out in the hall not contained was not appropriate.

Review of laboratory document with a release date of 7/10/14 indicated R53's gastrostomy site had a heavy growth of Methicillin resistant staphylococcus aureus.

Review of the policy titled, Multidrug-Resistant Organisms (MRSA,VRE,CRE and ESBL) with a revised date of 4/13 indicated soiled laundry should be placed directly in a moisture resistant container and not on room surfaces or the floor.

During observation on 7/16/14 at 7:03 a.m. upon entering R4's room a pair of brown dress slacks, 2 socks and a blue and white night gown were noted to be laying in the middle of the carpeted

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F 441	Continued From page 27	F 441		

floor in R4's room. The trained medical assistant (TMA)-A was assisting R4 in the bathroom. R4 was hooked up to a mechanical standing lift and was sitting on the toilet with her pants pulled down to the knees. TMA-A continued to assist R4 with direct cares until R4 stated she was done at 7:06 a.m.

At 7:10 a.m. TMA-A was wearing gloves on both hands when R4 was assisted out of the bathroom via mechanical standing lift. R4 was seated in the wheelchair and released from the lift. At 7:12 a.m. TMA-A went into the bathroom to collect the trash, came back out to pick up the soiled linen from the floor and draped the soiled linen and trash bag over the knee rest of the mechanical standing lift. TMA-A removed her gloves, washed her hands and set up R4 for oral cares. AT 7:19 a.m. TMA-A grabbed the trash off the mechanical standing lift with her right hand and grabbed the the bars of the mechanical standing lift with both hands and pulled the lift into the hallway with soiled linen draping over the knee rest of the mechanical standing lift. TMA-A took the soiled linen and trash into the dirty utility room and placed then in the proper bins. TMA-A washed her hands, came out and left the mechanical standing lift in the bathing room without sanitizing the lift.

During interview on 7/17/14 at 1:25 p.m. LPN-C confirmed soiled linen should not be left on the floor and it should be transported away from your body while wearing gloves. LPN-C stated, "This is not good infection control practice and dirty clothes is what causes cross contamination."

During interview on 7/17/14 at 3:32 p.m. director of nursing (DON) confirmed this is not the proper

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F 441	Continued From page 28 way to handle soiled linen and stated, "I always tell them to bag it and not to carry it next to their clothing." Furthermore the DON verified this is not good infection control practice and linen should not be handled this way. Review of the facility policy titled Soiled Laundry and Linen Pickup, revised on 11/2006, indicated resident clothing must be placed into a plastic bag and put into a soiled -laundry hamper designated for resident clothing.	F 441		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Good Samaritan Society Battle Lake, 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/07/2014

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was surveyed as two buildings. The Good Samaritan Society Battle Lake is a 1-story building, without a basement. The original building was built in 1973 and was determined to be Type II(000) construction. In 1994 additions to the south of the west wing and to the north of the north wing (Occupational and Physical Therapy - OT/PT) were constructed. The 1994 additions were determined to be Type V(111) construction. In 2004 a small vestibule was added to the west wing which included a walk in freezer, which is Type II (000) construction. In 2007 a connecting link, to the new assisted living apartments, was added to the south wing and was determined to be Type V (111). In 2010 an entrance addition was constructed to the north of the dining room which is 1-story, no basement and Type II (000) construction. In 2011 a 16 bed addition was added to the east of the north wing and was determined to be Type II (111) and a 8 bed addition was added to the east of the south east wing and was determined to be Type II (111)	K 000		

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K 000	Continued From page 2 construction. The building is divided into 3 smoke compartments by 30 minute rated fire barriers. The entire building is sprinkler protected with a system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). A fire alarm system with corridor smoke detection and smoke detection in common areas which was updated in 2010 in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition), that is monitored for automatic fire department notification. Additional automatic fire detection is provided in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 55 beds with a census of 54 residents at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		8/8/14

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K 029	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. The following deficient practice could negatively affect the residents, staff, and visitors as smoke and fire in this rooms could enter the corridor making it untenable. Findings include: On facility tour between 10:00 AM to 1:00 PM on 07/15/2014, observation revealed the following deficient conditions found to affecting 1 of several hazardous areas located throughout the facility: 1. The was a ceiling tile missing over the hot water heater that is located in the mechanical room 318, and 2. the door to the mechanical room 318 did not fully close and properly latch into the frame. This deficient practice was verified by the Facility Administrator (JW).	K 029	Facility maintenance staff has re-installed the missing ceiling tile in mechanical room 318. Facility maintenance staff has adjusted the mechanical room door #318 so that it now latches properly in the frame. These corrections were completed on August 8, 2014 by Carl Stromstedt, maintenance director. Compliance will be provided by random monitoring by Carl Stromstedt, Director of Maintenance.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 056		9/3/14

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K 056	Continued From page 4 Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 10:00 AM to 1:00 PM on 07/15/2014, observations reveled that the spare sprinkler head box located next to the main sprinkler riser assemble was not equipped with at least 2 of every type and style of sprinkler heads that are being used in the facility. The observed missing spare sprinkler heads were the side wall sprinkler heads located in the Northwest Service entry, and the sprinkler heads that are located in the mechanical room located in the Cottonwood neighborhood.	K 056	Facility maintenance director has ordered spare sprinkler heads on 8/5/14 so that two of every type of head currently installed in the building will be on hand as spares. The heads ordered were of the type used in the "side-wall" sprinkler located in the Northwest Service entry and sprinkler heads installed in the mechanical room located in the Cottonwood Neighborhood. The spare sprinkler heads will be on location in the nursing home by 9/3/14. Compliance will be provided by random monitoring by Carl Stromstedt, Director of Maintenace.	

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K 056	Continued From page 5 This deficient practice was verified by the Facility Administrator (JW).	K 056		

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	245403	A. BUILDING **02 - 2007 CONNECTING LINK** B. WING _____	**07/15/2014**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **02 - 2007 CONNECTING LINK** B. WING _____	**07/15/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was surveyed as two buildings. The Good Samaritan Society Battle Lake is a 1-story building, without a basement. The original building was built in 1973 and was determined to be Type II(000) construction. In 1994 additions to the south of the west wing and to the north of the north wing (Occupational and Physical Therapy - OT/PT) were constructed. The 1994 additions were determined to be Type V(111) construction. In 2004 a small vestibule was added to the west wing which included a walk in freezer, which is Type II (000) construction. In 2007 a connecting link, to the new assisted living apartments, was added to the south wing and was determined to be Type V (111). In 2010 an entrance addition was constructed to the north of the dining room which is 1-story, no basement and Type II (000) construction. In 2011 a 16 bed addition was added to the east of the north wing and was determined to be Type II (111) and a 8 bed addition was added to the east of the south east	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **02 - 2007 CONNECTING LINK** B. WING _____	**07/15/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 wing and was determined to be Type II (111) construction. The building is divided into 3 smoke compartments by 30 minute rated fire barriers. The entire building is sprinkler protected with a system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). A fire alarm system with corridor smoke detection and smoke detection in common areas which was updated in 2010 in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition), that is monitored for automatic fire department notification. Additional automatic fire detection is provided in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 55 beds with a census of 54 residents at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.	K 056		9/3/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **02 - 2007 CONNECTING LINK** B. WING _____	**07/15/2014**

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

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K 056	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 10:00 AM to 1:00 PM on 07/15/2014, observations reveled that the spare sprinkler head box located next to the main sprinkler riser assemble was not equipped with at least 2 of every type and style of sprinkler heads that are being used in the facility. The observed missing spare sprinkler heads were the sprinkler heads that are located in the kitchen's walk in cooler and walk in freezer, This deficient practice was verified by the Facility Administrator (JW).	K 056	Facility maintenance director has ordered spare sprinkler heads on 8/5/14 so that two of every type of head currently installed in the building will be on hand as spares. The heads ordered were of the type used in the "side-wall" sprinkler located in the Northwest Service entry and the sprinkler heads installed in the mechanical room located in the Cottonwood Neighborhood. The spare sprinkler heads will be on location in the nursing home by 9/3/14. Compliance will be provided by random monitoring by Carl Stromstedt, Director of Maintenance.	